FAMILY & HUMAN SERVICES COMMITTEE

November 23, 2020
9:00 A.M.
Virtual Meeting

The Public may observe and participate in the virtual Zoom meeting by using this link:
https://cccounty-us.zoom.us/j/88347701961

OR
Calling in using this phone number and Meeting ID code:
1-888-278-0254
Meeting ID: 786066

Supervisor John Gioia, Chair
Supervisor Candace Andersen, Vice Chair

Agenda Items:	Items may be taken out of order based on the business of the day and preference of the Committee

1. Introductions

2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).

3. RECEIVE and APPROVE the draft Record of Action for the Special Meeting of the Family & Human Services Committee Meeting on October 29, 2020.

4. CONSIDER making recommendations to the Board of Supervisors on the following advisory body appointments, re-appointments or vacancies:

   a. CONSIDER recommending to the Board of Supervisors the appointment to the Council for Homelessness, for two year terms, of:
      - Iman Novin of Walnut Creek to the Affordable Housing Developer seat;
      - Margaret Schlitz of Richmond to the Behavioral Health seat;
      - Teri House of Antioch to the City Government seat;
      - Jo Bruno of Antioch to the Consumer seat;
      - Alejandra Chamberlain of Pleasant Hill to the Education Vocational Training seat;
      - Gabriel Lemus of Martinez to the Emergency Solutions Grant seat:
      - Linea Altman of Concord to the Healthcare Provider seat;
      - Deanna Pearn of Pleasant Hill to the Homeless Service Provider seat;
      - Manjit Sappal of Martinez to the Public Safety #1 seat;
      - Misaki Hiriyama of Martinez to the Veteran Administration seat;

- Maureen Nelson to the Workforce Development seat; and
- Renee Hendrick of Crockett to the Youth representative seat.

(Jaime Jennett, Homeless Continuum of Care Planning and Policy Manager)

b. RECOMMEND to the Board of Supervisors the appointment of Penny Reed to Member At-Large Seat #1 on the Contra Costa Advisory Council on Aging (ACOA) for a term expiring on September 30, 2022., as recommended by the Council. *(Anthony Macias, Employment and Human Services Department)*

c. RECOMMEND to the Board of Supervisors the appointment of Ben Miyaji to the At-Large 2 seat on the Arts and Culture Commission of Contra Costa County to a term expiring June 30, 2023, as recommended by the Commission.

d. RECOMMEND to the Board of Supervisors the appointment of David Leimsieder to At-Large 3 seat expiring on September 30, 2021 and Jennifer Early to At-Large 5 seat expiring on September 30, 2022 on the Family and Children's Trust Committee, as recommended by the Employment and Human Services Department.

e. RECOMMEND to the Board of Supervisors the appointment of DeVonn Powers to Flex Seat #2 of the local Workforce Development Board (WDB) for a term that expires on June 30, 2024 as recommended by the WDB Board.

f. RECOMMEND to the Board of Supervisors the appointments of Stacey Norman to the vacant Community Representative - Central/South 2 seat and Liliana Gonzalez to the vacant Public Agency - Central/South 2 seat on the Local Planning and Advisory Council for Early Care and Education, as recommended by the County Office of Education.

5. CONSIDER accepting and submitting for approval by the Board of Supervisors modifications to the IHSS Public Authority Registry Policies and Procedures. *(Elizabeth Dondi, Executive Director, IHSS Public Authority)*

6. CONSIDER accepting and submitting for approval to the Board of Supervisors modifications to the Advisory Council on Aging Bylaws.*(Anthony Macias, Employment and Human Services Department)*

7. CONSIDER accepting report by the Health Care for the Homeless Program on the health status of the homeless population in Contra Costa County, forward this report to the Board of Supervisors and return quarterly for progress reports. *(Lavonna Martin, Director, Health, Housing and Homeless Services)*

8. CONSIDER accepting the updated Mental Health Services Act Three Year Plan, REFER to the Board of Supervisors for consideration. *(Suzanne Tavano, PH.D., Behavioral Health Director; Jennifer Bruggeman, MHSA Program Manager)*

9. ACCEPT the attached report on the Employment and Human Services Department's Innovative Community Partnerships. *(Devorah Levine, Employment and Human Services Department)*

10. The next meeting is to be determined, likely in early 2021.

11. Adjourn

The Family & Human Services Committee will provide reasonable accommodations for persons with disabilities planning to attend Family & Human Services Committee meetings. Contact the staff person listed below at least 72 hours before the meeting.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Family & Human Services Committee less than 96 hours prior to that meeting are available for public inspection at 1025 Escobar Street, 4th floor, Martinez during normal business hours.

Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact:

Dennis Bozanich, Committee Staff
Phone (925) 655-2050, Fax (925) 655-2066
Dennis.Bozanich@cao.cccounty.us

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **3.**

Meeting Date:	11/23/2020
Subject:	RECORD OF ACTION FOR THE PREVIOUS FHS MEETING
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	NA
Referral Name:	NA
Presenter:	Dennis Bozanich
Contact:	Dennis Bozanich; 925-655-2050

Referral History:

County Ordinance requires that each County body keep a record of its meetings. Though the record need not be verbatim, it must accurately reflect the agenda and the decisions made in the meeting.

Referral Update:

Attached is the draft Record of Action for the Special Meeting of the Family & Human Services Committee Meeting on October 29, 2020.

Recommendation(s)/Next Step(s):

RECEIVE and APPROVE the draft Record of Action for the Special Meeting of the Family & Human Services Committee Meeting of October 29, 2020.

Fiscal Impact (if any):

None

Attachments

DRAFT Record of Action - 10/29/2020

D R A F T

FAMILY AND HUMAN SERVICES COMMITTEE

RECORD OF ACTION FOR
October 29, 2020

Supervisor John Gioia, Chair
Supervisor Candace Andersen, Vice Chair

Present: John Gioia, Chair
Candace Andersen, Vice Chair

1. Introductions

   Meeting was called to order at 1:00P.M.

2. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to three minutes).

   No public comment.

3. RECEIVE and APPROVE the draft Record of Action for the September 28, 2020 Family & Human Services Committee Meeting.

   No public comment. Record of Action was approved.

   AYE: Chair John Gioia
   Vice Chair Candace Andersen

4. CONSIDER each of the following advisory board appointments, re-appointments or vacancy declarations for possible recommendation to the Board of Supervisors.

   a. RECOMMEND to the Board of Supervisors the appointment to the Council on Homelessness, for two year terms, of:
      - Iman Novin of Walnut Creek to the Affordable Housing Developer seat;
      - Margaret Schlitz of Richmond to the Behavioral Health seat;
      - Teri House of Antioch to the City Government seat;
      - Jo Bruno of Antioch to the Consumer seat;
      - Alejandra Chamberlain of Pleasant Hill to the Education Vocational

Training seat;

- Gabriel Lemus of Martinez to the Emergency Solutions Grant seat:
- Linea Altman of Concord to the Healthcare Provider seat;
- Deanna Pearn of Pleasant Hill to the Homeless Service Provider seat;
- Manjit Sappal of Martinez to the Public Safety #1 seat;
- Misaki Hiriyama of Martinez to the Veteran Administration seat;
- Maureen Nelson to the Workforce Development seat; and
- Renee Hendrick of Crockett to the Youth representative seat.

No public comment. Motion was made to continue this item until the meeting on November 23, 2020 due to incomplete applications provided in the agenda package. Motion to continue was approved.

AYE: Chair John Gioia
Vice Chair Candace Andersen

5. ACCEPT the annual report from the Public Health Division of the Health Services Department on the implementation of the Secondhand Smoke Protections Ordinance and DIRECT public health staff to forward the report to the Board of Supervisors for their information.

DIRECT staff from the Public Health Division to study the impacts of second-hand smoke exposure in close-proximity housing, such as mobile home parks, and return to the Committee with recommendation for enhanced protections within 6 months.

No public comment. Committee moved acceptance of the report and directed staff to bring an amendment to the existing ordinance to include restrictions at mobile home parks.

AYE: Chair John Gioia
Vice Chair Candace Andersen

6. ACCEPT report on the on the implementation of the tobacco retailer licensing and businesses zoning ordinances and return next year with an update.

DIRECT staff to track efforts by the tobacco industry to reverse the protections provided in SB 793, and to keep the Committee informed.

No public comment. Committee moved acceptance of the report and directed staff to track efforts by the tobacco industry to reverse statutory restrictions and keep the committee informed.

AYE: Chair John Gioia
Vice Chair Candace Andersen

7. ACCEPT this report from the Employment and Human Services Department on youth services and the Independent Living Skills Program (ILSP); and continue to support the Children and Family Services Bureau and its efforts to serve foster youth in the ILSP program.

No public comment. Committee moved acceptance of the report.

AYE: Chair John Gioia
Vice Chair Candace Andersen

8. ACCEPT the report from the Employment and Human Services Department on the foster care Continuum of Care Reform implementation efforts and other challenges for the department including those caused by the COVID pandemic.

One public speaker. Committee moved acceptance of the report. Committee requested further discussion on EHSD data collection and utilization efforts as well as the department's work from home strategies.

AYE: Chair John Gioia
Vice Chair Candace Andersen

9. The next meeting of the Family and Human Services Committee is scheduled to be held virtually on November 23, 2020 at 9:00 AM.

10. Adjourn

Meeting was adjourned at 2:21 P.M.

AYE: Chair John Gioia
Vice Chair Candace Andersen

For Additional Information Contact:

Dennis Bozanich, Committee Staff
Phone (925) 335-1037, Fax (925) 646-1353
Dennis.Bozanich@cao.cccounty.us

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4.**

Meeting Date: 11/23/2020

Subject: CONSIDER recommendations to the Board on the following advisory body appointments, re-appointments or vacancies

Department: County Administrator

Referral No.: NA

Referral Name: Advisory Body Appointments

Presenter: Dennis Bozanich **Contact:** Dennis Bozanich; 925-655-2050

Referral History:

On December 6, 2011 the Board of Supervisors adopted Resolution No. 2011/497 adopting policy governing appointments to boards, committees, and commissions that are advisory to the Board of Supervisors. Included in this resolution was a requirement that applications for at-large/countywide seats be reviewed by a Board of Supervisors committee.

Referral Update:

Recommendation(s)/Next Step(s):

CONSIDER each of the following advisory board appointments, re-appointments or vacancy declarations for possible recommendation to the Board of Supervisors.

Fiscal Impact (if any):

NA

Attachments

No file(s) attached.

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. a.**

Meeting Date: 11/23/2020

Subject: RECOMMENDATION FOR APPOINTMENTS TO THE COUNCIL ON HOMELESSNESS

Submitted For: David Twa, County Administrator

Department: County Administrator

Referral No.: NA

Referral Name: Advisory Body Recruitment

Presenter: Jaime Jenett, Continuum of Care Planning and Policy Manager **Contact:** Jaime Jenett (925) 608-6700

Referral History:

On December 6, 2011 the Board of Supervisors adopted Resolution No. 2011/497 adopting policy governing appointments to boards, committees, and commissions that are advisory to the Board of Supervisors. Included in this resolution was a requirement that applications for at-large/countywide seats be reviewed by a Board of Supervisors committee. Review of appointments to Countywide and At-Large seats on the Council on Homelessness are assigned to the FHS Committee.

Referral Update:

This item was continued from the Special Meeting on October 29, 2020 due to a production error in the application documents. Those application documents were reproduced by staff and are attached for the committee and public's review.

Please see the attached memo from the Council on Homelessness, which details their request to fill the 12 vacancies on the 17-member council. All applications that were considered are also attached for the Committee's review.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointment to the Council on Homelessness, for two year terms, of:

- Iman Novin of Walnut Creek to the Affordable Housing Developer seat;
- Margaret Schlitz of Richmond to the Behavioral Health seat;
- Teri House of Antioch to the City Government seat;
- Jo Bruno of Antioch to the Consumer seat;
- Alejandra Chamberlain of Pleasant Hill to the Education Vocational Training seat;
- Gabriel Lemus of Martinez to the Emergency Solutions Grant seat:
- Linea Altman of Concord to the Healthcare Provider seat;

- Deanna Pearn of Pleasant Hill to the Homeless Service Provider seat;
- Manjit Sappal of Martinez to the Public Safety #1 seat;
- Misaki Hiriyama of Martinez to the Veteran Administration seat;
- Maureen Nelson to the Workforce Development seat; and
- Renee Hendrick of Crockett to the Youth representative seat.

Fiscal Impact (if any):

NA

Attachments

Appointment Memo For Council on Homelessness - October 2020

Proposed 2021 Roster

Application - Altman

Application - Bruno

Application - Chamberlain

Application - Hendrick

Application - Hiriyama

Application - House

Application - Lemus

Application - Nelson

Application - Novin

Application - Pearn

Application - Sappal

Application - Schlitz

ANNA ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR
LAVONNA MARTIN, MPH, MPA
HEALTH, HOUSING AND HOMELESS SERVICES DIRECTOR

CONTRA COSTA
HEALTH SERVICES

Contra Costa
Health, Housing and
Homeless Services
ADMINISTRATION
2400 Bisso Lane, Suite, D 2nd Floor
Concord, California
94520-4832
Ph 925-608-6700
Fax 925-608-6741

Date: October 7, 2020
To: Family and Human Services Committee
Supervisor John Gioia, District I, Chair
Supervisor Candace Anderson, District II, Co-Chair
From: Lavonna Martin, Director, Health, Housing and Homeless Services Division
CC: Anna Roth, RN, MS, MPH Health Services Director
Subject: Council on Homelessness Seat Membership Recommendation Process

The Director of Health, Housing and Homeless Services, Lavonna Martin, respectfully requests that the Family and Human Services Committee accepts the recommendation to appoint twelve (12) individuals for open seats on the Contra Costa Council on Homelessness (aka the Homelessness Advisory Board).

PURPOSE OF COUNCIL ON HOMELESSNESS

The Contra Costa Continuum of Care is governed by the Contra Costa Council on Homelessness (hereinafter referred to as the Council). The Council is appointed by the Contra Costa County Board of Supervisors to assist and provide guidance in the development and implementation of long-range planning and policy formulation of homeless issues in Contra Costa County.

The Contra Costa Council on Homelessness is responsible for making data driven, equitable decisions related to federal, state, and local regulations and funding guiding the administration of homelessness crisis response in the County. The Council also provides a forum for communication and coordination of the County's Strategic Plan to End Homelessness and to educate the community on federal, state and local policy issues affecting people who are homeless or at-risk of homelessness in Contra Costa County.

Governance

The Council on Homelessness is appointed by the Board of Supervisors and consists of 19 seats representing homeless or formerly homeless persons, community members, educational/vocational services, health care, housing providers, law enforcement, local government, the faith community, and homeless service providers including the Veterans Administration. All Council members reside in or are employed in Contra Costa County, demonstrate a professional interest in or personal commitment to addressing and alleviating the impact of homelessness, and be able to contribute unique expertise, opinions and viewpoints on homeless issues. Candidates will serve two-year terms.

SUMMARY OF RECRUITMENT EFFORTS/NOMINEES FOR MEMERSHIP

The Council on Homelessness continues to make every effort to fill its vacant seats. These efforts include sending a targeted email solicitation via the Continuum of Care mailing list (1000+ contacts that include each Supervisor's office), announcing vacancies at public Council on Homelessness meetings and posting information about the vacancies and application materials on the Council on Homelessness website.

A nominating committee consisting of three (3) seated nonconflicted Council on Homelessness members reviewed applications and supplemental information including a supplemental application for all seats. The committee used a rubric to evaluate the applicants that included capacity to meet the functions and tasks of the Council on Homelessness as stated in the Council's bylaws and evaluating the diversity of current and potential Council members to ensure that a diverse population contributes to deliberations and decision-making—including consumers and community members—as well as gender, ethnic, cultural, and geographical representation.

Following a close review of applications and interviews with the candidates by a nominating committee, the Council on Homelessness recommends appointing the following twelve (12) nominees:

1. *Affordable Housing Developer Representative*
   Iman Novin
   Consultant
   Novin Development Consulting
   Walnut Creek, CA

2. *Behavioral Health Representative*
   Margaret Schlitz
   Program Manager
   Portia Bell Hume Center's West County FSP program
   Richmond, CA

3. *City Government Representative*
   Teri House
   CDBG Manager
   City of Antioch
   Antioch, CA

4. *Consumer Representative*
   Jo Bruno
   Consumer
   Antioch, CA

5. *Educational/Vocational Representative*
   Alejandra Chamberlain
   Homeless Liaison
   Contra Costa County Office of Education
   Pleasant Hill, CA

6. *Emergency Solutions Grant (ESG) Representative*
   Gabriel Lemus
   Administrator, Community Development Block Grant Program and Emergency Solutions Grant Program
   Contra Costa Department of Conservation and Development
   Martinez, CA

7. *Healthcare Provider Representative*
   Linea Altman
   Public Health Program Specialist II
   Contra Costa Community Connect and Healthcare for the Homeless
   Concord, CA

8. *Homeless Service Provider Representative*
   Deanne Pearn
   Executive Director
   Hope Solutions
   Pleasant Hill, CA

9. *Public Safety #1 Representative*
   Manjit Sappal
   Chief of Police
   City of Martinez
   Martinez

10. *Veteran Administration*
    Misaki Hiriyama
    Coordinated Entry Specialist
    Northern California VA Healthcare System
    Martinez, CA

11. *Workforce Development Representative*
    Maureen Nelson
    Administrator
    One Stop Consortium

12. *Youth Representative*
    Renee Hendrick
    Youth Action Council Member
    Crockett, CA

The candidates have expressed a sincere interest in serving on the Council and are dedicated to fulfilling the mission and goals as outlines in the Council on Homelessness by-laws.

Based on the above information, the Director of Health, Housing and Homeless Services Division, on behalf of the Council on Homelessness respectfully recommends that the FHS Committee appoint the above listed people to the Council on Homelessness.

Encl:
Current Roster of Members as of 12/31/20
Full roster of applicants to open seats

ANNA ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR
LAVONNA MARTIN, MPH, MPA
HEALTH, HOUSING AND HOMLESS SERVICES DIRECTOR

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA HEALTH, HOUSING AND HOMELESS SERVICES
ADMINISTRATION
2400 Bisso Lane, D2
Concord, Califomia
94520
PH (925) 608-6700
FAX (925) 608-6741

Proposed Council on Homelessness Roster 2021

The Contra Costa Council on Homelessness (Council on Homelessness) is appointed by the Contra Costa County Board of Supervisors to assist and provide guidance in the development and implementation of long range planning and policy formulation that addresses homeless issues in Contra Costa County. The Council on Homelessness provides a forum for communication and coordination of the County's Strategic Plan to End Homelessness; educate the community on homeless issues, allocate federal HUD Homeless Assistance funding to providers, and advocate on federal, state and local policy issues affecting people who are homeless or at-risk of homelessness. Council on Homelessness members are appointed and serve two year terms.

	Seat Name	Appointee	Affiliation	City of Residence	Supervisorial District
1.	Affordable Housing Developer	Iman Novin	Novin Development Consulting	Walnut Creek	IV
2.	Behavioral Health Representative	Margaret Schlitz	Portia Bell Hume Center's West County FSP Program	Richmond	I
3.	City Government Seat	Teri House	CDBG Consultant, City of Antioch	Pittsburg	V
4.	CoC/ESG Program Grantee	Leslie Gleason	Executive Director, Trinity Center	Oakland	N/A
5.	Community Member Seat	Lindy Lavender	Policy Director, East Bay Leadership Council	Pacheco	V
6.	Consumer/Consumer Advocate	Jo Bruno	Consumer	Antioch	III
7.	Education and Vocational Services Representative	Alejandra Chamberlain	Homeless Education Liaison, Contra Costa Office of Education	Pleasant Hill	IV
8.	Emergency Solutions Grants Representative	Gabriel Lemus	Contra Costa Department of Conservation and Development	Martinez	V
9.	Employment and Human Services (EHSD) Representative	Sherry Lynn Peralta	Program Director, Employment and Human Services Department	Hercules	I
10.	Faith Community Representative	Doug Leich	Multi-Faith ACTION Coalition	Danville	II
11.	Health Care Representative	Linae Altman	Healthcare for the Homeless	Concord	IV
12.	Homeless Service Provider	Deanne Pearn	Executive Director, Hope Solutions	Moraga	II
13.	Public Housing Authority	Tony Ucciferri	Special Assistant to the Executive Director, Housing Authority of County of Contra Costa	Concord	IV
14.	Public Safety Representative #2	Shawn Ray	Lieutenant, San Pablo Police Department	San Pablo	I
15.	Public Safety Representative #1	Manjit Sappal	Chief, Martinez Police Department	Martinez	V
16.	Reentry Services Representative	Patrice Guillory	Managing Director, Healthright 360	Antioch	III
17.	Veterans Administration Representative	Masaki Hirayama	Northern California VA Healthcare System	Oakland	N/A
18.	Workforce Development	Maureen Nelson	One Stop Consortium	?	N/A
19.	Youth Representative	Renee Hedrick	Youth Action Council member	Rodeo	V

10.5.20

Application Form

Profile

Linae (First Name) | M (Middle Initial) | Altman (Last Name)

Home Address | Suite or Apt

Concord (City) | State | Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

- [x] District 4

Education

Select the option that applies to your high school education *

- [x] High School Diploma

College/ University A

Name of College Attended

Cal Poly, San Luis Obispo

Degree Type / Course of Study / Major

BS

Degree Awarded?

- (•) Yes
- ( ) No

College/ University B

Name of College Attended

Touro University

Degree Type / Course of Study / Major

Master of Public Health

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Healthcare Representative

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

20+

Please explain why you would like to serve on this particular board, commitee, or commission.

I would like to serve as the Healthcare Representative on the Council on Homelessness Board to bring my public health knowledge and partnership to the board. I currently work with our CCHS Public Health Department managing homeless services, Health Care for the Homeless, CommunityConnect and homeless liaison for school-based clinics, public health nursing, AOD programs and the Health, housing and Homeless services. Since the beginning of our COVID response, I have been working very closely with the Health, Housing and Homeless Division on the new hoteling project and provide support to our service providers throughout the county. I have been working for the Contra Costa County for 8 years within the Public Health Department and have seen an amazing growth in collaboration and partnership between our county division and community partners. I look forward to assisting in this work and

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

2019 - Present CommunityConnect & Health Care for the Homeless, Public Health Program Specialist II - serve as the homeless liaison for public health clinic service programs. Provide direct supervision to 7 Homeless Services Specialist with CommunityConnect which work closely with H3, community partners and Health Care for the Homeless. Assist HCH Project Director with grant requirements and submission. Serve as the HCH program administrator for the HCH Co-Applicant Board. Serve as the program manager for coordination of health services for those experiencing homelessness throughout the county. Serve as the public health homeless services liaison with H3, Behavioral Health and city officials. In response to COVID-10 pandemic, I have been working on the Hoteling Project closely with H3 and our Incident Command Branch directors to provide shelter for those experiencing homelessness who are at risk for severe symptoms of COVID-19.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

◉ Yes ○ No

If Yes, please identify the nature of the relationship:

I am an full time employee of Contra Costa Health Services and work for a federally funded grant program within the Public Health Department.

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Linae Young

Education
Touro University, California
Master of Public Health, 2013
Major: Global/International Health
California Polytechnic State University (Cal Poly), San Luis Obispo
Bachelor of Science, June 2009
Major: Kinesiology

Contra Costa County Public Health Clinic Services, Concord, CA
Public Health Program Specialist I, Whole Person Care, CommunityConnect September 2017-Present

- Manage and supervise Homeless Service Specialists
- Lead, coordinate and maintain County division collaboration efforts
- Coordinate and attend meetings with County-wide programs and community based organizations
- Establish program priorities, goals and objectives
- Review, evaluate, implement and interpret program policies to insure compliance with State and Federal program mandates
- Lead and assist in pilot program planning and project development
- Lead program innovation projects
- Evaluate and review staff performance and productivity
- Provide reflective supervision for staff on a bi-monthly basis
- Develop workflows, processes and procedures for care coordination
- Lead staff recruitment, hiring and evaluating the work of program staff
- Interprets policies and procedures for program staff
- Monitor and evaluate program activities and budget
- Practice cultural competency differences of the County's diverse population

Contra Costa County Public Health Clinic Services, Concord, CA October 2016-Present
Planning and Policy Manager, Health Care for the Homeless

- Set goals and objectives and establish program priorities
- Reviews, evaluates, implements and interprets program policy to insure compliance with State and Federal program mandates
- Annually review, update, monitor and evaluate program activities and budget
- Review and prepare annual and quarterly reports to manager and Board for approval
- Identify urgent needs for program services and makes appropriate referrals
- Lead and coordinate program planning efforts
- Provide supervision, technical assistance and consultation to program staff
- Participate in recruitment, hiring and evaluating the work of program staff
- Represent the program at meetings with local, State and Federal program representatives
- Coordinate and attend meetings with County-wide programs and community organizations
- Write and review proposals for grant submissions and reports
- Develop and conduct community needs assessments and satisfaction surveys
- Conduct program evaluation and develop future recommendations
- Collect, analyze and report statistical data

- Plan and supervise educational outreach activities and develops program informational material
- Coordinate County-wide clinical and health education programs
- Organize and advise Federal program Governing Board in compliance with Federal requirements

Contra Costa County Public Health Clinic Services, Martinez, CA January 2016 – October 2016

Senior Health Education Specialist, Health Care for the Homeless

- Plan, conduct and evaluate health education and health prevention aspects of programs and recommends policies to protect and promote public health.
- Coordinate multiple program elements such as outreach efforts, health education and community awareness & involvement.
- Confer with and advise staff on strategies to integrate health education into the department's functions.
- Represent the department with various community organizations and citizen committees.
- Conduct needs assessments and prepares reports and recommendations on community health needs and services.
- Collect, analyze and report statistical data
- Develop health education curriculum based on needs assessment for Contra Costa County community members.
- Reduce barriers for homeless clients by offering affordable, accessible and quality health care in non-traditional settings.
- Educate the homeless population within the shelter environment on health education topics such as hypertension, diabetes management, wound care and much more.
- Organize and arrange for discussion groups on health problems.
- Evaluate reports on health education services and educational programs.
- Direct and coordinate relevant training activities as needed.
- Attends meetings and seminars and participates on various community committees.
- Maintains and distributes health educational material to the staff and the general public as appropriate.
- Prepare visual aids, display and outreach materials
- Publicize health programs and services through various media.
- Present health education material at the individual, group and community level.

Contra Costa County Public Health Clinic Services, Martinez, CA October 2013 – December 2015

Health Education Specialist, Public Health School-Based Clinics

- Assist administrators and supervisors in planning, conducting and evaluating health education and health prevention aspects for Contra Costa County Public Health Clinic Services.
- Confer with and advise staff on health education and preventive principles and the techniques of community organization.
- Review publications for education sustainability and curriculum development to promote health. Assist in community needs assessments.
- Develop health education curriculum based on needs assessment for community of Contra Costa County.
- Reduce barriers for adolescents by offering affordable, accessible and quality health care at the high schools.
- Manage Contra Costa County school-based health clinic flow and scheduling. Educate adolescents on anatomy, reproductive, mental and preventive health.

- Encourage and empower adolescents to take interest in their own health responsibilities.
- Manage the communications and relationships between Contra Costa County Public Health Clinic Services and local schools and community organizations.
- Evaluate and report on health education services and programs within the county.
- Develop, maintain and distribute health education material to the staff and members of the community.
- Develop and create visual aids and display materials to promote health services.
- Conduct research and needs assessment for colleague trainings and educational updates.
- Organize and arrange for discussion groups on health problems within the community.
- Present health education material at the individual, group and community level.
- Provide excellent customer service to all clients, colleagues, and community partners.

Capstone Paper, Touro University, Vallejo, CA February –May 2013
Knowledge of Mother-to-Child Transmission of HIV/AIDS in Ethiopia
American Public Health Association National Conference Abstract Accepted 2013
Author

- Background research, secondary data collection, regional sample selection, ordinal data analysis (Descriptive, Bivariate and Multivariate Analysis – Ordinal Multiple Logistic Regression using SPSS) data interpretation, recommendations based on findings
- Paper construction and formatting
- Granted authorization of Ethiopia Demographic and Health Survey
- PowerPoint development and presentation of research and findings.

Jimma University Hospital, Jimma, Ethiopia September –December 2012
Assessment of CD4+ T-Cell Levels in HIV Infected Breast Milk
Project Manager

- Served as the Touro University primary point of contact on Touro Breast Milk Project while in Ethiopia while collaborating with the Head of the Pharmacy Department and Director of Maternity Ward and Head of Obstetrics at Jimma University.
- Demonstrated strong interpersonal skills for working closely with team members.
- Administrative duties managing research and study teams in varying departments.
- Developed fiscal projections and budgets while overseeing the fiscal aspects of project locally and globally.
- Development and completion of study materials such as team member orientation and instructions, consent forms, questionnaires, data collection records, supply inventory and financial/grant documents.
- Recruitment of project team members (10) and participants of approximately 60.
- Attend & contribute to project meetings with collaborators and team & take minutes/notes.
- Assess project progress & any issues that may arise and report to principle investigator.
- Ensure quality of data collected
- Manage and help with any lab procedures or experiments if needed
- Monitor all activities that are related to the research project such as: patient recruitment, data collection, data interpretation & analysis, lab analysis, & study progression.

Health Education and Wellness Program, Elsa Widenmann Elementary, Vallejo, CA 2011- 2012
Public Health Educator

- Needs Assessment establishing participant's demographics and prior knowledge.
- Lesson plan development

- Health education mentoring and activity leader
- Engaging young students about healthy behaviors such as dietary, oral, physical activity.

Application Form

Profile

Jo
First Name

Middle Initial

Bruno
Last Name

Without residency, Antioch
Home Address

Suite or Apt

Antioch
City

CA
State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 1

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

Los Medanos College, Pittsburg CA

Degree Type / Course of Study / Major

AA Journalism, graphic design

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

Western Oregon University, Monmouth OR

Degree Type / Course of Study / Major

BA Anthropology, writing

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

National Holistic Institute, Emeryville CA

Degree Type / Course of Study / Major

Certified Massage Therapist

Degree Awarded?

◉ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted
Mental Health Commission: Submitted
Planning Commission: Submitted
Housing Authority - BOS Appointees: Submitted

Seat Name

Consumer/Consumer Advocate

Have you ever attended a meeting of the advisory board for which you are applying?

○ Yes ◉ No

If you have attended, how many meetings have you attended?

Please explain why you would like to serve on this particular board, commitee, or commission.

My return to Antioch is my return home, and I'm planting my roots here. Also, currently without residency and building a network of peer support specialists in Contra Costa County, we have created a number of programs that'll help with transitional housing with mental health expertise as its focus. Trauma informed care is essential as Antioch builds on the historical beauty it holds for the Delta, so I want to share my peer voice as we grow. To be involved is the only way for me to see the change in which Antioch needs. So, I would like to serve as a board member to share a unique perspective of lived experience.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

At LMC 2008-2010 I was a club member for multiple school clubs, lead student ambassador, graphic design artist for multiple departments. At WOU 2010-12014 I was the non traditional student peer advisor, president of the anthropology club for two years, and help membership positions with the leadership boards for student life activities WOU 2013 - student leadership position for a trip to Haiti for my graduation project POCC 2016-2018 - chair of the public policy and education committee Massage Pit Crew 2017-2018 - Business Owner CEO of on-site chair massage. Currently out of business, but I managed 20+ therapists throughout the Bay Area and trained over 100 students who came from NHI BNI 2017-2018 - Held a position on a business networking board representing massage therapy. I was the events coordinator. Delta Peers 2018 - recent - Founder of Delta Peers, chair of committee. Currently seeking an executive director, partnerships and sponsorships for the organization Health Leads (Housing is Health Committee) 2019 - Recent - As a peer support specialist, I am an advisor for the Housing is Health Committee that is working with housing issues within the bay area.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

When it concerns my education, I'm an anthropologist, a writer and graphic design artist. Not quite qualifications for committee board member. But when it concerns my lived experience, that's where I'm qualified for a position with the City of Antioch. My journey, which I hold sacred to my purpose being back home, is published #CupOfJoBruno. My intention is to build a more trauma informed community in Antioch. As peer support specialists, who aren't recognized for the work we do, I come from a group of peers who have an empathetic approach to building community while in crisis. We are in crisis. Antioch is in crisis. That's why I'm qualified. I'm in crisis, as a unhoused resident of Antioch. My lived experience now, like my lived experience before, is needed.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

EDUCATION

Certification for Massage Therapy Graduated April 2017

- National Holistic Institute (NHI), Emeryville, CA
  - Completion of 900-hour training program
  - Current Student Ambassador and Student Internship Mentor

Bachelor of Science in Anthropology with Writing Minor Graduated June 2014

- Western Oregon University (WOU), Monmouth, OR
  - Who's Who Award 2012 and 2014
  - Service-Learning Trip to Haiti 2013
  - Anthropology Club Founder and President 2010-2012

Associates of Art in Journalism (Photography and Graphic Design) Graduated June 2010

- Los Medanos College (LMC), Pittsburg, CA
  - Office of Student Life: Leader for Social Change Award 2010
  - Lead Student Ambassador 2009-2010
  - Photo editor of newspaper 2009-2010
  - National Journalism Conference 2008 and 2009

WORK EXPERIENCE

Certified Massage Therapist, CEO June 2017 – February 2020

- The Massage Pit Crew, Bay Area California
  - CEO and program manager of on-site chair massage
  - Manage NHI externship program

Social Media Consultant/Graphic Design March 2016 – Present

- California Association of Mental-Health Peer Run Organizations (CAMHPRO), California
  - Maintain and update website, manage blog posts, and provide data for online platforms
  - Expand educational and informational material on CAMHPRO social media platforms

Blogger/Photographer January 2014 – June 2014

- Public Relations Department, Western Oregon University, Monmouth Oregon
  - Responsible for attending campus events and reporting via campus blog with photos
  - Self efficiently wrote 500-700-word blogs for each event

Non-Traditional Student Peer Advisor September 2011- May 2014

- Student Leadership and Activities Department, Western Oregon University, Monmouth Oregon
  - Create and schedule programs for current non-traditional student population
  - Produce and publish a bi-weekly newsletter via email

LEADERSHIP POSISTIONS

Delta Peers

- Founder, Committee Chair, Antioch, CA June 2018-Recent

Pool of Consumer Champions

- Public Policy & Education Committee Chair, Oakland CA Sept. 2018 – June 2019

Business Networking International

- Event Coordinator of Referral Factory, Brentwood CA Sept. 2017 – Sept. 2018

Application Form

Profile

Alejandra
First Name

Middle Initial

Chamberlain
Last Name

Home Address

Suite or Apt

Pleasant Hill
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 3

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

California State University, Sacramento

Degree Type / Course of Study / Major

Master of Science in Counseling

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

California State University, Sacramento

Degree Type / Course of Study / Major

Child Development BA

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Educational and Vocational Services

Have you ever attended a meeting of the advisory board for which you are applying?

○ Yes ◉ No

If you have attended, how many meetings have you attended?

Attending board meeting since appointed

Please explain why you would like to serve on this particular board, commitee, or commission.

The COE Youth Services department provides support and resources to the 18 school districts in the county, CCCOE-operated school sites, and charter schools to implement McKinney-Vento. Technical assistance and trainings are available to District Homeless Liaisons and other staff who are involved in working with homeless children and youth. As the County Office of Education County Homeless Liaison, my team and I coordinate with the 18 school districts to ensure that homeless students have access to the same free, appropriate public education, including public preschools, as provided to other children and youths. Furthermore, COE Youth Services gathers a network of District Homeless liaisons quarterly for the Homeless and Foster Youth Collaborative meetings, facilitated by the County Homeless Liaison. These collaborative meetings provide an opportunity for LEAs to work together to develop policies and protocols for services. Other functions of the quarterly meetings are for Education for Homeless Children and Youth staff to provide legislated updates, inform LEAs about Continuum of Care and Council on Homelessness activities, provide guest speakers on relevant topics and community services, review homeless children and youth data and to provide a venue for districts to share concerns, case studies and best practices from their experience working with homeless students. As the Education and Vocational representative on the Contra Costa Council on Homelessness, I advocate and bring awareness to the issues relating to children and youth homelessness. I also advise on policies relating to youth homelessness in the context of representing our 18 districts.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

As the Education and Vocational representative on the Contra Costa Council on Homelessness for the last four year, I advocate and bring awareness to the issues relating to children and youth homelessness. I also advise on policies, coordinate, and collaborate with community stakeholders relating to youth homelessness in the context of representing our 18 districts. As previously mentioned, as the County Office of Education County Homeless Liaison, my team and I provide support, resource, TA and PD to the 18 school districts in order to ensure that homeless students have access to the same free appropriate public education as their peers. Furthermore, I am passionate and committed to ending children and youth homelessness while ensuring student facing homelessness have access to their education.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

◉ Yes ○ No

If Yes, please identify the nature of the relationship:

As the CCCOE Youth Services Manager receives contracts to provide services for foster youth through EHSD and services for WIOA through the WDB.

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Application Form

Profile

Renee (First Name) J (Middle Initial) Hedrick (Last Name)

Home Address

Suite or Apt

Crockett (City)

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

- [x] District 5

Education

Select the option that applies to your high school education *

- [x] High School Diploma

College/ University A

Name of College Attended

Occidental College

Degree Type / Course of Study / Major

Sociology

Degree Awarded?

- ○ Yes
- ◉ No

College/ University B

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Youth Representative

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

2

Please explain why you would like to serve on this particular board, commitee, or commission.

As an acting member on the Youth Action Council and as of now having attended a few CoC/CoH meetings, I feel fully comfortable looking to become further involved in the discussions within that space. My overall goal is to share the experiences and knowledge of myself and my peers with the rest of the council. Additionally I want to continue to maintain the work the Youth Action Council has completed in direct coordination with the Contra Costa Council on Homelessness as well as to grow our capacity to do even more in collaboration down the road.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Standing member on the Youth Action Council CCYCS Program participant

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Standing member on the Youth Action Council Education experience in sociology Lived experiences in the CCYCS - resume attached -

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

◉ Yes ○ No

If Yes, please identify the nature of the relationship:

As a participant in the CCYCS I would also be related to any county grants, contracts or economic relations tied to youth services.

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Renee Juno Hedrick

SUMMARY

Motivated and focused with a diverse skill set. Experienced in technology, communications and customer service including years of experience in leadership roles. Passion for computer science and hardware engineering as well as sociology with a distinct focus on race and gender. Specialized in computer hardware and hardware engineering, fulfilled private contracts for computer part acquisition and construction. Skills in managing business media outlets and communication services. Extensive experience in the service industry.

EXPERIENCE

MHW - Autosplitter Project
Crockett, CA — 2020

Personal software engineering project involving C++ with the goal of designing and writing an Auto-splitting stopwatch program that interfaces with various other programs and clients. Program is designed to be used for timed computer activities/challenges. Considering placing this program on the Microsoft app store.

Quality Auditor
Hello Fresh
Richmond, CA — 2019-2020

The Quality Associate ensures that Hello Fresh quality standards are achieved through inspection of grocery ingredients during the receiving/yielding, production auditing and discarding processes in support of production goals for Hello Fresh meal subscriptions

Conservation Corp.
Contra Costa County
Richmond, CA — 2019-2019

Maintained and conserved Contra Costa County parks grounds while learning about various methods of gardening, park upkeep skills, wildlife preservation and creation of park materials like park benches and fences.

Office Assistant
Occidental College Grants Office
Los Angeles, CA— 2018

Completed various office tasks. Assigned multiple independent projects to complete efficiently. Performed some data entry tasks.

Barista
Occidental College “Green Bean” Coffee Shop
Los Angeles, CA — 2017-2018

Barista trained by Caffe Vita (http://www.caffevita.com/). Mixed drinks, pulled espresso shots, served customers through the register and stocked inventory. Participated in deep shop cleans. Closed the shop.

Barback
Spats Berkeley
Berkeley, CA — 2016-2017

Prepared all garnishes, bar tools and glasses. Ran food from the kitchen. Stocked all fridges and kegs. Served guests. Opened and Closed the shop. Was the youngest barback on staff.

Personal Contract Work
Remote Work
New York City, NY — 2016

Self taught how to construct computers as well as the skill of part acquisition at the most efficient cost point. Leveraged this knowledge to fulfill personal contract work in constructing high-end computers for business acquaintances, school connections and friends.

Field Manager
ACLU Manhattan
New York City, NY — 2015

Lead canvassing teams out in the field and organized daily activities. Trained prospective staff members and organized canvassing routes on a daily basis. Worked alongside coworkers making NY, Manhattan the top ALCU office for funds raised in the country multiple weeks consecutively. Staffed without ever falling behind quota.

Paid Internship
Tonic Beverage Catering
San Francisco, CA — 2013-2014

Actively created content for social media communication and helped manage those same outlets in dispersal of that content. Assisted with information acquisition and graphic design services for investor information packets. Assisted with organizing and work at multiple music festivals and company bar events.

EDUCATION

Occidental College
Bachelor's Degree of Sociology — In progress

St. Paul's School - Concord, NH
High School — 2010-2014

Received diverse liberal arts education with a focus on writing, leadership and problem solving skills. Participated in a school funded independent study project to explicate the entirety of Dante's *The Divine Comedy* and used it to inform my own creative poetry. Was the head of the school choir and was the school cantor for religious services.

SKILLS

- Computer Engineering
- Software Design
- Adept leader and manager.
- Classically trained vocalist.
- Pop culture and social media expert.
- Motivated and enthusiastic with a keen eye for detail.
- Adept problem solving skills and strategic thinker.

Application Form

Profile

Masaki
First Name

Middle Initial

Hirayama
Last Name

Home Address

Suite or Apt

Oakland
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

None Selected

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

UC Santa Barbara

Degree Type / Course of Study / Major

BA

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

UC Los Angeles

Degree Type / Course of Study / Major

MSW

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Veterans Administration Representative

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

Please explain why you would like to serve on this particular board, commitee, or commission.

I am an LCSW with the Homeless Program at the VA Northern California Healthcare System. I actively work with homeless providers in CC County to house homeless veterans.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Please see attached resume.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

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☑ I Agree

SUMMARY OF QUALIFICATIONS

- Proven ability to promote VA commitment to ending homelessness by forming effective partnerships with three Continuum of Cares with a diverse group of providers, governing bodies, and veterans.
- Direct key VA activities, strategic planning, system performance evaluation and partnerships and engagement in compliance with federal, state and local CoC program requirements.
- Proven ability to work and prioritize multiple tasks independently and with minimum supervision.
- Excellent written/ oral communication and interpersonal skills as well as clinical/administrative consultative skills.
- Experience developing technical assistance and drafting clear and concise correspondence.
- Expertise in working with diverse patient populations and making relevant referrals, including chronic homelessness, dual diagnosis, substance use disorder, severe mental illness, women, combat Veterans, and older adults.

PROFESSIONAL EXPERIENCE

08/2019 – Present **Coordinated Entry Specialist**
Northern California VA Healthcare System Oakland, CA

- Represent the VA in relevant community-wide planning efforts to end homelessness.
- Maintain knowledge and expertise regarding VA and CoC regulations and requirements to ensure that VA activities are following VA expectations and HUD.
- Overseeing the integration of VA resources into the larger CoC homeless systems to support increased accessibility, transparency, and utilization of VA resources.
- Develop and maintain active collaborations with governmental and non-governmental leadership, local, state and national advocacy groups, homeless service providers, and formerly homeless clients.
- Lead veteran case conferences and leadership meetings for resource-matching and prioritization of resources.
- Provide leadership in the community by actively participating in local plans to end Veteran homelessness as well as conducting and leading the coordination of outreach services to homeless Veterans.
- Developing a communication strategy and protocols for VA medical centers (VAMCs), Veteran Integrated Service Networks (VISNs), collaborating VA offices, and non-VA partners related to new approaches for targeting Veterans and providing case management and supportive services in HUD-VASH.
- Identifying the steps and tasks for both the VA, public housing authorities (PHAs), and non-VA partners to increase the utilization of HUD-VASH vouchers.

06/2014 – 08/2018 Grant and Per Diem (GPD) Liaison
Northern California VA Healthcare System Oakland, CA

- Provide oversight of GPD programs with two models to ensure the programs provide quality services that comply with applicable regulations as well as the GPD proposal that was submitted and approved for funding.
- Partner with outside agencies in negotiating the needs of the greater community with the priorities of the VA.
- Collaborate with GPD providers to use data from HOMES and VSSC and incident reports to monitor and improve program outcomes, lengths of stay, lower barriers to admission, and to identify staff's training needs.
- Assemble a team of subject matter experts to complete yearly inspections and deciding for approval of continued per diem payments based on the program meeting GPD requirements and standards.
- Quarterly, provide VSSC scorecard outcomes as well as occupancy rates to program administrators and provide consultation on how to maintain compliance with GPD expectations.
- Provide clinical consultation to GPD programs for complex cases, e.g. active substance abuse; conflict between veterans; discharge planning within 24 months; and providing relevant resources and referrals.
- Establish accurate billing procedures to submit GPD vouchers and invoices in a timely manner.
- Determine eligibility for GPD programs, including eligibility for various GPD models; consult VA eligibility and HEC.
- Complete accurate documentation in a thorough and timely manner in CPRS and in HOMES.

05/2013 – 06/2014 Compensated Work Therapy (CWT) Coordinator & Case Manager
San Francisco VA Medical Center San Francisco, CA

- Monitored two homeless Transitional Residences (11 vets) and Transitional Work Experience program (20 vets).
- Oversaw all operations of 11 bed Transitional Residence, including health/safety inspections, clinical documentation, billing procedures, and mediating conflicts between residents.
- Developed policies and procedures that comply with CARF, JCAHO, as well as VA handbooks.
- Completed VA reports to local leadership, VISN, and VACO accurately and on time.
- Reviewed and assigned electronic CWT consults to most clinically indicated program.
- Completed documentation in a thorough and timely manner in CPRS, including HOMES and NEPEC forms.
- Provided consultation to staff regarding psychosocial needs of Veterans and the impact of psychosocial problems related to substance use, mental and physical health care.
- Provided effective discharge planning, including coordinating referrals to HUD-VASH and providing housing referrals.
- Provided case management to Veterans with complex mental health and substance abuse issues, including a variety of physical and mental health care needs.

01/2010 – 05/2013 PACT Social Worker, Medical Practice, Geriatrics, Women's Clinic
San Francisco VA Medical Center San Francisco, CA

- Coordinated referrals to housing programs (HUD-VASH, GPD, HCHV) to address unstable housing and homelessness; also made referrals to address eviction, rental assistance grants, and locating low-income housing.
- Coordinated and implemented treatment plans with the Veteran, family and providers to minimize risk.
- Provided consultation to interdisciplinary team about psychosocial issues that impact treatment plans.
- Assessed Veterans that have a wide range of complicated biopsychosocial issues in primary care and specialty clinics with over 13,000 patients combined.
- Appropriately responded to crises, including APS, CPS, domestic violence, and homelessness.
- Organized and delivered group clinics to Veteran for efficient dissemination of information.
- Created and delivered training on elder abuse to geriatric fellows and MSW interns.
- Completed documentation in a thorough and timely manner in CPRS.

09/2009 – 01/2010 Medical Social Worker and Clinical Therapist (24 hours/ week)
Community Health Resource Center San Francisco, CA

- Provided outpatient case management and consultation services to patients in Hematology/Oncology, Cardiology, and Pulmonary clinics of California Pacific Medical Center, San Francisco.
- Conducted assessments and interventions to a medically fragile population.
- Provided referrals to relevant community resources.
- Provided outpatient therapeutic services, utilizing a variety of therapeutic modalities.

10/2007 – 02/2009 Social Worker, MHRRTP - Domiciliary
VA Greater Los Angeles Los Angeles, CA

- Provided complex treatment coordination and discharge planning for homeless population.
- Coordinated referrals to housing programs (HUD-VASH, GPD, HCHV) to address unstable housing and homelessness; also made referrals to address eviction, rental assistance grants, and locating low-income housing.
- Conducted assessments and treatment plans for a diverse group of Veterans, including chronic homelessness, substance abuse, and mental health issues.
- Collaborated with an interdisciplinary team to develop, coordinate and implement treatment plans.
- Provided weekly individual and group therapy; utilized CBT, crisis intervention, and Seeking Safety.
- Completed documentation in a thorough and timely manner in CPRS.

6/2007 – 10/2007 Contract Social Worker, MHRRTP
VA Greater Los Angeles Los Angeles, CA

- Provided complex treatment coordination and discharge planning for homeless population.
- Coordinated referrals to housing programs (HUD-VASH, GPD, HCHV) to address unstable housing and homelessness; also made referrals to address eviction, rental assistance grants, and locating low-income housing.
- Conducted assessments and treatment plans for a diverse group of Veterans, including chronic homelessness, substance abuse, and mental health issues.
- Collaborated with an interdisciplinary team to develop, coordinate and implement treatment plans.
- Provided weekly individual and group therapy; utilized CBT, crisis intervention, and Seeking Safety.
- Completed documentation in a thorough and timely manner in CPRS.

09/2006 – 05/2007 Social Work Intern (24 hours/ week)
VA Greater Los Angeles Los Angeles, CA

- Provided weekly therapy and case management in the Day Treatment Program.
- Assessed Veterans with serious mental illness and geriatric issues.
- Co-facilitated groups using CBT, MI, supportive therapy, psychoeducation, and psychotherapy.
- Collaborated with an interdisciplinary team to develop, coordinate and implement treatment plans.
- Organized and delivered presentations on early dementia to families of Veterans.

10/2005 – 06/2006 Social Work Intern (16 hours/ week)
Prototypes Los Angeles, CA

- Provided weekly psychotherapy to homeless victims of domestic violence and Prop. 36 clients in a residential treatment facility for women and children in Los Angeles.
- Provided case management, court accompaniment, and advocacy for mothers to regain custody of children and file restraining orders.
- Collaborated with an interdisciplinary team to coordinate and implement treatment plans and discharge plans.

EDUCATION

06/2007 Masters, Social Welfare (Specialization: Gerontology)
University of California, Los Angeles

01/2000 BA Cultural Anthropology and BA Japanese Studies
University of California, Los Angeles

- Graduated with Honors, Dean's List of Academic Excellence, Golden Key National Honor Society

LEADERSHIP ACTIVITIES AND PROFESSIONAL PRESENTATIONS

08/2020 **HUD-VASH National Orientation Call Presenter:** Partnering with SSVF – A Pilot Project

07/2020 **Supportive Services for Veteran Families National Call Presenter:** Partnering During COVID-19

07/2018 **Grant and Per Diem National Call Presenter:** Integration of GPD with Coordinated Entry

10/2015 – 3/2020 Co-Chair & Secretary, Professional Standards Board, Northern CA VA Healthcare System

- Review recommendations of initial appointment of new employees as well as promotions of existing employees to be compliant with SW Standards Board Handbook

02/2011 – 06/2013 Co-Chair, Professional Standards Board, SF VA Medical Center

- Review recommendations of initial appointment of new employees as well as promotions of existing employees to be compliant with SW Standards Board Handbook.

12/2010 – 05/2013 Contributor, Committee Leadership in Aging

- Recruited gerontological social workers by writing quarterly publications for a national newsletter that is distributed to MSW students and practitioners.

09/2005 – 06/2007 Co-Chair, Gerontology Student Caucus, UCLA

- Organized and executed activities to increase awareness of gerontological social work, such as a tour of senior programs for students and a shadowing experience with 2nd year students.

03/2006 – 06/2006 Mentee, Senior Fellows Mentorship Program, UCLA

- Selected amongst applicants to be mentored by David E. Janssen, Chief Administrative Officer, County of Los Angeles, to organize and present community presentation on housing and homelessness**.**

PROFESSIONAL DEVELOPMENT

06/2013 Psychiatric Rehabilitation Association Annual conference
07/2011 Approaches to the Challenges of Dementia conference
06/2011 PACT New Models of Care conference
11/2010 Motivational Interviewing for Hazardous Drinking in Patients with Hepatitis C conference
10/2010 Emerging Leaders Development Program
05/2008 Acceptance and Commitment Therapy conference
12/2007 Seeking Safety conference

Application Form

Profile

Teri
First Name

Middle Initial

House
Last Name

Home Address

Suite or Apt

Pittsburg
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 5

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

CSU Hayward

Degree Type / Course of Study / Major

MS, Counseling Psychology

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

CSU Hayward

Degree Type / Course of Study / Major

BS, Psychology

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Bassist College, Portland OR

Degree Type / Course of Study / Major

BA, Apparel Design

Degree Awarded?

◉ Yes ○ No

Other schools / training completed:

Course Studied

University of San Francisco, Development Director Certificate Program

Hours Completed

1 year course of study

Certificate Awarded?

◉ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Government

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

Over 500 since the BOS first established the Board in the late 1990s

Please explain why you would like to serve on this particular board, commitee, or commission.

Thank you for this opportunity to submit my application for reappointment to the Council on Homelessness. It is my honor to have served as Chair and Vice Chair of this body several times since it was established by the BOS. It is my life's commitment to work closely with residents, nonprofit agencies, as well as local, regional and federal government to help find solutions to homelessness. I have a passion for the plight of people on the streets with no home, because I am a formerly homeless youth. For almost two years, I lived in my car, on the streets, with friends, in boarded up buildings. I know what it is like to raid grocery story dumpsters and forage for food, cooking what I found over a single-burner camp stove. I know what it is like to have to clean up and "bathe" in public restrooms. I know what it is like to feel dehumanized, cold, hungry, alone. Thanks to help from the faith community, I escaped this nightmare with my life, and sanity and transitioned into successful adulthood. Many others are not so fortunate. Our society can do better, and our Homeless Continuum of Care is striving every day to do better to help those who are impoverished, mentally ill, drug and alcohol addicted. Everyone needs to be warm and dry with a roof over their heads and food in their belly. I truly believe that homelessness is not an insurmountable problem, although many times it seems that way. It is my heartfelt desire to continue to serve on the Council on Homelessness and be part of the solution to homelessness in East Contra Costa County for another term so that I may continue to make meaningful contributions to help those in our community without a place to call home.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

Currently Board member of Council on Homelessness, Contra Costa Healthcare for Homeless, United Way/FEMA Local Board, past member of Coco Lead+ Board.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I have worked in the field of homelessness and housing for over 30 years, as a past Development Director for Shelter Against Violent Environments (emergency shelter and transitional housing) in Fremont, and past Executive Director of Habitat for Humanity Contra Costa (now East Bay/Silicon Valley). For the past 23 years I have managed federal CDBG and other resources to benefit lower income communities, providing services and developing affordable housing for the cities of Concord, Pittsburg and Antioch. I have worked for the City of Antioch for past decade and have lived in East Contra Costa for 25 years, so I know the area and its challenges well. Last year I conducted the public outreach and needs analysis for the Contra Costa HOME/CDBG Consortium, to develop the 2020-25 Consolidated Plan. This was an extensive year-long process that involved outreach to underserved and minority populations as well as intensive data analysis of CHAS and other housing and demographic data, as well as school and other data sources. In addition to serving on the COC Rating and Ranking Committee for federal applications since my initial appointment, I also help evaluate ESG and United Way applications for funding.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Application Form

Profile

Gabriel
First Name

Middle Initial

Lemus
Last Name

Home Address

Suite or Apt

Martinez
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 5

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

UCLA

Degree Type / Course of Study / Major

B.A. - History and Chicana/o Studies

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

Cornell University

Degree Type / Course of Study / Major

M.R.P. - City and Regional Planning

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Emergency Solutions Grant Representative

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

50-60

Please explain why you would like to serve on this particular board, commitee, or commission.

I've served on this Council for 5 years now sitting in the Emergency Solutions Grant (ESG) Representative seat. Homelessness is a growing issue in the County and those who are experiencing homelessness in our community deserve to have access to services and affordable housing. Serving on this council assists in preserving the services and housing that currently exist but also expanding them.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

I have served on the Contra Costa Council on Homelessness since 2015. I have also served as on the Planning Commission as a Planning Commissioner for the City of Martinez from October 2014 to March 2019.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I have worked with Contra Costa County for 18 years, primarily working on assisting various programs that serve low-income populations, including those who are experiencing homelessness. My role as the administrator of the the Community Development Block Grant Program and the Emergency Solutions Grant Program has led me to cultivate working partnerships with various public agencies and service providers that assist in providing resources, access to services, and access to affordable housing to low-income residents and those experiencing homelessness throughout the County. I have served on the Council on Homelessness for 5 years and have enjoyed the experience to collaborate with other stakeholders to provide the necessary services and affordable permanent housing to those experiencing homelessness or those at imminent risk of becoming homeless.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Gabriel C. Lemus

PROFESSIONAL EXPERIENCE

Contra Costa County, Department of Conservation and Development
CDBG Program Manager (Principal Planner – Level A & Level B-Advanced Level) May 2016-Present
Overall administrative management and oversight of the Community Development Block Grant (CDBG) Program, Neighborhood Preservation Program, and Emergency Solutions Grant (ESG) Program, including the State ESG Program (approximately $5.1 million total in Program funds). Management of over 40 Community Development Block Grant (CDBG) economic development, infrastructure/public facilities, public service and Emergency Solutions Grant (ESG) Program contracts; Grant application review of 40-60 applications, preparation and presentation of reports and materials for County Board of Supervisors and their subcommittees, program budget review, and supervising and reviewing work of four subordinate staff; NEPA environmental review specialist and NEPA Certifying Officer for the County, including review and sign-off of staff's completed environmental review documents under NEPA; Established and maintained excellent relationships with non-profit community organizations (30 to 40 organizations) throughout the County; Established and maintained excellent working relationships with U.S. Department of Housing and Urban Development (HUD) representatives with no major programmatic findings during HUD audits; Thorough knowledge of HUD reporting system (IDIS reporting system) for the CDBG and ESG Programs. Advise and present to various County committees, community stakeholders, and residents on project findings and proposals at monthly meetings/hearings.

Contra Costa County, Department of Conservation and Development
CDBG Program Planner/Redevelopment Project Manager (Planner III) May 2006-April 2016
Contract/Project management of various Community Development Block Grant (CDBG) economic development, infrastructure/public facilities, public service and Emergency Solutions Grant (ESG) Program contracts; Preparation and presentation of reports and materials for County Board of Supervisors and their subcommittees, Review work of three subordinate staff; Implementation of the County's CDBG-Recovery (CDBG-R) Program (approximately $1 million in Program funds), which included completion of 14 public facility improvement projects for various non-profit and public agencies throughout the County; Implementation of the County's National Stabilization Program 3 (NSP3), which included the project management of a $1.8 million rehabilitation project of a 16-unit multi-family apartment building; Management and creation of the 5-year Consolidated Plan for federal programs, which included coordination with four other CDBG entitlement cities in the County and coordination of community outreach efforts; NEPA environmental review specialist and NEPA Certifying Officer for the County, including review and sign-off of staff's completed environmental review documents under NEPA; Established and maintained excellent relationships with non-profit community organizations (30 to 40 organizations) throughout the County; Established and maintained excellent working relationships with U.S. Department of Housing and Urban Development (HUD) representatives with no major programmatic findings during HUD audits; Thorough knowledge of HUD reporting system (IDIS reporting system) for the CDBG and ESG Programs. Advised and presented to various County committees, community stakeholders and residents on project findings and proposals at monthly meetings/hearings; Conducted and coordinated inventories and/or interpret their findings on subjects such as physical resources, land use, facilities, and transportation for a redevelopment project area (Note: Redevelopment Agency work ended in February 2012 due to elimination of redevelopment agencies in California).

Contra Costa County, Community Development Department-Redevelopment Division
Planner II (CDBG Program Planner/Redevelopment Project Planner) March 2004-April 2006
CDBG Program and Redevelopment Agency: Project manager for public service projects and various infrastructure and rehabilitation projects (20-30 contracts totaling approximately $760,000 each year), which included management of rehabilitation projects to various public facilities and infrastructure within low-income neighborhoods; Conducted and completed environmental reviews for all CDBG funded projects; Review of 50-60 CDBG public service and infrastructure/public facilities applications; Preparation of staff reports for all CDBG public services applications and various infrastructure/public facilities applications; Project Manager/Planner for a Redevelopment Project area in the western portion of Contra Costa County, which included preparation of reports, and holding monthly redevelopment and community advisory committee meetings, included grant writing for "complete street" improvements.

Contra Costa County, Community Development Department-Redevelopment Division
Planner I (CDBG Program Planner) Dec. 2002-Feb. 2004
CDBG Program: Project manager for all CDBG public services projects (40-45 contracts totaling over $680,000 each year) that provided services to a wide range of low-income populations, including the homeless, elderly, persons with disabilities, victims of domestic violence, low-income renters, and persons residing in low-income neighborhoods; Review of 50-60 CDBG public services applications; Preparation of staff reports for CDBG public services applications; Conducted and completed environmental reviews for all CDBG funded projects (housing, economic development, infrastructure, and public service projects).

OTHER EXPERIENCE

City of Martinez, Planning Commission
Planning Commissioner Oct. 2014-March 2019

Contra Costa County, Contra Costa Council on Homelessness
Council Member (Chair: August 2016 – February 2018) February 2016-Present

PROFESSIONAL QUALITIES

•Communication/Customer Service	•Budget Writing and Management	•Quantitative Skills
•Project Management	•Public Presentation	•Leadership
•Teamwork	•Analytical Thinking & Problem Solving	•Organizing & Coordinating

COMPUTER SKILLS
Solid PC skills and familiar with Apple Macintosh; Windows; Microsoft Word; Microsoft Excel; Microsoft Works; Microsoft PowerPoint

LANGUAGES
Fluent in English and Spanish

EDUCATION
CORNELL UNIVERSITY, School of Architecture, Art, and Planning
Master's in Regional Planning: Concentration in Economic and Community Development

UNIVERSITY OF CALIFORNIA, LOS ANGELES**,** College of Letters and Sciences
Bachelor of Arts in History and Bachelor of Arts in Chicana/Chicano Studies

REFERENCES:

Application Form

Profile

Maureen
First Name

P
Middle Initial

Nelson
Last Name

Home Address

Suite or Apt

Walnut Creek
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 4

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

Cal State East Bay

Degree Type / Course of Study / Major

B.A., Liberal Studies

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

John F. Kennedy University

Degree Type / Course of Study / Major

M.A., Career Development

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Management & Supervision

Hours Completed

Certificate Awarded?

◉ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Workforce

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

6

Please explain why you would like to serve on this particular board, commitee, or commission.

I have always been interested in assisting people who are unsheltered or fragilely housed. I have friends and family who have experienced homelessness. I feel that Contra Costa is doing a great job delivering homeless services and I have been so impressed by the Council on Homelessness meetings I have attended. There is so much expertise and dedication in the room. I want to join that team and contribute at a higher level. I believe the knowledge I bring about workforce development will help move the Council's work forward.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Executive Committee, Contra Costa Interfaith Housing (now Hope Solutions). Overnight Shelter Monitor, Holy Trinity, Richmond, Winter Nights Shelter. Instructor, Global Career Development Facilitator training. Instructor, Basic Employment Specialist Training (BEST). Lobbied at State Capitol for transgender community and also on workforce development priorities. Presented at Human Trafficking Summit on resources at the One-Stop Career Centers. Produced CD and 12-binder set on career development resources for transgender job seekers and those who serve them. Edited Trauma Nurses' Manual on Sexual Assault.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Volunteer for Point-in-Time Homeless Count (2 years). Volunteer overnight shelter monitor for Winter Nights Shelter. Have friends/family who are unsheltered. I am applying for the Workforce seat. I have been employed in the career and workforce development field for 15 years. I have managed grants and contracts, conducted focus groups, written policies, led trainings, done public speaking, published articles, and supervised teams. I have skills in analysis and recommendation, project development and implementation, planning and policy. I am eager to dig in and serve in any capacity that will help the effort to have all Contra Costans housed.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

MAUREEN NELSON, M.A.

ONE STOP CONSORTIUM ADMINSTRATOR

GRANT OVERSIGHT | BUDGET MANAGEMENT | COMPLIANCE & MONITORING
PARTNER ENGAGEMENT | PROGRAM COORDINATION & EVALUATION | STRATEGIC PLANNING

Fifteen years in workforce development with responsibilities ranging from management of grants, programs, projects and budgets *to* supervising and developing staff *to* convening partnerships to support shared clients/ students to achieve success. Experience in higher education, government and non-profit settings. Passionate proponent of Strong Workforce, promoting Career Education programs, especially to underserved groups, as pathways to high-wage jobs. Excel in communication; background in publishing and training.

M.A. in Career Development • *Global Career Development Facilitator (GCDF) Instructor*

PROFESSIONAL HISTORY & HIGHLIGHTS

CONTRA COSTA COUNTY, EMPLOYMENT & HUMAN SERVICES, Concord, CA 2012–Present

Administrator – America's Job Center of California (AJCC) **2017–2020**
Assistant Administrator **2012–2017**

Oversee and support four sites of America's Job Center of California (AJCC), all core programs and grants. Hire, train, supervise and evaluate site managers and support staff. Promote programs and services throughout county. In collaboration with education partners, promote middle-skill trainings in strategic industries: Advanced Manufacturing; Health Care/Biotech; Information and Communication Technology (ICT); Transportation and Logistics; Construction; Energy. Serve as face of AJCCs to community; resolve complaints. Serve as key contact for bureau in Executive Director's absence.

Roles & Responsibilities:

- **PROGRAM MANAGEMENT.** Oversee all programs, projects and budgets of AJCCs, ensuring equal access to all groups and a diverse clientele. Track and analyze data and report outcomes. Analyze regulations and develop policy, procedures, trainings and tools. Supervise four managers plus support staff. Hire, train, motivate, coach and evaluate staff. Use best practices of progressive discipline. Successfully partner with unions. Active in county mentoring program and cross-functional roundtables. Planned and executed staff enrichment series, securing speakers.
- **GRANT MANAGEMENT.** Serve as co-lead on grant life cycle from application to close, including budget monitoring, data tracking, quarterly and final reporting. Key contributor to extension/ modification (including budget) requests. (Also served as rater for proposals *submitted* to WDB.)
- **COLLABORATIVE WORK.** Convened One-Stop Consortium (in which Diablo Valley College participated), superseded by MOU Partnerships. Subsequently launched Workforce Integration Networks (WINs), comprised of organizations focused on career education and employment. Serve on advisory committees at Diablo Valley (MTEC and Manufacturing) and Los Medanos (PTEC) campuses, as well as at Martinez Adult Education. Active in Contra Costa College job fairs.
- **STRATEGIC LEADERSHIP.** Serve on EASTBAY *Works* (regional consortium) Coordination Team. As part of website revamp workgroup, developed RFP for designer and wrote business success stories. Collaborating with Calif. Emerging Technology Fund and Tech Exchange to bring free computers and broadband to low-income clients. Key contributor to WDB's strategic planning process, particularly in relation to Business Services (2012-2017) and Adult Services (2017-2020).

Selected Achievements:

- **CoCo SOARS (Sustainable Occupational Advancement for Reentry Success), AB 2060 funded.** As of Q7 (March 2018), 48 probationers enrolled **(96% of goal);** 9 completed training, earning 14 credentials; 13 are employed (8 in strategic industries). Grant extension approved by State.
- **WIOA (Workforce Innovation & Opportunity Act), Dept. of Labor funded.**
  For PY 2015-2016 (latest year for which State-validated data is available):

  9,268 New Registrants in CalJOBS. **740** Clients Enrolled in WIOA. **408** Placed in Employment.

  Dislocated Workers: 85% of clients employed **(110% of State-negotiated performance goal);** 86% retained jobs **(101% of goal);** average earnings of $45,000 **(111% of goal)**
  Adults: 74% of clients employed **(99% of goal);** 86% retained jobs **(104% of goal);** average earnings of $36,300 **(99% of goal).**

  - ***Strategic Sectors:*** Centers delivered 28 presentations on trainings in target industries; spotlighted trainings were offered at community colleges and partnership programs.
  - ***Online Training:*** Issued Metrix licenses to over 1,000 job seekers. The top 10 Metrix users passed 673 courses and logged over 1,000 hours, mostly in strategic sectors.
  - ***Collaboration:*** All education partners participate in their local Workforce Integration Network (WIN) and all site coordinators sit on community college or adult education advisory boards. All COHORT TRAININGS in sectors were developed in partnership.
- **SCSEP (Senior Community Service Employment Program), Dept. of Labor funded.** During PY 2012-2013 (year of my oversight): 92 very low-income older (55+) workers with substantial barriers worked in subsidized positions across county. 35% gained unsubsidized employment.

OAKLAND PRIVATE INDUSTRY COUNCIL (OPIC), Oakland, CA 2009–2012
Manager, Workforce Investment Act (WIA) Program
Co-Site Manager, Oakland Career Center
Oversee 20-person staff in career center serving 250+ clients per day, plus 10-person Adult Career Dept. Hiring, train, manage performance and compliance. Build relationships with community colleges.

ONE STOP CAREER LINK, GOODWILL OF SF, San Francisco, CA 2008–2009
Business Relations Specialist *and* **Chair, Bay Area Coalition of Employment Developers**

NATIONAL CAREER DEVELOPMENT ASSN, *Career Convergence,* Walnut Creek, CA 2006–2008
Dept. Editor, Non-Profits / Coach / Author / Speaker

Product Manager, PIVOTAL RESOURCES (process training/consulting), Walnut Creek, CA 2001–2006

ACADEMIC BACKGROUND

M.A., Career Development ▪ John F. Kennedy University

B.A., Liberal Studies, ***Math Minor*** ▪ California State University − East Bay

Your report on the third Sanctuary Café was, as always, a stellar report. You were a great champion and facilitator for the entire trauma-informed training series and we can all be proud, thanks to your efforts and leadership in this endeavor.
— Donna Van Wert, Executive Director, Workforce Development Board

PROFESSIONAL DEVELOPMENT, 2012–Present

■ ■ ■ WORKING WITH DIVERSE POPULATIONS

Key Legal Issues in Reentry, Bay Area Legal Aid, in conjunction with Reentry Success Center, *Richmond*
Clean Slate, pre-trial/early representation, expungements, employment barriers, housing/benefits barriers, traffic, child custody, child support, restraining orders, domestic violence, substance abuse, "crimmigration"

Windmills Disability Awareness, Milt Wright & Associates, *Bay Point*

Conversation on Homelessness, panel, County Continuum of Care, *Concord*

Gender-Responsive Interventions + Post-Prison Shock Syndrome, HealthRight360, *Pittsburg*

Trauma-Informed Care and Self-Care for Providers, Contra Costa County Mental Health, *Antioch*

Transgender/Ally Leadership Summit, *Los Angeles (2006) & Sacramento (2007)*

■ ■ ■ ENSURING UNIVERSAL ACCESS TO SERVICES

Partnerships that Unlock Social Mobility, Community Colleges, Adult Eds & Workforce, *Richmond*

Workplace Diversity ▪ Implicit Bias ▪ Sensitivity in the Workplace, County Staff Dev., *Concord*

Universal Design: Customer-Centered Approach, *webinar* ▪

Designing Accessible Documents, EDD Capacity Building Unit, *Sacramento*

■ ■ ■ CONFERENCES

National Association of Workforce Boards (NAWB) Conference, 2017 *Washington DC*
Attended sessions on sector strategies; WIOA and TANF; veterans, people with disabilities; technology, finance, health care, hospitality; career readiness measurement tools.

California Workforce Association (CWA) Spring Conference, 2012 & 2018, *San Diego*

Forward Focus *(reentry grant)* **Communities of Practice Convening, 2017,** *Los Angeles*

Forward Focus *(reentry grant)* **Communities of Practice Convening, 2016,** *Sacramento*

Human Trafficking Summit, HealthRight360, *Concord*

Government Transformation & Innovation Conference, *Sacramento*

Developing the Homeless Workforce, Saffron Strand, *Richmond*

■ ■ ■ EXTENDED MANAGEMENT TRAININGS

Supervisory Effectiveness *(12 months),* UC Davis (County-sponsored), *Concord*

Leadership Academy *(6 months),* Millenium Career Advantage (County-sponsored), *Concord*

Mentoring Program *(6 months),* Employment & Human Services Dept., *Concord*

■ ■ ■ BRIEF MANAGEMENT TRAININGS

Customer Service for Managers, focused on internal customers, Contra Costa County, *Concord*

Labor Relations for Managers, Labor Relations, County Administrator's Office, *Concord*

Weingarten Rights, Target Solutions, *webinar*

■ ■ ■ SAFETY

CPR/AED/First Aid for Adults and Children, 2017, County Risk Management Department, *Concord*

Red Cross Shelter Fundamentals, County Risk Management Department, *Concord*

PRESENTATIONS, 2012–Present

Presented on WIOA and American Job Center programs, services and partnerships, including career pathways, strategic sectors, trainings, work with diverse populations and special grants to following groups:

State Legislative Analyst's Office ▪ California Legislative Staff Education Institute
Congressman Jerry McNerney ▪ Assemblyman Tim Grayson's staff ▪ Supervisor Diane Burgis' staff
National Asian Pacific Council on Aging ▪ Concilio Latino, West County ▪ Young Men of Color
Social Policy Research Associates ▪ Bay Area Literacy Programs (BALIT) ▪ Rubicon Programs
County Probation Dept.'s Managers and Supervisors ▪ General Public *(at county services fair)*
County Mentor/Mentee Orientation ▪ Family & Human Services Committee, Board of Supervisors
Putnam Clubhouse *(for those recovering from mental illness)* ▪ Human Trafficking Summit

STRATEGIC & ADVOCACY WORK, 2012–Present

Visits with Lawmakers on Capitol Hill, Washington DC, 2017
Met with four congress members to share success stories, achievement data and needs of their constituencies; requested full funding of WIOA at level Congress authorized.

State One-Stop Certification Workgroup, Sacramento, 2017
Developed tool for evaluating AJCCs for certification, including refining 64 criteria (divided in eight Hallmarks of Excellence); also refined certification process.

DVC PATHWAYS TO LLNL □ Partnership to put low math achievers on track to STEM internships.
Presented opportunity for WIOA co-enrollment to provide supportive services for interns.

Education Partners Focus Group (DVC hosted location)
Co-facilitated group to gather partner input on Workforce Development Board's strategic plan.

Workforce Development Board □ Local Strategic Plan 2017-2020
Presented to Board at two sessions and co-facilitated discussions around Board priorities.

CAPACITY BUILDING WORK, 2012–Present

***As a strong advocate of equipping personnel with the knowledge and skills to do their best work, below is a list of trainings I was instrumental in bringing to my staff. Trainings I delivered are in* bold.**

Ethics in the Workplace
Civility in the Workplace
Sharepoint Fundamentals
Trauma-Informed Treatment
FMLA (for staff and managers)
Coordinated Entry for Homeless
File Audit Training for Site Coordinators
Hallmarks of Excellence *(for AJCC Certification)*
Services for Vision-Impaired *(Hatlen Center for the Blind)*
CMIA (Confidential Medical Information) for Supervisors
Interpersonal Violence & Human Trafficking *(Family Justice Center)*
Mental Health First Aid *(8-hour, certification)*

I really appreciate the way you think on the broader level. You clearly see and understand the importance of looking holistically at the organization.

— Mickey Williams, Division Manager, Staff Development and Mentoring Program

Application Form

Profile

Iman
First Name

Middle Initial

Novin
Last Name

Home Address

Suite or Apt

Walnut Creek
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

- [x] District 2

Education

Select the option that applies to your high school education *

- [x] High School Diploma

College/ University A

Name of College Attended

University of California San Diego

Degree Type / Course of Study / Major

B.S. Structural Engineering & B.A. Urban Studies & Planning

Degree Awarded?

- (•) Yes
- ( ) No

College/ University B

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Affordable Housing Developer

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

3

Please explain why you would like to serve on this particular board, commitee, or commission.

Got to know the Contra Costa Council on Homelessness as a volunteer on the Affordable Housing Awareness Month Planning Committee some years ago. As a local Contra Costa County based Affordable Housing Developer, I believe my professional background in shaping affordable housing policy and experience implementing policy, would be a good addition to the Council on Homelessness.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

Board Member for Trinity Center in Walnut Creek, non-profit that provides services to homeless and working poor Vice Chair of the Walnut Creek Planning Commission (former) Walnut Creek Chamber of Commerce Board of Directors Sunflower Hill Advisory Board (former), non-profit dedicated to vocational training and housing for children with autism

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

NOVIN DEVELOPMENT

Key Principal Bio

Iman Novin, has over 14 years of experience in the real estate development sector with a focus on mixed-income and transit-oriented development. Iman has considerable experience with the acquisition and project management of both new construction multifamily projects and rehabilitation of existing properties.

Iman previously worked at MidPen Housing as Director of Acquisitions and at BRIDGE Housing as a Project Manager in both northern and southern California. While at MidPen, Iman managed MidPen's acquisition efforts across the Bay Area closing dozens of deals and managing broker and investor relationships.

While at BRIDGE, Iman helped secure entitlements for MacArthur Transit Village, a 675 unit mixed-income TOD project in Oakland with 42,500 square feet of ground floor retail including a 5,000 square foot childcare facility. Through BRIDGE's innovative $300M CalPERS partnership, BRIDGE Urban Infill Land Development (BUILD), Iman gained experience with a wide variety of development and investment types including mixed-income, mixed-use, large master-plan, TOD and a portfolio of market-rate value-add investment properties acquired with CalPERS equity.

Prior to BRIDGE, Iman worked in the Real Estate and Planning Divisions of the Centre City Development Corporation (CCDC) on redevelopment and affordable housing initiatives within the Downtown San Diego Redevelopment Project Area, as well as with Keyser Marston Associates (KMA) in their San Diego office.

Iman is actively involved with the Urban Land Institute and has published three ULI transit-oriented development technical assistance panel reports. Iman has volunteered as a classroom facilitator for the UrbanPlan Program at Berkeley High School and has served as Vice Chair of the Walnut Creek Planning Commission. Iman also serves on the Board of Directors for the Walnut Creek Chamber of Commerce and the Trinity Center, a non-profit which provides services to the homeless. Iman holds joint degrees in Structural Engineering and Urban Studies and Planning from the University of California, San Diego with honors.

Application Form

Profile

Deanne (First Name) | M (Middle Initial) | Pearn (Last Name)

Home Address | Suite or Apt

Moraga (City) | State | Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

- [x] District 2

Education

Select the option that applies to your high school education *

- [x] High School Diploma

College/ University A

Name of College Attended

Stanford University

Degree Type / Course of Study / Major

BA Human Biology

Degree Awarded?

- (•) Yes
- ( ) No

College/ University B

Name of College Attended

UC Berkeley

Degree Type / Course of Study / Major

MA Public Policy

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Homeless Service Provider

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

30

Please explain why you would like to serve on this particular board, commitee, or commission.

As the Executive Director of Hope Solutions, an organization the provides permanent housing and vital support services to highly vulnerable populations in Contra Costa County, I have a unique perspective on how well our homeless service system is functioning and how we can improve it to end homelessness quickly and permanently for our residents. Our organization works in a highly collaborative way with other non-profits, community groups and the County and will be better able to provide impactful services by deepening our partnerships through participation in the COH.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

I am currently serving on the Contra Costa County Council on Homelessness Board. I served for 6 years on the Housing California Board, another 6 years on the Alameda County EveryoneHome Board (including two years as Board Chair), and served 4 years on my children's preschool Board (including serving as President.)

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

See resume

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

the non profit for which I am the Executive Director (Hope Solutions) has contracts with the County.

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Deanne Pearn

Contra Costa Interfaith Housing

SUMMARY

Visionary and dynamic professional provides leadership on a local, statewide and national landscape addressing the needs of homeless populations. Co-created and expanded $20 million nonprofit organization to respond to alleviate poverty and eliminate disparities between vulnerable youth and their peers. Highly successful fund raiser plays lead role in policy development and organizational impact and growth. Works highly collaboratively and has written extensively about systems of care for children and their families.

EDUCATION

M.P.P., Goldman School of Public Policy, University of California at Berkeley
B.A. Human Biology, Stanford University

PROFESSIONAL EXPERIENCE

CONTRA COSTA INTERFAITH HOUSING, PLEASANT HILL, CA

April 2017-Present

Executive Director of organization committed to ending poverty and homelessness among the most vulnerable families and individuals by providing permanent supportive housing and intensive services.

- Set vision and strategy for dynamic non-profit that serves 1,100 people per year in Contra Costa County
- Lead staff of 45 and manage $4.2M agency budget
- Lead team of 5 Directors to implement 5 major program areas across the County
- Ensure systems in place to deliver highest quality services to residents and clients of CCIH
- Work with other providers and county partners to fundamentally improve housing and homeless service delivery system county-wide

FIRST PLACE FOR YOUTH, OAKLAND, CA

June 1998-Present

Co-Founded premier organization designed to end homelessness among former foster youth.

- **Helped grow** agency from 2-person start-up into statewide organization touching 2500 youth per year with budget of $20 Million and over 100 employees; highly respected organization known for innovation, being performance/outcomes driven, and embodying youth development framework

Vice President of Policy July 2010-Present

- **Created** policy department to strengthen organizations efforts to shape systems level change to fundamentally improve outcomes among transition age foster youth

- **Advocate** key policy changes--*California's Fostering Connections to Success Act extends foster care to 21. P*articipate in statewide/local county working groups to implementation of key policies/programs
- **Advocate** for transparency/performance standards among public contracts to ensure public investments in transition age youth are yielding a strong return on investments
- **Author** regular issue briefs to help build the field and promote best practices. Present at national, state and local conferences regarding best practices for helping homeless youth attain permanent housing and strong educational and employment gains

Chief Development Officer

- **Lead** department to raise $7.8 million through individual, foundation, government and event revenue in FY 2010. Manage agency communications, marketing strategies, messaging and branding
- **Responsible for** agency communications--quarterly newsletters, website, annual report, collateral materials, press releases, and donor engagement
- **Raise issues** awareness through speaking engagements and presentations to state legislators, academic audiences, funders and service providers

Program Director

- **Designed programs and evaluation measurement** combining scattered site housing, education and employment support, and intensive case management to help transition age foster youth achieve long-term self sufficiency; Developed partnerships with community of providers--county stakeholders and young adult participants; created Youth Advisory Board to provide input and worked with partner organizations in Alameda County to birth the Alameda County Foster Youth Alliance.

Alameda County, Social Services Agency, Oakland, CA
Graduate Research Associate June 1997- September 1997

- Analyzed research and developed empirically based employability assessment tool for welfare recipients.
- Presented findings to 50 Agency managers/executives.

Jesuit Volunteer Corps
Placement at Volunteer Legal Services Program, San Francisco, CA
Special Projects Coordinator August 1995- August 1996

- Spent year exploring the intersection of spirituality, social justice and community with cohort of full-time volunteers. Provided advocacy and holistic case management for homeless clients; coordinated monthly legal clinic for San Francisco residents; and conducted client intake and referral on poverty law issues.

Research Analyst, Health Systems Research, Inc., Washington, DC October 1993 - July 1995

- Researched federal, state, local maternal/child health programs and state health care reform initiatives.

Environmental Fellow, Homemaker's Union and Foundation, Taipei, Taiwan, ROC
June 1991- September 1991

- Facilitated public awareness campaign of environmental issues; taught environmental education classes.

BOARD MEMBERSHIPS

- *Contra Costa County Council on Homelessness (2018-)* - Advisory Board to County's Health, Housing and Homeless Service Department and Board of Supervisors regarding community's efforts to end homelessness
- *Housing California Board Member, (2009-2016)* Board member for statewide policy and advocacy organization dedicated to affordable housing for most vulnerable.
- *Sequoia Nursery School Board (2010 – 2013)* Board President, Vice President, Secretary for cooperative preschool

RECENT PUBLICATIONS

- Van Buren, Pearn, Leer, Jones, Cobbs; "More than Me: 2015 Exploratory Study of Pregnant and Parenting Youth in the Foster Care System," Issue Brief published by First Place for Youth, March 2016.
- Pearn, Orozco, Selver, Cobbs; "Staying Power: Longer Stays in the My First Place Program Contribute to Successful Outcomes for Transition Age Youth," Issue Brief published by First Place for Youth, October 2012.

HONORS AND AWARDS

*0 Keynote commencement speaker, University of California at Berkeley, Goldman School of Public Policy, May 2003
*1 Guest Lecturer, Public Management Class, UC Berkeley Goldman School of Public Policy
*2 "Alumnus of the Decade", Goldman School of Public Policy to honor contribution made to foster care community through development of First Place Fund for Youth. September 2001

RECENT PRESENTATIONS – (full list of presentations available)

- "Strategic Use of Longer-Term Housing Options for Youth," workshop presented at National Alliance to End Homelessness National Conference on Ending Family and Youth Homelessness, Oakland, CA February 19, 2016.
- "Working with Systems Involved Youth," workshop presented at National Alliance to End Homelessness National Conference on Ending Family and Youth Homelessness, San Diego, CA, February 20, 2015.
- "Improving Economic Self-Sufficiency: Enhancing Employment Outcomes and Increasing Income," workshop presented at National Alliance to End Homelessness Nat'l Conference, Ending Family and Youth Homelessness, New Orleans, LA, 2014.
- "Fulfilling the Promise of the Fostering Connections to Success Act: Lessons From California," presentation to National Resource Center for Youth Development Conference, Philadelphia, PA, August 7, 2014
- "Promoting Housing Stability for Newly Re-housed Families and Youth: Case Management and Financial Assistance," workshop presented at National Alliance to End Homelessness National Conference on Ending Family and Youth Homelessness, New Orleans, LA, February 19, 2014.

Application Form

Profile

Manjit
First Name

Middle Initial

Sappal
Last Name

Home Address

Suite or Apt

Martinez
City

State

Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

☑ District 2

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

Golden Gate University

Degree Type / Course of Study / Major

Public Administration

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

University of Phoenix

Degree Type / Course of Study / Major

Business Administration

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

San Francisco State University

Degree Type / Course of Study / Major

Biology

Degree Awarded?

○ Yes ◉ No

Other schools / training completed:

Course Studied

FBI National Academy

Hours Completed

400

Certificate Awarded?

◉ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Appointed

Seat Name

Public Safety Seat

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

I have been on the Council for the previous two years and have attended over 20 meetings

Please explain why you would like to serve on this particular board, commitee, or commission.

I have served on the Contra Costa Council on Homelessness for the past two years as a Public Safety Representative. As the police chief for the City of Martinez I have helped to coordinate a variety of endeavors related to serving the homeless such as being one the first cities to collaborate with CH3 on homeless outreach, working with CH3 on identifying information needed through data collection efforts, working on collaborations between the police department and non-profit organizations to provide service to the homeless population, and creating a full-time police officer position to work with the homeless population. I would like to continue serving on this Council in an effort to continue expanding ways to help the vulnerable homeless population in our County. The ability to collaborate with other people and entities allows us, from the policing side, to gather important perspectives on how we can all work together to impact the less fortunate in meaningful ways.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

I have serves on the Contra Costa Council on Homelessness for the past two years.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I have served as a police officer, supervisor, and manager in police agencies in this county prior to being appointed as the police chief in the City of Martinez. I have been the police chief in Martinez for the last five years and have a strong foundation in a variety of aspects of policing from patrol t investigations to administration.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

◉ Yes ○ No

If Yes, please identify the nature of the relationship:

The City of Martinez has a contract with the Contra Costa County Division of Health, Housing, and Homeless Services as well as with the Pleasant Hill Police Department for CORE Team services for the homeless population.

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Manjit Sappal

E-mail Address:

Contact Number:

Education:

Master's Degree – Public Administration, Golden Gate University, San Francisco, CA (2014)
- Focus on public administration, completed in thirteen months with a 4.0 GPA

PERF Senior Management Institute for Police, Boston University, MA (2012)
FBI National Academy Session 241, Quantico VA; (June 2010)
Bachelor's Degree – Business Management, University of Phoenix, San Francisco, CA (2003)
San Francisco State University, San Francisco, CA; September 1992 to December 1994
Diablo Valley College, Pleasant Hill, CA; September 1989 to June 1992
Contra Costa College, San Pablo, CA; 1989 to 1990

Professional Experience:

Chief of Police, Martinez Police Department, CA (pop. 39,000), 2015 to present
- 55 personnel; $12m budget
- Provide policy direction for an organization of over 50 employees to enhance the safety and quality of life of our community.
- Leverage partnerships in a variety of collaborations to enhance the quality of life for our residents and visitors.
- Provide opportunities for team building, employee development, and problem solving within the organization.
- Work with City Government and City Departments to solve neighborhood problems.
- Implemented geographic based community policing model for neighborhood problem solving.

Captain (+other ranks), Richmond Police Department, Richmond, CA (pop. 110,000), 1997 to 2015
- 320 personnel
- Exercised managerial command over the Northern Policing and Southern Policing Districts as well as the Criminal Investigative Section, the Crime Analysis Unit, the Police Service Dog program, the Range/Armory program, and chaired department Use of Force Review Committee.
- Developed crime reduction, crime prevention, and quality of life improvement strategies to facilitate neighborhood problem solving.
- Formulated crime reduction strategies with a heavy emphasis on managing neighborhood beat projects and engaging the community with an emphasis on building collaborative relationships.
- Crime reductions were achieved each year in the Northern District for a 31% decrease in residential burglaries and a 19% reduction in auto thefts in 2014.

- Led and managed the Professional Standards Unit and was involved investigating several high profile cases of corruption. Coordinated with the FBI on corruption cases and introduced technology for case management that was later adopted department wide for use of force reprting.
- Created CompStat program for the police department with a component of crime mapping and data analysis.
- Experience in numerous areas of policing to include Patrol, SWAT, Narcotics Enforcement, and Investigating homicides, gang crimes, and gun offenses.

Police officer, Pittsburg Police Department, CA (pop. 65,000), 1995 to 1997
Provided police services and served as a School Resource Officer at Pittsburg High School

Certifications:
- POST Executive Development Course certificate
- POST Management and Supervisory certificates
- POST Advanced, Intermediate, and Basic certificates
- Executive Development course certificate – POST mandated for police chief Executive Certificate

Professional Memberships and Civic Organizations:
- International Association Chiefs of Police (IACP)
- Police Executive Research Forum (PERF)
- FBI National Academy Associates
- Member of Rotary and Kiwanis in Martinez
- Member of Contra Costa County Council on Homelessness from 2018 to 2020
- Advisory Board member for the Boys and Girls Club - El Sobrante, CA
- Cub Scout Pack 645 – Assistant Cubmaster
- Lamorinda Youth Association coach (2007, 2010, 2012, and 2014) for kindergarten – second grade sports

Application Form

Profile

Margaret (First Name) | A (Middle Initial) | Schiltz (Last Name)

Home Address | Suite or Apt

Richmond (City) | State | Postal Code

Primary Phone

Email Address

Which supervisorial district do you live in?

- [x] District 1

Education

Select the option that applies to your high school education *

- [x] High School Diploma

College/ University A

Name of College Attended

University of Notre Dame

Degree Type / Course of Study / Major

B.A. Program of Liberal Studies

Degree Awarded?

- (•) Yes
- ( ) No

College/ University B

Name of College Attended

The Wright Institute

Degree Type / Course of Study / Major

PsyD Doctor of Psychology

Degree Awarded?

◉ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted

Seat Name

Behavioral Health Representative

Have you ever attended a meeting of the advisory board for which you are applying?

○ Yes ◉ No

If you have attended, how many meetings have you attended?

Please explain why you would like to serve on this particular board, commitee, or commission.

I am interested in addressing homelessness in Contra Costa County. I work for the Portia Bell Hume Center's West County FSP program as their Program Manager, as well as, program manager for the step-down outpatient program. Homelessness and behavioral health are closely connected. I would like to represent the experiences I have gained as the Behavioral Health Representative on the Council on Homelessness. I have past experience as an Administrative Director for Habitat for Humanity in Orange County, CA decades ago. Providing affordable housing is a passion of mine. I would love to contribute again in this area.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I have been in graduate school obtaining my PsyD degree as a clinical psychologist. For the the past four years I have been part of the supervisory team that built the Hume's Richmond community mental health clinic. I am now Clinic Manager. I would like to give back to Contra Costa my clinical observations and experiences gained from working with homeless participants with serious to severe mental health for the past 7 years. Working with the behavioral health symptoms that can contribute to chronic homelessness is an important part of any plan or solution to address homelessness in our communities. In a previous job in the 1990's, I worked as Administrative Director in tandem with a contractor and board of directors to establish Orange County's Habitat for Humanity office. We were able to build 75 condominium units and 5 homes while I was in that role. It taught me a great deal about housing issues and how stabilizing for individuals and families a secure home is. This has been an interest of mine ever since that time. It would be an honor to serve on the Contra Costa Council on Homelessness.

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

MARGARET SCHILTZ, PsyD

EDUCATION

4/2014 **The Wright Institute,** Berkeley, CA
Accredited Doctor of Psychology in Clinical Psychology

5/1980 **University of Notre Dame**, Notre Dame, Indiana
Bachelor of Arts, Program of Liberal Studies

CLINICAL/WORK EXPERIENCE

8/19-Present **Portia Bell Hume Behavioral Health and Training Center**
Community Mental Health Clinic, Richmond, CA
Clinic Manager, Richmond Clinic
Program Manager, Community Support Program – West (CSP-W)
Program Manager, Community Integrated Outpatient Services (CIOS)
Manage and oversee daily operations of Richmond clinic with support of Clinical Administrative Assistant. Manage and supervise delivery of clinical and case management services to 100 adults with moderate to severe mental health disabilities such as schizophrenia, bipolar disorder, major depressive disorder and post-traumatic stress disorder as program manager for CSP-W and CIOS programs. Provide weekly group and individual supervision for mental health clinician and case managers. Supervise daily morning meeting for CSP-W program. Supervise two licensed Clinical Supervisor Psychologists. Maintain a personal caseload of clients. Maintain charting and provide ongoing review of assessments, treatment plans, and session notes as clinical supervisor in accordance with Hume Center Medi-Cal and Medicare procedures and regulations. Manage expenses to program budget. Interview and select new staff as needed to fulfill contract requirements.

7/16-7/19 **Portia Bell Hume Behavioral Health and Training Center**
Community Mental Health Clinic, Richmond, CA
Program Manager, Community Integrated Outpatient Services
Manage and supervise delivery of clinical and case management services to 70 adults with moderate to severe mental health disabilities such as schizophrenia, bipolar disorder, major depressive disorder and post-traumatic stress disorder. Provide weekly group and individual supervision for clinicians and case managers each, as well as one hour of didactic training. Maintain a personal caseload of six clients. Provide onsite management of two administrative staff and collaborate with Hume Center Operations Manager to oversee office operations. Established charting set-up and provide ongoing review of assessments, treatment plans, and session notes as clinical supervisor in accordance with Hume Center and Medi-Cal procedures and regulations. Develop and manage program budget. Interview and select new staff as needed.

2/16-7/16 **Program Coordinator, Community Integrated Outpatient Services**
Participated with Program Director in the start-up of a new community mental health clinic in West Contra Costa County for the Hume Center following the award of a Medi-Cal funded contract by Contra Costa Health Services, Behavioral Health Division. Took lead as program coordinator for the newly created West County Outpatient Mental Health Services. Assisted with interviews and hiring of staff, build out and furnishment of new

office space, outreach to and engagement of 80 transfer clients from the former contractor, Rubicon. Supervised and reviewed the assessment and treatment plan development for each client engaged. Trained and supervised 3 clinicians and two case managers.

9/15-2/16 **Portia Bell Hume Behavioral Health and Training Center**
Community Mental Health Clinic, Concord & Pittsburg, CA
Mental Health Clinician
Continued to provide group and individual psychotherapy to existing caseload of 20 clients in the Contra Costa Outpatient Program (CCOP) upon completion of post-doctoral fellowship. As of November, 2015 began working two days per week in the Community Support Program (CSP) as a transition into a full-time role February 1, 2016 as a license eligible staff psychologist.

8/14-8/15 **Portia Bell Hume Behavioral Health and Training Center**
Community Mental Health Clinic, Concord, CA
Post-Doctoral Fellow
Provided group and individual psychotherapy to adult community mental health clients with moderate to severe mental health disabilities working in the Partial Hospitalization Program (PHP) and the Outpatient Program (OP).

In PHP, worked as part of a clinical team with 15 to 20 clients in a day treatment program. Facilitated stabilization of clients recently released from the hospital and prevented decompensation leading to re-hospitalization. Facilitated process and educational groups utilizing CBT, DBT and SMART Recovery treatment protocols; developed activities and programs; provided family therapy and collateral care coordination for clients; and performed intake assessments and discharge planning. Staffed PHP after-hours crisis phone one week per month.

In the Outpatient Program, provided individual and family psychotherapy to 18-20 clients 3 days per week. Treated adult clients with moderate to severe chronic mental health diagnoses. Performed intake assessments, treatment planning, collateral calls with case managers, doctors and family members, and maintained appropriate charting paperwork. Facilitated a weekly Aftercare group for client's recently graduated from the PHP into the clinic's outpatient psychotherapy program.

Training and supervision were conducted in a collaborative, consultative environment. Received training in such areas as suicide assessment, family therapy, and SMART Recovery.

4/14-7/14 **Aegis Treatment Centers, LLC**, Santa Maria, CA
Clinic Manager Trainee
Worked as Clinic Manager in training for a substance abuse clinic for the treatment of opiate addiction. Terminated due to inadequate post-doctoral fellowship supervision to obtain licensure hours.

9/13-4/14 Completed dissertation for The Wright Institute on "Attention Deficit/Hyperactivity Disorder in Adult Women: Personality and Neurotransmitters as measured by the Neurotransmitter Attributes Questionnaire (NAQ)." Acted as in-home caregiver for aging parents as mother recovered from stroke.

7/12-8/13 **Portia Bell Hume Behavioral Health and Training Center**
Community Mental Health Clinic, Concord, CA
Pre-Doctoral Intern

Provided group and individual psychotherapy to adult community mental health clients with severe mental health disabilities working in the Partial Hospitalization Program (PHP) and the Outpatient Program (OP). Full-time internship was equally divided between PHP, an outpatient day treatment program, and OP, outpatient individual psychotherapy services.

Within PHP provided group and individual psychotherapy in order to stabilize clients recently released from the hospital or to prevent decompensation and re-hospitalization. Worked as part of a treatment team with 15 - 20 clients diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder and major depressive disorder. Provided after hours crisis line coverage on a rotation schedule. Performed intake assessments, discharge planning, and collaboration with other community service agencies with the goal of increasing clients' independent functioning. Collaborated with program psychiatrist and clinical team for treatment planning.

Provided individual psychotherapy to 12 clients with moderate to severe mental health disabilities. Performed intake assessments, treatment planning, and collaboration with community based providers.

Training and supervision were conducted in a collaborative, consultative environment. Received training in such areas as crisis management, couples therapy, post-traumatic stress disorder protocols, DBT, psychodynamic diagnostic and treatment planning protocols.

1/12-4/12 **Cognition, Emotion & Personality Course, Clinical Psychology Doctoral Program, The Wright Institute,** Berkeley, CA
Teaching Assistant
Co-taught the winter 2012 trimester course on Cognition, Emotion & Personality as one of three teaching assistants. The course was mandatory for all second year Wright Institute PsyD students. Was responsible for attending lecture series, grading weekly student writing assignments, and leading three discussion classes.

8/11-6/12 **The Wright Institute Advanced Assessment Practicum,** Berkeley, CA
Psychodiagnostic Assessment Trainee, Fourth Year Practicum
Provide comprehensive psychological assessment testing services for children (6 and older) and adults. Testing includes clinical interview, cognitive, projective, and neuropsychological measures administration, scoring, interpretation, diagnosis, report writing, recommendations, and client feedback on a minimum of six full batteries. Supervised by Howard Friedman, Ph.D., ABPP

8/11 – 9/13 **Dr. Lynn O'Connor's Emotion, Personality & Altruism Research Group Lab,** San Francisco, CA
Lead Research Assistant

4/11 – 9/11 **Research on neuropsychological measures of ADHD in adolescents,** Walnut Creek, CA
Research Assistant
Assisted Howard Friedman, Ph.D., ABPP, a neuropsychologist within the community, with data entry design and data input from archival files. Scored Rorschach tests in the RIAP5 scoring system.

7/10 –8/11 **Portia Bell Hume Behavioral Health and Training Center**
Contra Costa County Outpatient Program, Concord, CA
Therapist, Third Year Practicum

Provided individual psychotherapy to adult community mental health clients at The Hume Center's outpatient clinic. Treated clients with serious, chronic mental illnesses such as Schizophrenia and Bipolar Disorder. Created and started with a fellow student trainee a psycho-education group for clients on coping with depression and anxiety. Received training in the areas of crisis management, reporting law, diagnostic and treatment issues in the areas of PTSD, autism, and mental disability, and theoretical orientations such as Narrative, ACT, and DBT. Presented two didactic trainings to fellow outpatient clinic student trainees: one on the effects of toxins on mental health and a second on language aphasias in schizophrenia. Training and supervision were conducted in a collaborative, consultative environment.

4/10 – 3/11 **Multicultural Course, Clinical Psychology Doctoral Program,**
The Wright Institute, Berkeley, CA
Teaching Assistant
Co-taught the spring 2010 trimester course on Multicultural Awareness as one of five teaching assistants. The course was mandatory for all first year Wright Institute PsyD students. Course focused on expanding students understanding of race, gender, and sexual orientation issues as they relate to their work as a psychologist. I also participated with two fellow teaching assistants in the research and selection of a new video for the sexual orientation segment of the multicultural course. The new video was shown to the spring 2011 class.

3/10-6/10 **ANKA Behavioral Health, Nevin House Residential Program,** Richmond, CA
Therapist, Second Year Practicum
Nevin House is a 16 bed, 3 – 6 month residential dual diagnosis treatment program for individuals with substance abuse and serious mental illness. Assisted with individual and group psychotherapy in a multicultural, milieu setting for adults faced with multiple life challenges

9/09–1/10 **Kaiser Permanente Medical Center, Department of Child Psychiatry,** Richmond, CA
Therapist, **Second Year Practicum**
Assisted clinical team with weekly group assessment of new clients. Provided observational feedback on assigned children from the group assessment to clinicians at the clinical team's case dispositions once a week. Co-led a psychotherapy group for children ages 8 – 11 years of age with a treatment goal to improve social and coping skills once a week. Co-taught a thirteen week psychoeducational workshop to parents of strong-willed adolescents with department head. Participated in didactic training provided weekly on topics related to child therapy. Provided individual psychotherapy to children.

9/08–6/09 **Options Recovery Services,** Berkeley, CA
Therapist, First Year Practicum
Provided individual supportive and insight therapy to Options Recovery clients and led a didactic, addiction recovery group three nights per week. Participated in weekly training sessions on addiction recovery topics and psychotherapy interventions, as well as, attended group supervision.

7/08-9/10 **Lincoln Financial Advisors Corporation**, San Francisco, CA
Administrative Assistant to Paul Solorzano
Worked part-time as a licensed administrative assistant to a financial planner in the downtown San Francisco office of Lincoln Financial Advisors.

9/06–6/08 **Lincoln Financial Advisors Corporation,** Salt Lake City, UT
Business Operations Manager

Managed the business operations for a regional branch office of 70 financial planners. Was responsible for the implementation of human resources, regulatory compliance and operations procedures. Turned around staffing issues in the Salt Lake City office and prepared office for a successful internal audit by January 2007. Coordinated and managed a successful office move into new space without any disruption of business in the summer of 2007.

CERTIFICATES

California State University, Long Beach, Long Beach, California
Certificate in Administration of Non-Profit Programs

Visiting Nurse Association of Orange County Hospice, Orange, CA
Certified Hospice Volunteer

References available upon request

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. b.**

Meeting Date:	11/23/2020
Subject:	Appointment to the Advisory Council on Aging
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	N/A
Referral Name:	Appointments to Advisory Bodies
Presenter:	Anthony Macias **Contact:** Anthony Macias, 925.602.4175

Referral History:

On December 6, 2011 the Board of Supervisors adopted Resolution No. 2011/497 adopting policy governing appointments to boards, committees, and commissions that are advisory to the Board of Supervisors. Included in this resolution was a requirement that applications for at-large/countywide seats be reviewed by a Board of Supervisors committee. The Advisory Council on Aging provides a means for county-wide planning, cooperation and coordination for individuals and groups interested in improving and developing services and opportunities for the older residents of this County. The Council provides leadership and advocacy on behalf of older persons and serves as a channel of communication and information on aging.

The Advisory Council on Aging (ACOA) consists of 40 members serving 2 year staggered terms, each ending on September 30. The Council consists of representatives of the target population and the general public, including older low-income and military persons; at least one-half of the membership must be made up of actual consumers of services under the Area Plan. The Council includes: 19 representatives recommended from each Local Committee on Aging, 1 representative from the Nutrition Project Council, 1 Retired Senior Volunteer Program, and 19 Members at-Large.

The Area Agency on Aging, the ACOA Membership Committee and the Clerk of the Board, using CCTV, recruit for these seats. The Contra Costa County EHSD website contains dedicated web content where interested members of the public are encouraged to apply. The website provides access to the Board of Supervisors official application with instructions on whom to contact for ACOA related inquiries, including application procedure.

Referral Update:

The Contra Costa Area Agency on Aging (AAA) recommends the appointment of Penny Reed to Member At-Large Seat #1 assigned to the Contra Costa Advisory Council on Aging (ACOA) for a term expiring on September 30, 2022.

The Membership Committee and the Executive Committee of ACOA recommends the appointment of Ms. Reed. Please find a copy of the member's applications provided as separate attachment.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointment of Penny Reed to Member At-Large Seat #1 on the Contra Costa Advisory Council on Aging (ACOA) for a term expiring on September 30, 2022., as recommended by the Council.

Fiscal Impact (if any):

There is no fiscal impact.

Attachments

Application Memo
Application - Reed

Contra Costa County California
Employment & Human Services

Kathy Gallagher, Director
40 Douglas Dr., Martinez, CA 94553 ✶ Phone: (925) 313-1579 ✶ Fax: (925) 313-1575 ✶ www.cccounty.us/ehsd.

MEMORANDUM

DATE: 10/21/2020

TO: Family and Human Services Committee

CC: Tracy Murray, Director, Aging and Adult Services

FROM: Anthony Macias, Staff Representative for the Advisory Council on Aging

SUBJECT: Advisory Council on Aging – Appointment Requested

The Contra Costa Area Agency on Aging (AAA) recommends for immediate appointment to the Contra Costa Advisory Council on Aging (ACOA) the following applicant: Ms. Penny Reed for Member at Large (MAL) Seat #1. The MAL #1 seat is undesignated and has remained vacant since 12/31/2019, with the term ending 9/30/2022.

The Area Agency on Aging, the ACOA and the Clerk of the Board, using CCTV, assisted with recruitment. AAA staff has encouraged interested individuals including minorities to apply through announcements provided at the Senior Coalition meetings and at the regular monthly meetings of the ACOA. The Contra Costa County EHSD website contains dedicated web content, where interested members of the public are encouraged to apply and provided an application with instructions on whom to contact for ACOA related inquiries, including application procedures.

Ms. Reed submitted an application for ACOA membership dated 08/10/2020 that is provided as a separate attachment. The ACOA Membership Committee interviewed Ms. Reed on 09/16/2020. The Membership Committee recommended Ms. Reed to the ACOA Executive Committee to fill MAL#1 seat. The ACOA Executive Committee approved Ms. Reed to fill MAL#1 at their 10/07/2020 meeting. Members of the ACOA voted unanimously to approve Ms. Reed's appointment to MAL#1 seat at their 10/21/2020 meeting.

Thank You.

RECEIVED
AUG 10 2020
CLERK BOARD OF SUPERVISORS
CONTRA COSTA CO.

Contra Costa County

For Office Use Only
Date Received:

For Reviewers Use Only:
Accepted Rejected

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

MAIL OR DELIVER TO:
Contra Costa County
CLERK OF THE BOARD
651 Pine Street, Rm. 106
Martinez, California 94553-1292
PLEASE TYPE OR PRINT IN INK
(Each Position Requires a Separate Application)

BOARD, COMMITTEE OR COMMISSION NAME AND SEAT TITLE YOU ARE APPLYING FOR:

CCC Advisory Council on Aging — PRINT EXACT NAME OF BOARD, COMMITTEE, OR COMMISSION
Member at Large — PRINT EXACT SEAT NAME (If applicable)

1. Name: Reed (Last Name) Penny (First Name) Rae (Middle Name)

2. Address: [redacted] (No.) [redacted] (Street) Richmond (Apt.) ca (State) [redacted] (Zip Code)

3. Phones: [redacted] (Home No.) (Work No.) [redacted] (Cell No.)

4. Email Address: [redacted]

5. EDUCATION: Check appropriate box if you possess one of the following:

High School Diploma ☒ G.E.D. Certificate ☐ California High School Proficiency Certificate ☐

Give Highest Grade or Educational Level Achieved Masters Degree, MSW

Names of colleges / universities attended	Course of Study / Major	Degree Awarded	Units Completed		Degree Type	Date Degree Awarded
			Semester	Quarter		
A) San Francisco State Uni	Social work	Yes ☒ No ☐	4		MSW	5/2004
B) San Diego State Uni	Social work	Yes ☒ No ☐	4		BSW	5/1997
C)		Yes ☐ No ☐				
D) Other schools / training completed: LCSW	Course Studied: Clinical Therapy	Hours Completed: 3200			Certificate Awarded: Yes ☒ No ☐	

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6. PLEASE FILL OUT THE FOLLOWING SECTION COMPLETELY. List experience that relates to the qualifications needed to serve on the local appointive body. Begin with your most recent experience. A resume or other supporting documentation may be attached but it may not be used as a substitute for completing this section.

A) Dates (Month, Day, Year)	Title	Duties Performed
From: 4/2019 To: Present Total: Yrs. 2 Mos. 4 Hrs. per week 40 . Volunteer ☐	Counseling Supervisor Employer's Name and Address Rossmoor Counseling Golden Rain Foundation 1001 Golden Rain Rd. Walnut Creek, Ca 94595	Hiring & Training new Clinicians & Staff Managing Budget Provide clinical consultation Work in Liaison w/ Managerial Team, Senior Staff, GRF Board To enhance services to Senior residents of Rossmoor.
B) Dates (Month, Day, Year)	Title	Duties Performed
From: 10/2013 To: 4/2019 Total: Yrs. 4 Mos. 6 Hrs. per week 40 . Volunteer ☐	Counselor / Social Worker Employer's Name and Address Rossmoor Counseling Golden Rain Foundation 1001 Golden Rain Rd. Walnut Creek, Ca 94595	Provide Psychotherapy and Support groups to residents of 55+ Community. Coordinate events and provide lectures to best serve the interests and needs of residents.
C) Dates (Month, Day, Year)	Title	Duties Performed
From: 8/2012 To: 10/2013 Total: Yrs. 1 Mos. 2 Hrs. per week 40 . Volunteer ☐	Program Director Employer's Name and Address Marin Day activity center STA NorCal 7 Mount Lassen Dr. #C128 San Rafael, Ca 94903	Supervise and create Programming for adults with ID and severe behavioral issues. Manage Program Budget Provide Clinical Consultation/Supervision.
D) Dates (Month, Day, Year)	Title	Duties Performed
From: 1/2012 To: 8/2012 Total: Yrs. 0 Mos. 8 Hrs. per week 40 . Volunteer ☐	Behavioral Health Specialist Employer's Name and Address Center for Elders' Independence 7200 Bancroft Ave. Oakland, Ca 94605	Provide Supportive therapy and crisis intervention for seniors. Provide Staff training & Consultation to enhance services for seniors w/ mental health issues.

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7. **How did you learn about this vacancy?**

☒ **CCC Homepage** ☐ **Walk-In** ☐ **Newspaper Advertisement** ☐ **District Supervisor** ☐ **Other** _____

8. **Do you have a Familial or Financial Relationship with a member of the Board of Supervisors? (Please see Board Resolution no. 2011/55, attached): No** ☒ **Yes** ☐

If Yes, please identify the nature of the relationship: _____

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publically accessible. I understand and agree that misstatements / omissions of material fact may cause forfeiture of my rights to serve on a Board, Committee, or Commission in Contra Costa County.

Sign Name: _____ **Date:** 6/5/2020

Important Information

1. This application is a public document and is subject to the California Public Records Act (CA Gov. Code §6250-6270).
2. Send the completed paper application to the Office of the Clerk of the Board at: **651 Pine Street, Room 106, Martinez, CA 94553.**
3. A résumé or other relevant information may be submitted with this application.
4. All members are required to take the following training: 1) The Brown Act, 2) The Better Government Ordinance, and 3) Ethics Training.
5. Members of boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.
6. Advisory body meetings may be held in various locations and some locations may not be accessible by public transportation.
7. Meeting dates and times are subject to change and may occur up to two days per month.
8. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

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Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. c.**

Meeting Date:	11/23/2020
Subject:	Appointment to the Arts and Culture Commission
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	N/A
Referral Name:	N/A
Presenter:	Dennis Bozanich
Contact:	Dennis Bozanich 925-655-2050

Referral History:

On December 6, 2011 the Board of Supervisors (BOS) adopted Resolution No. 2011/497 adopting policy governing appointments to boards, committees, and commissions that are advisory to the BOS. Included in this resolution was the requirement that applications for at-large/countywide seats be reviewed by a Board of Supervisors committee.

Referral Update:

The Arts and Culture Commission advises the Board of Supervisors in matters and issues relevant to Arts and Culture, to advance the arts in a way that promotes communication, education, appreciation and collaboration throughout Contra Costa County; to preserve, celebrate, and share the arts and culture of the many diverse ethnic groups who live in Contra Costa County; to create partnerships with business and government; to increase communications and understanding between all citizens through art. Most importantly, the Commission will promote arts and culture as a vital element in the quality of life for all of the citizens of Contra Costa County.

The Arts and Culture Commission (AC5) is composed by one representative from each of the five supervisorial districts, four at-large representatives and one alternate, for a total of ten seats. Appointments are for a four-year period with terms expiring on June 30 of alternating odd numbered years. The current roster is attached. At their November 2, 2020 meeting, the Commission considered four applicants. At that same meeting the, the Commission voted to nominate Ben Miyaji to the At Large 2 seat, for which the term expired on June 30, 2019.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointment of Ben Miyaji to the At-Large 2 seat on the Arts and Culture Commission of Contra Costa County (AC5) to a term expiring June 30, 2023, as recommended by the Arts and Culture Commission.

Fiscal Impact (if any):

None

Attachments

Application - Miyaji

Applications also considered on 11-2-2020

AC5 Roster - November 2020

Print Form

Please return completed applications to:
Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553
or email to: ClerkofTheBoard@cob.cccounty.us

Contra Costa County

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Ben

Last Name Miyaji

Home Address - Street [redacted]

City Pittsburg

Zip Code 94565

Phone (best number to reach you) [redacted]

Email [redacted]

Resident of Supervisorial District: 5

EDUCATION *Check appropriate box if you possess one of the following:*

☑ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
University of Maryland	General	☐ Yes ■ No
University of Chicago	General	☐ Yes ■ No
Evergreen Valley College	General	■ Yes ☐ No

Other Training Completed: USAF Meteorological School; various USAF Training Courses

Board, Committee or Commission Name Arts and Culture Commission

Seat Name Commissioner

Have you ever attended a meeting of the advisory board for which you are applying?

☐ No ■ Yes If yes, how many? 2

Please explain why you would like to serve on this particular board, committee, or commission.

As person of color, I think all people should have access to the arts. The arts make our lives complete. The arts are more important now than ever before. The arts allow us to use our own creativity to create meaningful pieces that reflect our unique experiences. Veterans, especially those veterans returning from deployment to the Middle East can use the arts to help recover from the trauma of war. Children from lower economic areas benefit from the arts in so many ways – creating something using their own hands; a sense of accomplishment; planning and reviewing their project and finishing the project. An "A" needs to be added STEM making it STEAM.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Please see attached resume.

I am including my resume with this application:

Please check one: ■ Yes ☐ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.

Please check one: ■ Yes ☐ No

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Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ☐ Yes ■ No

List any volunteer and community experience, including any boards on which you have served.

Please attached resume.

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publicly accessible. I understand and agree that misstatements and/or ommissions of material fact may ca[redacted]ard, committee, or commission in Contra Costa County.

[redacted] **Date:** [redacted]

Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

Questions about this application? Contact the Clerk of the Board at (925) 335-1900 or by email at ClerkofTheBoard@cob.cccounty.us

Important Information

1. This application and any attachments you provide to it is a public document and is subject to the California Public Records Act (CA Government Code §6250-6270).

2. All members of appointed bodies are required to take the advisory body training provided by Contra Costa County.

3. Members of certain boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.

4. Meetings may be held in various locations and some locations may not be accessible by public transportation.

5. Meeting dates and times are subject to change and may occur up to two (2) days per month.

6. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

7. As indicated in Board Resolution 2011/55, a person will not be eligible for appointment if he/she is related to a Board of Supervisors member in any of the following relationships: mother, father, son, daughter, brother, sister, grandmother, grandfather, grandson, granddaughter, great-grandfather, great-grandmother, aunt, uncle, nephew, niece, great-grandson, great-granddaughter, first-cousin, husband, wife, father-in-law, mother-in-law, daughter-in-law, stepson, stepdaughter, sister-in-law, brother-in-law, spouse's grandmother, spouse's grandfather, spouse's granddaughter, and spouses' grandson, registered domestic partner, relatives of a registered domestic partner as listed above.

8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

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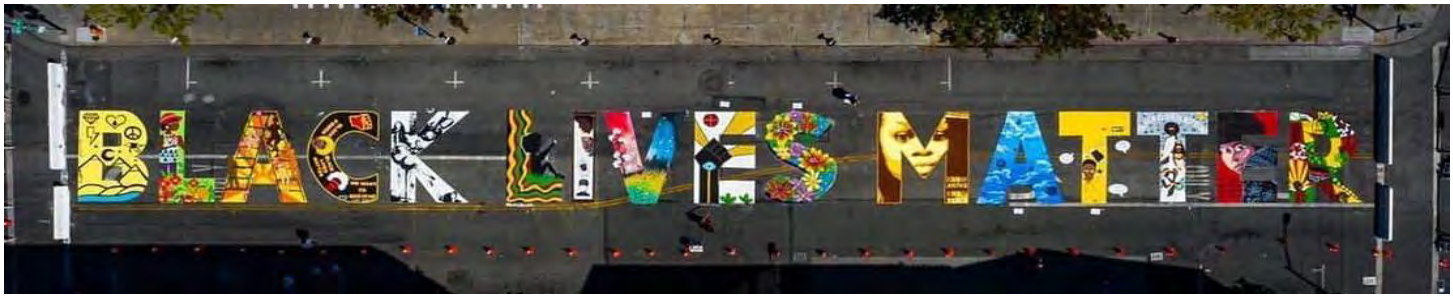
I have over 25 years of experience in the non-profit sector in various positions including board member, staff positions and executive director. I have served on numerous grants panels for small, medium and large size organizations. I have also submitted grants proposals. I have a unique perspective as a funder and grantee. I believe my experiences would be a benefit as a Contra Costa County Arts & Culture Commissioner.

- 7/1992 – 6/1996, 7/1999-6/2007, 7/2010-2/2015: City of San Jose Arts Commission (Chair 2003-2006). Served on numerous grants panels. Chair San Jose Mineta International Airport Public Art Steering Committee.
- 1992 – 1999. Children's Musical Theater of San Jose (CMTSJ) – Largest children's musical theater organization in the United States. CMTSJ's mission is to train and educate today's youth so that they will become the artists, patrons and leaders of tomorrow. Co-President Parents Auxiliary and board of directors member.
- 1/1997 – 6/1999: Asian Heritage Council. Board President.
- 1/2004 – 6/2006: Founding member South Bay Arts Forum: *First Voice, South Bay Arts Forum, builds opportunities for artists and arts organizations by providing a forum for multicultural arts communities to address issues of policy and equity through advocacy.* Organized candidate forums for mayoral candidates.
- 6/2008 – Present: Deputy Commissioner of Civil Marriages, performed over 5800 marriage ceremonies.
- 6/2013 – Present: City of Palo Alto Public Art Commission. Current Chair. Chair of the Palo Alto Public Art Master Plan Steering Committee.
- 2019 & 2020 – Served on California Arts Council Veterans in Arts grants panel and the Silicon Valley Creates Local Arts Group grant panels.
- 6/2020 – Palo Alto Public Art Commission approved a Black Lives Matter mural on Hamilton Avenue in from of Palo Alto city hall. An important piece of public art in our culture. Sixteen artists or artist teams were selected and assigned a letter. No better way to employ artists and make a beautiful statement.



RECEIVED
AUG 06 2020
CLERK OF THE BOARD

Print Form

Contra Costa County

Please return completed applications to:
Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553
or email to: ClerkofTheBoard@cob.cccounty.us

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Anna

Last Name Smith

Home Address - Street [redacted]

City Richmond

Zip Code 94801

Phone (best number to reach you) [redacted]

Email [redacted]

Resident of Supervisorial District: 1

EDUCATION *Check appropriate box if you possess one of the following:*

☑ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
Pacific Conservatory of the Performing Arts	Theatre	☑ Yes ☐ No
College of Santa Fe	BFA, Musical Theatre	☑ Yes ☐ No
San Francisco State University	MA, Equity and Social Justice in Education	☑ Yes ☐ No

Other Training Completed:

Board, Committee or Commission Name Arts & Culture

Seat Name At-Large-2

Have you ever attended a meeting of the advisory board for which you are applying?

☐ No ☑ Yes If yes, how many? 1

Please explain why you would like to serve on this particular board, committee, or commission.

Access to arts programming, both educational and recreational, is incredibly important to me. Growing up in Contra Costa County I was fortunate enough to have parents with the means to provide me with arts education and exposure, and now I am committed to giving that back to my community.
As a commissioner I hope to use my nonprofit experience and educational skills to expand the amount and variety of opportunities available for young people and adults in Contra Costa County.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

While my background is in musical theatre I am also a committed educator and activist with deep roots in Contra Costa County. As a nearly lifelong resident of West County I know how it feels to be in an overlooked corner of our community. My path has led me from performing to teaching to directing, and finally to founding a nonprofit committed to providing accessible arts education to my hometown school district.

I am including my resume with this application:

Please check one: ☑ Yes ☐ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.

Please check one: ☑ Yes ☐ No

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Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ☐ Yes ■ No

List any volunteer and community experience, including any boards on which you have served.

Member of Pinole Rotary, 2019-Present
Volunteer Drama Teacher, 2011-2015

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application [redacted] and agree that misstatements and/or ommissions of material fact may cause forfei[redacted]ard, committee, or commission in Contra Costa County.

Signed: [redacted]

Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

Questions about this application? Contact the Clerk of the Board at (925) 335-1900 or by email at ClerkofTheBoard@cob.cccounty.us

Important Information

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3. Members of certain boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.

4. Meetings may be held in various locations and some locations may not be accessible by public transportation.

5. Meeting dates and times are subject to change and may occur up to two (2) days per month.

6. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

7. As indicated in Board Resolution 2011/55, a person will not be eligible for appointment if he/she is related to a Board of Supervisors member in any of the following relationships: mother, father, son, daughter, brother, sister, grandmother, grandfather, grandson, granddaughter, great-grandfather, great-grandmother, aunt, uncle, nephew, niece, great-grandson, great-granddaughter, first-cousin, husband, wife, father-in-law, mother-in-law, daughter-in-law, stepson, stepdaughter, sister-in-law, brother-in-law, spouse's grandmother, spouse's grandfather, spouse's granddaughter, and spouses' grandson, registered domestic partner, relatives of a registered domestic partner as listed above.

8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

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Anna Smith, M.Ed

[redacted], Richmond, CA 94801
[redacted]

Objective

To encourage empathy in young people by providing them with opportunities to put themselves in another person's shoes, and give students the chance to see themselves within their education so that students can recognize and embrace their own agency.

Experience

The Quinan Street Project — 10/2011 – Present

- Founding Executive Director, providing K-6 drama curricula to the West Contra Costa USD.

Redwood High School — 8/2011 – Present

- Director, choreographer, teaching artist for high school students.

California Shakespeare Theater — 6/2011 – 7/2016

- Director and teaching artist for after school and summer camps. Grades 3-8.
- Internship completed (6/2011-8/2011).

142 Throckmorton — 1/2013– 1/2015

- Director and teaching artist for grades K-8 (after school, junior productions).

Berkeley Playhouse — 7/2012– 6/2014

- Teaching artist for after school theatre labs and camps. Grades K-6.

Town Hall Theatre — 2/2011 – 7/2012

- Director, choreographer, teaching artist for grades 3-8.

New Conservatory Theatre Center — 11/2010 – 4/2011

- Teaching artist and assistant teacher for after school enrichment. Grades Pre-K thru 3.

StageWrite — 08/2010 – 6/2011

- Internship completed for the school year 8/2010-5/2011.

Education

San Francisco State University — 08/2013 – 6/2015

Master of Arts in Education, concentration in Equity and Social Justice in Education

College of Santa Fe (Currently Santa Fe University of Art and Design) — 08/2007 – 12/2009

Bachelor of Fine Arts in Musical Theatre, Summa Cum Laude

Pacific Conservatory of the Performing Arts (PCPA) — 08/2005 – 05/2007

Certificate of Completion

Skills

Various theatre games
Experience teaching ages 3 to adult
Proficient in singing, acting technique
Improvisation
Reading music
Playing piano and vocal warm-ups
Dancing and choreography
Able to manage classes up to 26 students in size
Excellent people and phone skills
Grant writing
Responsible and organized
Self-motivated
Hygienic

Anna Smith
[redacted]
Richmond, CA 94801

OAKLAND CA 945
04 AUG 2020 PM 5 L

REC'D
AUG 06 2020
CLERK BOARD OF SUPERVISORS
CONTRA COSTA CO.

Clerk of the Board
of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

94553-12999

107

Print Form

Contra Costa County

Please return completed applications to:
Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553
or email to: ClerkofTheBoard@cob.cccounty.us

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Patrick

Last Name Gutierrez

Home Address - Street [redacted]

City San Ramon

Zip Code 94583

Phone (best number to reach you) [redacted]

Email [redacted]

Resident of Supervisorial District: Yes

EDUCATION *Check appropriate box if you possess one of the following:*

☑ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
San Jose State University	Majored in Radio/TV/FIlm & Minor in Broacast Journalism	■ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Other Training Completed: A.A. at Ohlone College in Fremont, CA

Board, Committee or Commission Name Arts Advisory Commitee for City of San Ramon

Seat Name

Have you ever attended a meeting of the advisory board for which you are applying?

■ No ☐ Yes If yes, how many?

Please explain why you would like to serve on this particular board, committee, or commission.

I would love to be on the board of the Arts and Culture Commision of Countra Costa County. I'm currently on the Arts Advisory Committte for the City of San Ramon and love the work we do.

I especillay enjoy how we can see our work directly benefit in the community on local public Art Work like the Public Utilty Box project. My whole life I loved giving back with public service and I have a deep passion for the Arts.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I think I can contribute to the Arts and Culture Commission in many different ways. I feel my vast experience working with various clients many of whom are non-profit in radio on the sales and marketing side over the past 16 years has helped me learn better about the Arts and I can apply it in this position. Some of them include the following: Diablo Ballet, Danville Chamber, Lafayette Chamber, Oakland Ballet, and the Diablo Regional Arts Association (just to name a few). I have worked on numerous campigns with them to help drive traffic to their events/websites and promote community outreach for them. That should help me in this position to help come up with creative ways to get people to local venues in the County to promote Public Art. Also I was a publicist for McCann Erickson working on the Sony films account in charge of publicty materials for 5 markets as well as a film critic so I have a long track record of promotiong the Arts. Those our just a few of the ways that I hope to contribute if I'm fortunate enough to be chosen on the Commision for the County I live in and love so much. Thank you for your consideration.

I am including my resume with this application:

Please check one: ☐ Yes ■ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.

Please check one: ■ Yes ☐ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ☐ Yes ■ No

List any volunteer and community experience, including any boards on which you have served.

I have worked for the local YMCA in Fremont growing up as Indoor Youth Sports Programs in high school. I volunteered for the Commonwealth Club in SF at various events. I have been a screening rep for various studies hosting sneak movie premieres for the media and local audiences as well. I just applied to be on the San Ramon Arts Foundation (still waiting to see if I'm accepted on that).

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ■ Yes ☐ No

If Yes, please identify the nature of the relationship: Last yer I worked with the Contra Costa DA's Office on a Victimes Awareness campaign b

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publicly accessible. I understand and agree that misstatements and/or ommissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

Signed: [redacted] **Date:** [redacted]

Submit this application to: Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

Questions about this application? Contact the Clerk of the Board at (925) 335-1900 or by email at ClerkofTheBoard@cob.cccounty.us

Important Information

1. This application and any attachments you provide to it is a public document and is subject to the California Public Records Act (CA Government Code §6250-6270).

2. All members of appointed bodies are required to take the advisory body training provided by Contra Costa County.

3. Members of certain boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.

4. Meetings may be held in various locations and some locations may not be accessible by public transportation.

5. Meeting dates and times are subject to change and may occur up to two (2) days per month.

6. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

7. As indicated in Board Resolution 2011/55, a person will not be eligible for appointment if he/she is related to a Board of Supervisors member in any of the following relationships: mother, father, son, daughter, brother, sister, grandmother, grandfather, grandson, granddaughter, great-grandfather, great-grandmother, aunt, uncle, nephew, niece, great-grandson, great-granddaughter, first-cousin, husband, wife, father-in-law, mother-in-law, daughter-in-law, stepson, stepdaughter, sister-in-law, brother-in-law, spouse's grandmother, spouse's grandfather, spouse's granddaughter, and spouses' grandson, registered domestic partner, relatives of a registered domestic partner as listed above.

8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

Print Form

Contra Costa County

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Martinez, CA 94553
or email to: ClerkofTheBoard@cob.cccounty.us

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Naina | **Last Name** Shastri

Home Address - Street [redacted] | **City** San Ramon | **Zip Code** 94582

Phone (best number to reach you) [redacted] | **Email** [redacted]

Resident of Supervisorial District: 3

EDUCATION *Check appropriate box if you possess one of the following:*

☐ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
CSU Hayward	Masters Certification in Biotechnology	☑ Yes ☐ No
University of Mysore, India	Masters in Biotechnologoy	☑ Yes ☐ No
		☐ Yes ☐ No

Other Training Completed:

Board, Committee or Commission Name Arts and Culture Commission | **Seat Name** At-Large-2

Have you ever attended a meeting of the advisory board for which you are applying?

☑ No ☐ Yes If yes, how many?

Please explain why you would like to serve on this particular board, committee, or commission.

Being a member of the Arts Advisory Committee of San Ramon City for the past 4yrs, I have been involved in promoting varied art forms in the community. As a practitioner, performer, and educator of Indian Classical Dance, I bring a different perspective and I believe that I will be a valuable addition and asset to the Commission.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Member of San Ramon City's Arts Advisory Committee (http://www.sanramon.ca.gov/our_city/boards_committees_commissions/arts_advisory_committee)
Founder/Director of Namaha Foundation for the Arts, www.namahaarts.org
Founder/Artistic Director of Ushanjali School of Dance, www.ushanjali.com
Member of the Entertainment Committee, Tri Valley Kannada Sangha

I am including my resume with this application:

Please check one: ☑ Yes ☐ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.

Please check one: ☑ Yes ☐ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ☐ Yes ■ No

List any volunteer and community experience, including any boards on which you have served.

Member of the Planning committe for San Ramon City's "Culture in the Community" event, 2020
Launched "Kaleidoscope San Ramon"; An initiative to bring unique performance based programs to the community; August 2nd 2020 (https://www.facebook.com/namahafoundation/)
Organized Fundraisers through performing arts events, for SEWA International USA, Bay Area

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publicly accessible. I understand and agree that misstatements and/or ommissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

Signed: [redacted] **Date:** [redacted]

Submit this application to: Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

Questions about this application? Contact the Clerk of the Board at (925) 335-1900 or by email at ClerkofTheBoard@cob.cccounty.us

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1. This application and any attachments you provide to it is a public document and is subject to the California Public Records Act (CA Government Code §6250-6270).

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3. Members of certain boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.

4. Meetings may be held in various locations and some locations may not be accessible by public transportation.

5. Meeting dates and times are subject to change and may occur up to two (2) days per month.

6. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

7. As indicated in Board Resolution 2011/55, a person will not be eligible for appointment if he/she is related to a Board of Supervisors member in any of the following relationships: mother, father, son, daughter, brother, sister, grandmother, grandfather, grandson, granddaughter, great-grandfather, great-grandmother, aunt, uncle, nephew, niece, great-grandson, great-granddaughter, first-cousin, husband, wife, father-in-law, mother-in-law, daughter-in-law, stepson, stepdaughter, sister-in-law, brother-in-law, spouse's grandmother, spouse's grandfather, spouse's granddaughter, and spouses' grandson, registered domestic partner, relatives of a registered domestic partner as listed above.

8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

Naina Shastri **Ph: 510-565-6202**
Artistic Director,
Ushanjali School of Dance, San Ramon,
Website: www.ushanjali.com; www.nahamaarts.org
Facebook: https://www.facebook.com/ushananjali2008/
https://www.facebook.com/namahafoundation/
LinkedIn: Naina Shastri
Instagram: @nainashastri
Twitter: @NainaShastri

I am a Bharatanatyam Dancer, Performer, Choreographer, Educator and Researcher.

Some of my performances:

- Mbongui Square Festival, 2018, 2019
- Performed for "Women's Day" event by SAVE (Safe Alternatives for Violent Environments)
- San Francisco International Movement Arts Festival 2018, 2019
- San Francisco International Arts Festival, SFIAF 2018
- West Wave Dance Festival, SAFEhouse Arts, SF
- Articulate Festival, Mysore
- APAture 2016, Kearny Street Workshop
- Mysore Dasara Festival, Mysore
- Every Friday Youth Performance, Yavanika, Bengaluru
- Events organized by the Kannada and Culture Dept.

And many more around the Bay Area and in India

Other Achievements and Collaborations:

- I have served three sessions as a RAW resident artist at SAFEhouse for the Arts, San Francisco.
- I have been an Artist-in-Residence at the Oakland Asian Cultural Center, Oakland, CA.
- I was selected to present my original work "Morning Raga" at the APAture Festival, 2016 organized by Kearny Street Workshop.
- I have been regularly presenting a collaborative work with Visual Artist, Salma Arastu exploring poetry by Persian Mystic Mevlana Rumi and Indian Bhakti Saint Meera Bai through Indian Classical Dance, recitation, music and multimedia.

Community Service:

- Member of San Ramon City's Arts Advisory Committee (http://www.sanramon.ca.gov/our_city/boards_committees_commissions/arts_advisory_committee)
- Founder/Director of Namaha Foundation for the Arts, www.namahaarts.org
- Member of the Entertainment Committee, Tri Valley Kannada Sangha
- Ex-Board Member; Asian Pacific Islander American Public Affairs (APAPA)
- CoFounder: Kalasangha - East Bay Artists Exchange
- Assisting the City Staff in planning, organizing and executing MultiCultural events like "Culture in the Community"
- Organized Dance Festival to help raise funds for "Women Empowerment" projects of SEWA International USA, Bay Area
- Involved with local, San Ramon based grassroots organization Rewire Community in an artistic capacity, choreographing and performing for their events on Women oriented topics.

Educator and Teacher:
Founder/Artistic Director of Ushanjali School of Dance, www.ushanjali.com

- As the Artistic Director of Ushanjali School of Dance I teach Indian Classical Dance at 3 locations (San Ramon, Pleasanton and Berkeley), currently training over 100 students. My students regularly perform at various dance festivals, City and Community organized cultural events throughout the Bay Area. The senior students are trained to present their *"Rangapraveshas" (Debut Solo Performance)*, an intensive program where the dancers present Solo for over 2 hours with Live Orchestra accompaniment.
- My school and I have been featured in NBC BayArea's program Asian Pacific America with Robert Handa.
- We have presented Lecture/Demonstrations at Libraries around San Ramon, Pleasanton and Pinole, for Girls Scouts group at a local school, International Day performances at Schools around San Ramon and Danville.

NonProfit Work:
I am the Founder/Director of the Non-profit organization, Namaha Foundation for the Arts.
Through this we conduct:

- An annual Dance and Music Festival, "Karnataka Composers Day"
- The Monthly Solo Indian Dance performance series, Naipunya Dance Festival every 2nd Saturday of the Month. This provides a platform and opportunities for upcoming soloists.
- Launched, "Kaleidoscope San Ramon" on August 2nd, 2020; An initiative to bring Artists from all genres of Arts, Ethnicities and Genders for a Collaborative and Harmonious expression of experiences.

Academic Background

- I have a Masters degree in Biotechnology from the University of Mysore.
- A Masters Certification in Biotechnology from CSU Hayward.
- I have worked in the Biotech Industry(Discoverx) and later at the Research Laboratory, Lawrence Berkeley National Lab; Emeryville.

I currently reside in San Ramon, California with my husband and two children.

Arts and Culture Commissioners

process:
Individuals are interviewed and

DISTRICT	REPRESENTATIVE	TERM START	TERM	ADDRESS
I	Silvia Ledezma	7/1/2017	06/30/21	Richmond, CA
II	Beverly Kumar	7/1/2019	06/30/23	Danville, CA
III	Vacant		06/30/23	
IV	Elizabeth Wood	Was first appointed on 10/1/2013. CB CCC Website says 2nd Term Jul 1, 2019.	06/30/23	Concord, CA 94521
V	Teresa Snook O'Riva	10/23/2018	06/30/21	Rodeo, CA 94572
At-Large 1	Y'Anad Burrell	Was frist appointed on 7/1/2011. CB CCC Website says 7/1/2019.	06/30/23	Richmond, CA 94806
At-Large 2	Vacant		06/30/21	
At-Large 3	Joan D'Onofrio	11/6/2018	06/30/23	Concord, CA 94518
At-Large 4	Lanita Mims	11/6/2018	06/30/21	Antioch, CA
Alternate	Pearl Parmelee	9/6/2019	06/30/23	Pinole, CA 94564
Managing Director	Jenny Balisle W:510- 255-1582		N/A	10 Douglas Drive Martinez, CA 94553

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. d.**

Meeting Date:	11/23/2020
Subject:	Appointments to FACT
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	NA
Referral Name:	Advisory Board Appointment
Presenter:	Laura Malone **Contact:** Laura Malone; 8-4943

Referral History:

On December 6, 2011 the Board of Supervisors adopted Resolution No. 2011/497 adopting policy governing appointments to boards, committees, and commissions that are advisory to the Board of Supervisors. Included in this resolution was the requirement that applications for at-large/countywide seats be reviewed by a Board of Supervisors sub-committee. The Family and Children's Trust Committee (FACT), was established in 1982 by the Contra Costa County Board of Supervisors to make funding recommendations on the allocation of a variety of funds for prevention and intervention services to reduce child abuse and neglect, provide supportive services to families and children, and promote a more coordinated, seamless system of services for families. Funding for FACT supported projects derived from federal and state program legislation, and donations to the County's Family and Children's Trust Fund. Every two years, the members of the FACT establish a series of County priorities for the use of these funds through review of existing data and reports and by holding Public Hearings in various areas of the county. The Committee then develops a competitive bidding process to select non-profit, community-based agencies that can best provide the services determined to be most important. Program recommendations are made to the Board of Supervisors which makes the final funding decisions. The Committee continues to evaluate these funded programs to ensure continued provision of quality service and achievement of stated goals. Programs currently being supported include countywide parenting classes, therapeutic day care for emotionally disturbed children, treatment for families, young children and teens with both substance abuse and child abuse issues, services for homeless families, and projects to support children whose mothers have been victims of domestic violence and sexual assault. The FACT has up to fifteen members who are appointed by the Board and include citizens with expertise in children's issues, education, law, non-profit agency management, public health, and program research/evaluation. In addition, the Director of the Child Abuse Prevention Council sits as ex-officio member of the Committee and participates in all matters except actually voting on funding recommendations. Terms for all Commission seats are two years. At-Large and non-District appointed seat vacancies on the FACT have been assigned for Family and Human Services Committee (F&HS) review since 2003.

Referral Update:

The Committee has vacancies in At-Large 3 seat and At-Large 5 seat . Please see the attached memo for more information.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointment of David Leimsieder to At-Large 3 seat expiring on September 30, 2021 and Jennifer Early to At-Large 5 seat expiring on September 30, 2022 on the Family and Children's Trust Committee, as recommended by the Employment and Human Services Department.

Fiscal Impact (if any):

No fiscal impact.

Attachments

Appointment Memo
Application - Leimsieder
Application - Early
Redacted Roster - November 2020

CONTRACOSTA COUNTY

EMPLOYMENT & HUMAN SERVICES

MEMORANDUM

Kathy Gallagher, Director

40 Douglas Drive, Martinez, CA 94553 • (925) 608-5000 • Fax (925) 313-9748 • www.ehsd.org

To: Family and Human Services Committee
Supervisor Candace Andersen, District II, Chair
Supervisor John Gioia, District I, Vice Chair

Date: November 23, 2020

From: Kathy Gallagher, EHSD Director
Laura Malone, FACT Staff

Subject: Family and Children's Trust (FACT) Committee Seat Membership Recommendation

The Employment and Human Services Department Director, Kathy Gallagher, respectfully requests that the Family and Human Services Committee accept the following recommendations.

Please accept the recommendation to appoint the following applicant to the FACT Committee:

Name	Seat	Area
David Leimsieder	At-Large Seat 3	Central County
Jennifer Early	At-Large Seat 5	West County

At-Large Seat 3 was declared vacant on September 8, 2020 upon incumbent resignation. The FACT Committee voted on October 5, 2020, to recommend appointment of David Leimsieder to At-Large Seat 3.

At-Large Seat 5 was declared vacant on October 1, 2020, upon incumbent renewal membership expiration. The FACT Committee voted on November 2, 2020, to recommend appointment of Jennifer Early to At-Large Seat 5.

Candidates for appointment to the FACT Committee typically serve a two-year term. The At-Large Seat 5 currently has a term expiration of September 30, 2022, and the At-Large Seat 3 currently has a term expiration of September 30, 2021, at which point the reapplication and reappointment process would be required.

PURPOSE OF COMMITTEE

The purpose of this committee is to establish priorities and make funding recommendations to the Board of Supervisors on the allocation of specific funds for the prevention/amelioration of child abuse and neglect, and the promotion of positive family functioning. These funds include: Child Abuse Prevention, Intervention, and Treatment funds (CAPIT) funds, (AB 1733), Birth Certificate revenue to the County Children's Trust (AB2994), the Ann Adler Children's Trust funds, Community-Based Child Abuse Prevention funds (CBCAP) and other funds as may be subsequently directed by the Board of Supervisors.

SUMMARY OF RECRUITMENT EFFORTS/NOMINIEES FOR MEMBERSHIP

The FACT Committee, in conjunction with the County Administrator's Office, continues to make every effort to fill its vacant seats. These efforts include releasing public notices on the EHSD social media sites, contacting each district Supervisor's office and releasing public notice, inviting interested parties to consider membership and soliciting the support of current members to outreach to potential candidates for consideration for membership.

FACT Committee membership consists of the following:

- Five AT-Large seats
- One representative from each of the five Supervisorial Districts
- Five discipline/sector specific seats

There are currently 11 seats filled on the FACT Committee. The Committee has vacancies in the District II and the District V Seat. As indicated above, At-Large Seat 3 was declared vacant on September 8, 2020 due to Seat 3 member resignation on August 4, 2020; At-Large Seat 5 was deemed vacant on October 1, 2020, when At-Large Seat 5 member did not pursue reappointment; District II Seat was declared vacant on October 20, 2020, resulting from committee member resignation on October 5, 2020; and the District V Seat was declared vacant on September 17, 2019, resulting from committee member resignation on August 25, 2019. The FACT Committee has actively recruited to fill the vacancies and submitted an applicant to Supervisor Glover's office for recommendation to the District V Seat.

If the seat members referenced herein are appointed, FACT Committee seat members will live or work in the following areas of the county (excluding the pending resignation):

- East (1): District III
- Central/South (9): Four discipline specific, Four At-Large, District IV
- West (3): District I, One discipline specific, One At-Large

The FACT Committee recommends appointing David Leimsieder to At-Large Seat 3 and Jennifer Early to At-Large Seat 5, which will have term expirations on September 30, 2021, and September 30, 2022, respectively.

The candidates have expressed a sincere interest in serving on the Committee and are dedicated to fulfilling the mission and goals as outlined in the Committee's policies and procedures.

Based on the above information, the Director of EHSD on behalf of the FACT Committee, respectfully recommends that the FHS Committee appoint David Leimsieder and Jennifer Early to serve as members on the FACT Committee.

Enc. Board, Committees, and Commission Application for *David Leimsieder*
Board, Committees, and Commission Application for *Jennifer Early*
FACT Roster - DRAFT

Application Form

Profile

David (First Name) | J (Middle Initial) | Leimsieder (Last Name)

[redacted] (Home Address) | [redacted] (Suite or Apt)

WALNUT CREEK (City) | CA (State) | 94596 (Postal Code)

[redacted] (Primary Phone)

daveleimsieder@berkeley.edu (Email Address)

Which supervisorial district do you live in?

☑ District 4

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

Salt Lake Community College

Degree Type / Course of Study / Major

Political Science

Degree Awarded?

○ Yes ◉ No

College/ University B

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Family & Children's Trust Committee: Submitted

Seat Name

At-Large

Have you ever attended a meeting of the advisory board for which you are applying?

○ Yes ◉ No

If you have attended, how many meetings have you attended?

N/A

Please explain why you would like to serve on this particular board, commitee, or commission.

I am an alumnus of Foster Care. I have spent most of my adult life advocating for improved systems of prevention, and better services for children and families already in the foster care system. I have spent my career working in Youth Development, both in prevention programs as well as working with children in foster care. I have a deep interest in driving lasting, positive impact in the lives of youth.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

- Beyond Emancipation, Oakland, CA (Board Member, December 2019 – Present) - Foster Care Alumni of America, Tucson, AZ (Communications Chair AZ Chapter; June 2009 – May 2011) - Arizona Foster Care Review Board – State Board, Arizona State Supreme Court, Phoenix, AZ (Appointed by Chief Justice Rebecca White Berch for At-Large Term; January 2009 – December 2011) - Community Partnership of Southern Arizona, Tucson AZ (Community Trainer and Peer Mentor; March 2002 – August 2007)

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Please see attached Resume.

_CC_County_FACT_Commission_Application__9-1-2020_.pdf

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

DAVID JOSEPH LEIMSIEDER
[redacted] Walnut Creek, CA 94596
E-MAIL: djliemer05@gmail.com

September 1, 2020

To Whom it May Concern,

Thank you for your consideration, I am truly honored to be considered for a seat on the Contra Costa County, Family And Children's Trust Committee (FACT). I have spent my entire career working to improve the lives of youth from less than fortunate backgrounds. I bring a plethora of both professional work experience, and life experience that I feel would be a great asset to this committee.

For eighteen (18) years, I have worked in the field of youth development, having started my career at the age of 16 working with the City of Tucson Parks & Recreation Department. I began working in (and then supervising) afterschool and summer programs in neighborhoods where poverty was widespread, the threats of gangs and violence was real, and the opportunity gap for kids was huge. While working for the City of Tucson, I also developed a Physical Education (P.E) program at a local school in Tucson, Arizona. I stayed on the school's faculty for five years as a Physical Education Specialist. While I maintained my job teaching P.E., I also gave back to my community.

At the start of my career I was still in foster care. While in care I was fortunate to have only resided in four placements over a six year period. Two group homes, one foster home, and one Transitional Housing program, not unlike the housing programs that Beyond Emancipation operates. I would go on to juggle several volunteer hats, while working a part time and full time job. At the age of 21, I took a job working in one of the same group homes I resided at. Eventually I began working at that home, and at another group home for young women. I stayed in that position for three years.

In 2011, I moved with my long-time partner to Salt Lake City. I continued my youth development career, and I worked with both Playworks, and the Boys & Girls Clubs where I eventually became an Area Director with oversight of six Boys & Girls Club locations including the management of staff, programs and facilities. In 2017, my partner and I relocated to the Bay Area so I could help boost the programs and operations of the Contra Costa County Boys & Girls Clubs. Most recently my career has brought me to UC Berkeley where I now serve as Director of Youth Programs with the Recreational Sports Department. I am currently overseeing a big multi-year effort to reorganize, develop, and implement new youth programs and outreach opportunities for a new generation.

Through it all, I have given back to my community. For more than three years, I served as a Board Member for the Arizona Chapter of the Foster Care Alumni of America. As a teenager I refused to sit back and watch while laws and policies were being delivered by the Arizona State legislature that disenfranchised youth in care. I served for more than six years as a Community Trainer, and was contracted as a Speaker/Presenter with the Community Partnership of Southern Arizona where I spoke to and trained case managers, therapists, attorneys, psychiatrists, and judges on the importance of providing sound care, and support for youth in foster care. For this work I was awarded the Youth Achievement award in 2005 by the Mental Health Association of Arizona.

I later served as a Member-At-Large on the Arizona State Foster Care Review Board, where I was appointed to a two year term by Arizona Supreme Court Chief Justice Rebecca White Berch. While I worked hard to advocate for youth in care, I also could not stand by and watch my peers in school across the state be persecuted for being gay, or transgender. During my senior year of high school I founded The Imagine Project GSA Network which was a joint project of the Gay Lesbian Straight Education Network (GLSEN) chapter in Tucson, AZ and the Wingspan LGBT Center. For six years I worked to help build the capacity of Gay-Straight Alliance clubs at more than 50 schools across the state of Arizona, and worked closely with Lambda Legal to ensure that schools and school districts did not disenfranchise youth, as protected by the Constitution.

I cannot even begin to list all of the work I have done in my life thus far. However I have always believed in being a driver of positive social impact for all youth. I am passionate about advocacy, and making the world a better place. Please accept my attached Resume, and Biography as further testament to my credentials. Thank you for your consideration.

Respectfully,

DAVID JOSEPH LEIMSIEDER

[redacted], Walnut Creek, CA 94596
E-MAIL: djliemer05@gmail.com
https://www.linkedin.com/in/david-leimsieder-69286b45

OBJECTIVE

To utilize my leadership experience in the areas of non-profit organizational management, recreation, program development, and education to support the development and growth of a reputable Non-Profit Organization.

CORE COMPETENCIES

Program Development, Management & Evaluation

- Measurement Tool Development & Execution
- Knowledge of Continuous Improvement Processes
- Youth Program Leadership and Development
- Curriculum Development and Adaptation
- Strategic Planning and Action Plan Development
- Multi-Tiered Program Management & Organization
- Leadership Development and Professional Mentoring

Community Outreach & Engagement

- Committees, councils, and coalitions
- Social Media, Branding, & Marketing Strategy
- Public Orating, Training Development & Facilitation
- Government & Community Group Relations and Advocacy

Organizational Leadership & Development

- Budget Development, process, and management
- Policy, Systems & Structures development/implementation
- Hiring and Retention of Professionals in Human Services field

PROFESSIONAL EXPERIENCE & ACHIEVEMENT

Director of Youth Programs — **University of California, Berkeley - Recreational Sports Department**
Berkeley, CA (October 2019 – Present)

- Develop, Oversee and Administrate the implementation, delivery, and evaluation of recreational youth programs
  - Provide support and leadership to Recreation Supervisors and Coordinators (leadership to all program staff)
  - Develop new programs and initiatives; provide oversight for program design, development and implementation
- Manage performance of Youth Programs staff in achieving goals, providing technical assistance and leadership in areas including program design, development, community relations and program operations
  - Implement and oversee annual performance evaluation process including coaching of staff, and performance goal setting
  - Establish and maintain annual work plans, including unit-wide shared work plan document
  - Establish, maintain, and manage partnerships with other Departments, schools, and colleges on UC Berkeley Campus
- Develop, and manage Youth Programs budget including the monitoring and reconciliation of income and expenses
  - Manage and maintain $3.5 Million dollar Youth Programs unit budget in coordination with Departmental Director
  - Set and Manage progress of annual revenue benchmarks and monitor monthly progress
- Provide risk management oversight and manage compliance with university, divisional, and departmental policies and procedures
- Develop, implement, and manage public relations and marketing for youth programs
  - Provide leadership to Marketing Department in regard to marketing campaigns, social media, and web updates
- Oversee and co-manage recreational facilities in coordination with Facilities Management Department
  - Lead and oversee facilities management of Golden Bear Recreation Center and Strawberry Canyon Recreation Area in coordination with Facilities Director and Rec. Supervisor

Director of Operations — **Boys & Girls Clubs of Contra Costa,**
El Sobrante, CA (November 2017 – February 2019)

- Oversee and Administrate the implementation, delivery, and evaluation of operations, programs, services and activities that facilitate achievement of Youth Development Outcomes
  - *Manage rollout of Continuous Improvement Process (YPQA Methods and YPQA Assessment)*
  - ***Certified as a YPQA Methods Trainer by the David P. Weikart Center for Youth Program Quality and BGCA***
- Manage performance of assigned staff in achieving goals, providing technical assistance and leadership in areas including program design, development, community relations and program operations.
  - *Manage 4 Club Sites including 20+ staff* ***(Opened two new program sites; 85% increase in Membership/ADA)***
    - *Led recruitment efforts for program expansion and 14 new program staff openings*
  - *Implement Performance Management standards and set yearly deadlines and goals for professional development*
  - *Perform regular program monitoring/site observation & provide effective feedback and resources for Site/Unit Directors*
- Support Board of Directors, including production of monthly program and operations reports, and regular updates on operations
  - *Develop comprehensive monthly reports and dashboard for Board of Directors*
  - *Co-Facilitate and manage community Advisory Board activities and meetings with Advisory Chair(s)*
  - *Staff manage all Safety Committee Activities including site tours, and quarterly meetings*
- Coordinate agency budget development; monitor and report variances in revenues and expenditures.
  - ***Manage $975,000.00 annual Operations Budget of $1.4 Million overall budget***
- Research, develop, and maintain all Organizational Safety, Technology, and Operating policies and standards
  - ***Researched policies, formulated drafts, worked with Safety Committee and Community Partners on development, approval, and implementation of Operations, Safety, Program, and Technology Policies and Standards (Spring 2018)***
  - *Co-Facilitate the development and maintenance of Human Resources Policy and Staff Code of Conduct*
- Oversee, and manage all Boys & Girls Club Facilities and overall day-to-day Operations
  - *Manage, coordinate, and facilitate the maintenance and repair of all facilities and equipment*
  - *Manage all contractors (I.T.; Janitorial; Supply) conduct bids, manage and oversee projects, and evaluate contractor productivity*
- Develop, strategize, and implement Professional Development, & Professional Standards for all Program Staff, Supervisors, and Managers
- Develop and maintain collaborative partnerships with other youth serving organizations, members, parents, families and community orgs

Professional Experience & Achievement Continued

Area Director (Midvale/Sandy Area) **Boys & Girls Clubs of Greater Salt Lake (formerly South Valley)**
Midvale Boys & Girls Club, Midvale, UT (March 2013 – November 2017)

- Oversee, and Manage Midvale Boys & Girls Club facility and programs (Teens & Juniors) (200 – 400 youth daily; up to 22 staff)
  - *Manage and maintain Club facility; ensure facility is in pristine working order and facilitate maintenance as necessary*
  - *Supervise cash collection and ensure that all incoming donations and dues are reconciled in line with budget revenue goals*
  - *Recruit, Hire, Train, Supervise, and Evaluate Program Directors and Youth Development Professionals* ***(78% Retention of all staff July 2015 – Oct. 2017)****; Oversee and manage large volunteer cohort*
    - *Oversee annual recruitment efforts for school-year and summer staff including interview and evaluation/recognition process*
    - *Manage and maintain large volunteer partnership program with local colleges and universities (25 -40 Annual Volunteers)*
  - *Oversee and manage special projects and renovations of Club Facilities*
    - ***Facilitated community asks and collaborated with Club Administration on grants that funded renovation and facility improvements including HVAC (8 units), Kitchen Overhaul, Gym Remodel and Upgrade, Teen center remodel, Tech Center Rebuild/Infrastructure upgrade, and build out of outdoor learning center***
  - *Led Area Club Sites/Staff through merger between Greater Salt Lake and South Valley Boys & Girls Clubs (July 2015)*
- Administrate, manage, support, and evaluate up to five out-of-school time programs (up to 800+ youth annually and 44 staff) in collaboration with school district partners
- Develop, study, implement, and evaluate effective youth development program curriculum
- Oversee Area Budget, manage grants and maintain relationships with funding partners
  - *Manage Area Operations budget ($350,000 - $750,000.00); Ensure that staffing, facility, and supply needs are met*
  - *Reconcile and report on all expenditures; manage appropriation of program funds and acquisition of program supplies, and equipment; report on all grants awarded to Area programs and Sites*
- Develop, coordinate, and manage Statewide Intramural Sports Program

Program Associate (Volunteer & Community Engagement Manager) **Playworks ,** Salt Lake City, UT
(February 2012- March 2013)

- Manage citywide volunteer programs (recruitment, training, support, recognition, and evaluation)
  - *Recruit volunteers through community outreach and partnerships with local colleges and universities*
- Lead training and support of volunteers citywide through regular orientations and on-site training and technical support
- Coordinate and support citywide hiring efforts and assist with maintaining local AmeriCorps compliance and management of members
  - *Evaluate applications of prospective hires, coordinate interview process with city staff, and initiate offer process including background checks, payroll, and initiation of training*
- Manage Salesforce Database for all Volunteers, Donors, and Corporate Supporters
- Direct the planning, development, management and execution of communitywide/fundraising events

Direct Support Professional **Devereux Foundation Arizona,** Tucson, AZ
(January 2008- April 2011)

- Provide support, counseling and mentoring to at-risk adolescent youth in a residential setting
- Coordinate food and supply purchasing for two group homes with limited weekly budget
- Coordinate and facilitate weekly recreation activities including yearly out-of-State trip in coordination with agency staff, CPS Caseworkers, Probation Officers, and judges
- Case Manage files for youth at two group homes with respect for youth confidentiality
- Ensure compliance with local, and state regulations as well as organizational policy directives

VOLUNTEER EXPERIENCE

Board Member
Beyond Emancipation (December 2019 - Present))

Serve a member of Board of Directors; Provide oversight and governance to Non-Profit organization. Helped launch new Program Committee

Member-At-Large
Arizona Foster Care Review Board (State Governing Board)
Arizona Supreme Court, Phoenix AZ (Jan 2009 - Dec. 2011)

Appointed for a 2 year term as a Volunteer member of the FCRB (Foster Care Review Board) by Arizona Chief Justice Rebecca White Berch; Represent youth in state foster care; advocated for sound policy as well as provided oversight to the Judiciary

Founder & Chief Program Officer
The Imagine Project G.S.A. Network (September 2004 - August 2009)

Founded The Imagine Project as a Senior in High School; Lobbied local school districts to change policies; Supported capacity building for over 50 GSA clubs in Southern and Central Arizona

Communications Chair/Member Alumni (Arizona Chapter)
Foster Care Alumni of America (June 2010 - May 2011)

Served as Communications Chair and coordinated all communications via e-mail, and printed newsletters; Served as liaison between national organization and chapter

EDUCATION

Associates of Science- Political Science/Public Policy
Salt Lake Community College, Salt Lake City, UT (2012 - 2014)
Pima Community College, Tucson AZ (2007 - 2009)

Biography for Dave Leimsieder

Dave Leimsieder has spent nearly 18 years as a professional leader working to support, and develop youth in a variety of recreational, educational, and social service programs. Through this youth development experience, Dave has built a powerful network, and has served as a youth advocate both on the local and national level. Dave is an alumnus of foster care, having spent more than six years in care as a teenager. Dave came out as gay while in foster care. Dave spent his early childhood years in a single parent household with his mother who brought him up with Mexican-American values and heritage. Dave is proud of his Chicano heritage, and maintains a close relationship with his family in Arizona.

Dave is presently working with the University of California, Berkeley in the Recreational Sports Department where he serves as the Director of Youth Programs. In this role Dave is overseeing a big multi-year effort to reorganize, develop, and implement new youth programs and outreach opportunities for a new generation. Dave is responsible for the management of over 300 seasonal staff, and additional 65 year-round contract, and career professionals. Dave has oversight of the Golden Bear Recreation Center, and the Strawberry Canyon Recreation Area.

Prior to working at UC Berkeley, Dave served as Director of Operations with the Boys & Girls Clubs of Contra Costa County. While working with the Clubs in Contra Costa County, Dave oversaw an expansion of services including the opening of two new program sites. Dave oversaw the entire day to day operations including staff management, facilities management, and oversight of the budget. Dave was responsible for developing and maintaining community partnerships, and was instrumental in helping the Clubs acquire more than $280,000 in annually renewable government contracts, and more than $300,000.00 in annual community contributions and sponsorships. Partnerships came from companies and foundations such as Valley Community Foundation, Lesher Foundation, Shell, Chevron, and Marathon (formerly Tesoro; Andeavor). Dave worked hard to improve the overall program quality at all sites, and overhauled the entire professional development program while fully implementing best practice methods from the David P. Weikart Center for Youth Program Quality. Dave was subsequently certified as a trainer and evaluator of the Youth Program Quality Assessment by the David P. Weikart Center and the Boys & Girls Clubs of America (BGCA).

Prior to his roles in Northern California. Dave served as an Area Director with the Boys & Girls Clubs of Greater Salt Lake, near Salt Lake City, Utah. Dave was responsible for supervising, managing, maintaining, and evaluating five (5) after school program sites in coordination with the Canyons School District, along with the Midvale Boys & Girls Club, its facilities and programs. Through a partnership with Canyons School District, Dave managed multiple government grant contracts including 21st Century Community Learning Center (CCLC) Grants, Child Care Development Fund (CCDF) grants, and Social Services Development Fund (SSDF) grants. In total, Dave managed and helped secure renewals totaling more than $6,000,000.00 over a five (5) year period.

Additionally Dave served on several community commissions and committees, including the Midvale Mayor's Homeless Taskforce, the Salt Lake County/Midvale Community IMPACT subcommittee, Salt Lake Area Gang Taskforce, and the Midvale Cinco De Mayo festival Board of Directors. For six years Dave maintained membership in the Boys & Girls Clubs Professionals Association, and was honored with the National Service to Youth award on his fifth anniversary of service to the Boys & Girls Clubs movement.

Before coming to work with Boys & Girls Clubs, Dave worked with Playworks in Salt Lake City. As both a Program Coordinator (Coach) and Program Associate, Dave worked to promote healthy play, positive leadership skills, and healthy developmental skills for youth across the Salt Lake Valley. Prior to moving to Utah, Dave spent 5 years as a Physical Education Specialist at Robison Elementary School in Tucson, AZ. During his tenure as P.E. Specialist Dave implemented the first P.E. program at the school in nearly two decades and worked to expand student access to athletics and helped bring in community support. This additional community support led to an expansion of healthy competitive sports programs for students at the school.

Dave started his career with the City of Tucson Parks and Recreation Department where he was a staff member and supervisor for the KIDCO after-school and summer program for almost 7 years. Dave consistently worked in low-income neighborhoods and often brought the community and families into the programs in which he worked. Dave was recognized several times for leadership, program quality, and regularly scored highly on satisfaction surveys from youth and parents.

Dave is an alumnus of foster care and has used his experience to further advance the lives of youth presently living in care. Dave entered foster care at the age of thirteen, and remained in the system through his 18th birthday. While in care, Dave resided in four different placements. On his 18th birthday, Dave voluntarily agreed to stay in the foster care system, and actively participated in Arizona's Young Adult Program. As a teenager Dave spoke to professionals and community members about the importance of offering sound and consistent psychiatric care and counseling for youth in foster care through the Community Partnership of Southern Arizona. Dave was a member of the Arizona CPS Youth Advisory Board, and through testimony to the Arizona State Legislature, helped get a youth's voice at the table when policy makers began reforming the continuum of care for youth in Arizona's foster care system. For this work, Dave was honored by the Mental Health Association of Arizona with the Youth Achievement Award.

Three years after aging out of foster care, Dave returned to work with the Devereux Foundation, at the same group home he resided in as an adolescent. Dave served for three years both as a staff member and youth mentor. Dave is a proud member of the Foster Care Alumni of America and served as Communication Director for the Arizona chapter. In December 2008 Dave was appointed by Arizona Supreme Court Chief Justice Rebecca Berch to serve on the Arizona State Foster Care Review Board. While serving on the state board Dave participated on the Advocacy committee and AdHoc/Awareness committee.

In addition to being an advocate for Foster Care youth rights, Dave also worked as an advocate for LGBT (Lesbian, Gay, Bi, Transgender) youth. As a senior in high school Dave founded The Imagine Project which served as a support network for LGBT youth to find resources and support getting Gay-Straight Alliance (GSA) clubs up and running at their schools. Dave served as a founding member of the National Association of Gay Straight Alliances and spoke to policy leaders at conferences in San Francisco, Phoenix, and Los Angeles. Dave served as a member of GLSEN (Gay Lesbian Straight Education Network) in Tucson, and became a National GLSEN Ambassador to youth in Arizona. Dave worked closely with Lambda Legal to help support and build the capacity of GSAs at schools throughout rural Central and Southern Arizona. Dave also became a contributor to the Lambda Law Review and Journal, where he published several op-ed stories about LGBT youth in the west.

At birth, Dave was diagnosed with life altering birth defects due to loss of oxygen. Dave is bilaterally hearing impaired, and has lost 67% of hearing in his left ear, and 52% of hearing in his right ear since he was born. From the age of 3 to the age of 7, Dave spent three to six hours a week in comprehensive occupational and physical therapy to help offset the effects of severe gross motor and fine motor delays. As a child Dave struggled with speech, and often lagged behind other youth his age physically. As Dave developed in his teenage years, he eventually caught up to his peers, and has been able to lead an otherwise normal lifestyle as an adult.

Dave was primarily raised by his biological mother prior to entering foster care. Dave's father left his life when he turned four, and re-entered his life after Dave entered foster care. Dave is part of a large and diverse extended Chicano-American Family that primarily resides in the Phoenix Metro Area. Today, Dave has a strong and healthy relationship with his biological father. Dave spent that last few years of his youth, and the first seven years of adulthood caring for his mother who lingered in nursing homes after suffering debilitating health issues when Dave was 15 years old. Dave's mother succumbed to years of various health problems, and passed away in September 2012.

Dave has been an avid cyclist for over 20 years, and enjoys reading immensely. Dave is particularly fond of history, and politics. Dave is a bit of home chef, and really enjoys cooking for friends and family alike. While working in group homes in Arizona, Dave coordinated the menus and food budget for both group homes, and oversaw the kitchen at the Valor Boys Group Home. While working for Boys & Girls Clubs, Dave planned, and coordinated annual Thanksgiving dinners for 300 - 500 youth and families. The entire meal was cooked from scratch, and took several days to prepare. Dave is also a cinema aficionado, and has immense respect for the Hollywood film industry. Dave has been with his partner [redacted] for nearly thirteen years. Dave and [redacted] presently reside in Walnut Creek, California with their longhaired dachshund, Luna.

Application Form

Profile

Jennifer (First Name) | D (Middle Initial) | Early (Last Name)

[redacted] (Home Address)

(Suite or Apt)

Richmond (City) | CA (State) | 94804 (Postal Code)

[redacted] (Primary Phone)

jennifer.early@ousd.org (Email Address)

Which supervisorial district do you live in?

☑ District 1

Education

Select the option that applies to your high school education *

☑ High School Diploma

College/ University A

Name of College Attended

San Francisco State University

Degree Type / Course of Study / Major

B.A. Africana Studies

Degree Awarded?

◉ Yes ○ No

College/ University B

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

Hours Completed

Certificate Awarded?

○ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

First 5 - Contra Costa Children and Families Commission: Submitted
Family & Children's Trust Committee: Submitted
Mental Health Commission: Submitted

Seat Name

Have you ever attended a meeting of the advisory board for which you are applying?

○ Yes ◉ No

If you have attended, how many meetings have you attended?

Please explain why you would like to serve on this particular board, commitee, or commission.

I am interested in serving as a board member because I believe in the spirit of our youth and families and the heights in which they can achieve when given the necessary tools and resources. Richmond is the City of Pride and Purpose and I hope as a Richmond native/resident I will be able to serve with passion, tenacity and pride. As an educator I have a background in mental health and trauma. I also have personal experiences in supporting my own family members through moments of mental health crisis. Through these experiences I have become more of an advocate around issues pertaining to mental health, mental illness and overall wellness.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

◉ Yes ○ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

○ Yes ◉ No

List any volunteer or community experience, including any advisory boards on which you have served.

Contra Costa Suicide Prevention Committee

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I have a history in working with youth and families in both mental health and education. I have served on the Coordination of Services Team which aims at providing youth with mental health resources and services. I currently participate in the Contra Costa Suicide Prevention Committee and I am currently in the process of receiving my certificate of Social Work and Human Services from Berkeley City College.

Resume_Jennifer_Early.pdf
Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

Jennifer Early

[redacted] Richmond, CA 94804 | [redacted] | jennifer.early@ousd.org

Objective

My current objective is to enter into new and dynamic spaces that are exciting, challenging, rewarding, and closely aligned to the ideas of growth, responsibility, and accountability.

Experience

Oakland Unified School District- Castlemont High School

College and Career Readiness Specialist *October 2017- Present*

- Monitored and managed campus pre-college and college advising programming
- Supported work-based learning pathway activities
- Arranged college field-trip, College Rep visits and presentations
- Acted as the student adviser for the Peer Forward College Summit program on campus
- Provided 1 on 1 and group college and career advising
- Planed, developed and implemented appropriate activities and services within a college and career center such as college and career speakers, career days, college fairs, special events and field trips.
- Reviewed transcripts for A-G completion, supported financial aid and scholarship application completion
- Leveraged partnerships with community based organizations aimed at college readiness, colleges (private, HBCU, community, local, and ivy league) to provide additional services to students.
- Supported student acquisition of internships and service work opportunities
- Managed the implementation on the Oakland Promise Scholarship at the school level
- Planned and coordinated student celebrations such as: College Signing Day, Scholarship Breakfast and Awards Ceremony, Financial Aid Nights and Campaigns
- Provided application assistance around EOP, Personal Insight Questions, and Personal Statements, Homeless and Foster services, and College Matching
- Collaborated with teachers, counselors, educational institutions, community agencies and businesses to develop college and career opportunities; provided college and career information through classroom presentations and workshops to students, parents and staff and served as a resource regarding career and college readiness information

University of California, Irvine

Comprehensive Review Reader/Admissions Evaluator *Nov 2018-Feb 2019*

- Performed comprehensive review and evaluation of a high volume of freshmen applications for undergraduate admissions.
- Consulted with experienced level staff when reviewing more complex applicants.
- Used University of California holistic evaluation methods and UC Irvine admissions standards and guidelines to make a comprehensive assessment of each applicant.

- Participated in required trainings, webinars, and online assessments.

Student Attendance Compliance Officer *August 2015- June 2017*

- Provided proactive assistance to school site personnel, parents, and community members in the areas of attendance, early intervention and support.
- Formatted, processed, and distributed student achievement certificates (student of the month, honor roll, etc.).
- Wrote and sent out donation requests for school and community events.
- Supported the planning and management of school and community events through the School Culture and Climate Team.
- Implemented State rules and regulations relating to compulsory school attendance.
- Maintained positive relationships with students, parents, staff, and community; communicated with students and staff to provide and receive information regarding activities.
- Served as a referral agent to community-based organizations and government agencies.
- Oversaw daily operations of student attendance programs; plan, coordinate, implement, and assign duties to participants; train and review work; conduct in-service training and other meetings.
- Provided School site management and support of the Alameda County Student Transit Pass Pilot Program and Safe Routes to School Program
- Attended meetings; confer with families to discuss student progress; assist in identifying resources for parent education, counseling and truancy reduction programs.
- Interpreted materials and school and District policies, programs and activities for parents, school personnel, students, and others as requested.

AmeriCorps VISTA/OUSD Attendance Project *August 2014-August 2015*

- Conducted and inputted training evaluations and survey data.
- Assisted with OUSD Community Outreach, Campaigns and Initiatives at School Sites: Lights on Afterschool, Shu the Flu, OUSD Back to School.
- Performed data analysis on back to school rates, truancy, and chronic absences.
- Assisted with school inquiries.
- Researched and monitored national mentoring programs, best practices, trends, and issues.
- Leveraged relationships with community partners, families, and students.
- Developed promotional materials for Attendance Discipline Student Support(ADSS) Team and School sites.
- Handled general office duties, providing support for ADSS Coordinator and Staff.
- Developed an OUSD implementation plan and proposal for a Success Mentors Program.
- Served on the Student Attendance Review Board(SARB) twice a week.

AmeriCorps State- Building Healthy Communities/Youth

School Site Mentor *August 2013-July 2014*

- Planned structured and meaningful mentor activities (grades 9-12).
- Implemented one-on-one and small group mentoring.
- Attended regular mentor training provided by program.

- Reported weekly on mentee contact logs and other appropriate logs.
- Underwent mandatory CPS reporting training and CPR/AED verification.
- Created and managed a schedule to ensure all mentees received appropriate hours.
- Recruited and coordinated community volunteers.
- Planned, implemented, and reported on mandatory service day activities geared towards strengthening the East Oakland community and promoting AmeriCorps identity.
- Planned and implemented recruitment activities and strategies geared towards target student population.
- Attended student field trips and meetings.
- Maintained daily contact with mentees, parents, other service providers, teachers, counselors, and support services related to student success and outcome.
- Initiated student referrals, SST meetings, parent meetings, IEP's, as well as academic, attendance, and disciplinary interventions.
- Participated in monthly collaborative meetings.
- Participated, initiated, and referred students into conflict mediation.

Education

San Francisco State University	B.A. Africana Studies	*August 2011-August 2013*

FACT ROSTER December 2020 - DRAFT

Committee Seats (5)

1. **First 5 Commission**
   Exp. 09/30/2022
   Lisa R. Johnson
   [redacted]
   Concord, CA 94520
   [redacted]

2. **School Representative**
   Exp. 09/30/2022
   Karin Kauzer
   [redacted]
   Walnut Creek, CA 94595
   [redacted]

3. **Child Development Early Childhood Education/Local Planning Council**
   Exp. 09/30/2022
   Micaela Mota
   [redacted]
   Richmond, CA 94804
   [redacted]

4. **Child Abuse Prevention Council**
   Exp. 09/30/2021
   Carol Carrillo, MSW
   [redacted]
   Concord, CA 94520
   [redacted]

5. **Mental Health**
   Exp. 09/30/2021
   Dr. Allyson Mayo
   [redacted]

At-Large Members (5)

1. **Mary Flott**
   Exp. 09/30/2022
   [redacted]
   Alamo, CA 94507
   [redacted]

2. **Katie Callahan Cisco**
   Exp. 09/30/2022
   [redacted]
   Concord, CA 94521
   [redacted]

3. **David Leimsieder**
   Exp. 09/30/2021
   [redacted]
   Walnut Creek, CA 94596
   [redacted]

4. **Joseph DeLuca**
   Exp. 09/30/2021
   [redacted]
   Lafayette, CA 94549
   [redacted]

5. **Jennifer Early**
   Exp. 09/30/2022
   [redacted]
   Richmond, CA 94804
   [redacted]

Staff to FACT (2)

Elaine Burres
[redacted]
Martinez, CA 94553
[redacted]

Laura Malone (temp)
[redacted]
Martinez, CA 94553
[redacted]

Reception: (925) 608-5000

District Seats (5)

District I
Exp. 09/30/2021
Supervisor John Gioia
Richard Bell
[redacted]
El Cerrito, CA 94530
[redacted]

District II
Exp. 09/30/2021
Supervisor Candace Andersen
Vacant

District III
Exp. 09/30/2022
Supervisor Diane Burgis
Stephanie Williams-Rogers
[redacted]
Brentwood, CA 94513
[redacted]

District IV
Exp. 09/30/2021
Supervisor Karen Mitchoff
Mujdah Rahim
[redacted]
Walnut Creek, CA 94598
[redacted]

District V
Exp. 09/30/2021
Supervisor Federal Glover
Vacant

DRAFT - Updated November 6, 2020
Blue Highlights represent Appointments or Vacancies Pending Final Approvals in November/December

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. e.**

Meeting Date:	11/23/2020
Subject:	Appointments to the Workforce Development Board
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	NA
Referral Name:	Advisory Board Appointment
Presenter:	Dennis Bozanich **Contact:** Dennis Bozanich 925-655-2050

Referral History:

On December 13, 2011, The Board of Supervisors adopted Resolution No. 2011/498 adopting policy governing appointments to independent boards, committees, and commissions, and special districts. Included in this resolution was a requirement that independent bodies initially conducting interviews for At-Large/Countywide seats provide appointment recommendations to a Board Committee for further review. The Workforce Development Board implements federal requirements for programs to address the education, skills, and employment needs for a skilled workforce, and that lead to an increase in the skills and earnings of Contra Costa residents.

On March 14, 2016, the Family and Human Services Committee (FHS) accepted the Employment and Human Services Department's recommendation to decertify the then-current Workforce Investment Act local Board and re-certify a new board structure in compliance with the new Workforce Innovation and Opportunity Act (WIOA). FHS approved these recommendations, and the Board did the same at its March 29, 2016 meeting.

Under new standards in WIOA (2016) and as adopted by the Board on March 29, 2016, the new Workforce Development Board structure is: a total of 23 required seats and 2 "optional seats", consisting of: 13 Business representatives, 5 Workforce representatives, and 5 Education and Training representatives as follows: (1) Adult Education/Literacy; (2) Higher Education; (3) Economic & Community Development; (4) Wagner Peyser representative; (5) Vocational Rehabilitation. Also two additional/ "optional" seats that may be filled from any of the 3 categories above.

The Executive Committee of the local WIOA board met January 21, 2016 and approved a recommended WIOA Board configuration, subsequently approved by the Board of Supervisors on March 29, 2016.

Referral Update:

Local board structure and size:
Compared to predecessor legislation, the Workforce Innovation and Opportunity Act (WIOA) substantially changes Local Board composition by reducing local workforce development board size while maintaining a business and industry majority and ensuring representation from labor and employment and training organizations.

- Category – Representatives of Business (WIOA Section 107(b)(2)(A))
  - Thirteen (13) representatives (52%)
- Category – Representatives of Workforce (WIOA Section 107(b)(2)(A))
  - Five (5) representatives (20%)
- Category – Representatives of Education and Training (WIOA Section 107(b)(2)(C))
  - One (1) Adult Education/Literacy Representative (WIOA title II)
  - One (1) Higher Education Representative
  - One (1) Economic and Community Development Representative
  - One (1) Wagner Peyser Representative
  - One (1) Vocational Rehabilitation Representative
- Two (2) additional seats from the above categories, including constituencies referenced in Attachment III of Training Employment & Guidance Letter (TEGL) 27-14.

The Workforce Development Board , on November 4, 2020, recommended the Board of Supervisors appoint DeVonn Powers to Flex Seat #2 for a term that expires on June 30, 2024. No other candidates competed for the seat.

Recommendation(s)/Next Step(s):

Board of Supervisor may consider appointing DeVonn Powers to Flex Seat #2 of the local Workforce Development Board (WDB) for a term that expires on June 30, 2024.

Fiscal Impact (if any):

NA

Attachments

Appointment Memo
Application - Power
WDB Roster - November 2020

Workforce Development Board
Contra Costa County

DONNA VAN WERT
EXECUTIVE DIRECTOR

MEMORANDUM

DATE: November 4, 2020
TO: Family and Human Services Committee
CC: Dennis Bozanich, CAO Sr. Deputy County Administrator
FROM: Donna Van Wert, Executive Director
SUBJECT: **Appointment to Workforce Development Board**

This memorandum requests the Family and Human Services Committee recommend to the Contra Costa County Board of Supervisors the appointment of the following candidates to the new WIOA compliant Workforce Development Board of Contra Costa County.

Background:

Local board structure and size:

Compared to predecessor legislation, the Workforce Innovation and Opportunity Act (WIOA) substantially changes Local Board composition by reducing local workforce development board size while maintaining a business and industry majority and ensuring representation from labor and employment and training organizations.

To meet the categorical membership percentages, the WDB recommended a board of twenty-five (25) members. This option represents the minimum required local board size under WIOA plus an additional six (6) optional representatives in the following enumerated categories: 1) business; 2) workforce; 3) education and training.

Category – Representatives of Business (WIOA Section 107(b)(2)(A))

- Thirteen (13) representatives (52%)

Category – Representatives of Workforce (WIOA Section 107(b)(2)(A))

- Five (5) representatives (20%)

Category – Representatives of Education and Training (WIOA Section 107(b)(2)(C))

- One (1) Adult Education/Literacy Representative (WIOA title II)
- One (1) Higher Education Representative
- One (1) Economic and Community Development Representative
- One (1) Wagner Peyser Representative
- One (1) Vocational Rehabilitation Representative

Two (2) additional seats from the above categories, including constituencies referenced in Attachment III of Training Employment & Guidance Letter (TEGL) 27-14.

Recommendation:

a) Recommend approval of local board candidates for the vacant board seat. *(Attached application and board roster) - Approved on November 4, 2020 at the Full Board Meeting*

- **DeVonn Powers**- Flex Seat #2

NEW APPOINTMENT

Seat	Last Name	First Name	Address & District #	Term Start Date	Term of Expiration	District (Resident)
Flex Seat # 2	Powers	DeVonn	1965 Colfax Ste. 204 Concord, CA District #4	11/1/2020	6/30/2024	District #4

Thank you

DVW/rms
attachment

Application Form

Profile

DeVonn
First Name

Middle Initial

Powers
Last Name

[redacted]
Home Address

Suite or Apt

Concord
City

CA
State

94520
Postal Code

[redacted]
Primary Phone

[redacted]
Email Address

Which supervisorial district do you live in?

☑ District 2

Education

Select the option that applies to your high school education *

☑ G.E.D. Certificate

College/ University A

Name of College Attended

DVC

Degree Type / Course of Study / Major

Psychology

Degree Awarded?

○ Yes ◉ No

College/ University B

Name of College Attended

Nan McKay University

Degree Type / Course of Study / Major

HUD - Section 8, Self-Sufficiency

Degree Awarded?

○ Yes ◉ No

College/ University C

Name of College Attended

Degree Type / Course of Study / Major

Degree Awarded?

○ Yes ○ No

Other schools / training completed:

Course Studied

OMB Cost Principles for Non profits

Hours Completed

16

Certificate Awarded?

◉ Yes ○ No

Board and Interest

Which Boards would you like to apply for?

Contra Costa Council on Homelessness: Submitted
Workforce Development Board: Submitted

Seat Name

Homeless or Employment Service Provider

Have you ever attended a meeting of the advisory board for which you are applying?

◉ Yes ○ No

If you have attended, how many meetings have you attended?

5

Please explain why you would like to serve on this particular board, commitee, or commission.

As a Homeless and Workforce Services Provider and a Contra Costa County resident, I am passionate about being a part of team that works towards developing policies and practices that impact our community in a positive way. I believe the "real work" starts with ourselves and then extends by our openness to work alongside others in the fight against homelessness. I bring a multitude of skill-sets and experiences that would allow for a positive contribution to the committee, I am excited about the opportunity to serve, develop and explore new strategies in doing the work better as our world changes.

Qualifications and Volunteer Experience

I would like to be considered for appointment to other advisory boards for which I may be qualified.

○ Yes ◉ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board, commission, or committee?

◉ Yes ○ No

List any volunteer or community experience, including any advisory boards on which you have served.

Reentry Contra Costa County Advisory Board (CAB) - Board Member, Alameda County Workforce Service Board, Board Member, National American Association Cancer Registry - Member, Rotary Club Member (Pittsburg, CA), First Presbyterian Church of Concord, Clerk of Session and Session Member, Reentry Success Center, Steering and planning Committee.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

Please see the attached resume for description of qualifications.

Resume_-_DeVonn_Powers_2020.pdf

Upload a Resume

Conflict of Interest and Certification

Do you have a Familial or Financial Relationship with a member of the Board of Supervisors?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the County such as grants, contracts, or other economic relations?

○ Yes ◉ No

If Yes, please identify the nature of the relationship:

Please Agree with the Following Statement

I certify that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and undersand that all information in this application is publicly accessible. I understand that misstatements and/or omissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

☑ I Agree

DeVonn Powers

[redacted]
[redacted] Concord, CA 94520 [redacted]

PROFESSIONAL OBJECTIVE

To be a part of a team where my years of experience will be utilized to: empower, motivate, and support an organization in creatively achieving their vision while accomplishing their mission.

EXECUTIVE LEADERSHIP
BUSINESS DEVELOPMENT & CONTRACT MANAGEMENT

6 years of experience as an Executive Director; on the Board of Directors
11 years of experience of departmental/division oversight
18 years of experience directing/managing multiple contracts and programs
17 years of experience in program design and program start-up
26 years serving diverse populations

CORE COMPETENCIES

Strategic Planning & Execution	**Fiscal Accountably**	**Contract Negotiation**
Process & System Integration	**P&L Management**	**Grant Writing-RFP Process**
Infrastructure & Program Design	**Business Development**	**Public Relations & Marketing**
Operational Oversight	**Performance Benchmarks**	**Coalition Building**
Leadership Development	**Policy Improvement**	**Accurate Reporting**

RECENT ACHIEVEMENTS

† **Established Humanity Way, Inc. non-profit organization in Contra Costa County**
† 4.5M revenue growth, 60% increase within 18 months (contract awards), 20 positions added
† Designed and implemented restructuring plan for Workforce Development Department
† 100% retention - Contract renewals for contracts, grants and gifts for exceptional performance
† Established 75+ community-based partnerships with signed Memorandums of Understanding
† Formed, participated & lead multi-agency collaborations for County, City and Federal contracts

BOARDS/COMMITTEES/AFFILIATES

Alameda Workforce Investment Board member, Community Advisory Board member, West County Reentry Success Steering Committee member, Data Evaluation Committee, Site Planning Committee, Rotary Club, Contra Costa County Employment and Human Services Department, Contra Costa County Administrators Office and Probation Department, Solano County Social Service Department, Alameda County, Contra Costa County One Network and NAACCR.

WORK EXPERIENCE

2016 – Present Founder/Chief Executive Officer (Paid Officer) – Humanity Way, Inc.
Confer with board members to discuss project issues, coordinate activities, resolved problems, collaboratively plan, ensure compliance organizational goals, objectives, mission and participate in strategic planning and execution, establish policies, procedures, operational oversight, analyze budgetary information, financial planning, revenue forecasts, P&L, pursue new funding opportunities.

2016 – 2018 Senior Manager of Registry Operations – Cancer Prevention Institute of California
Oversight of Cancer Registry federal contracts - Provide overall supervision and oversight of registry resources, ensure contract compliance, collaborate with oncology, researchers and MDs, strategic planning, operating budget of 31M, comprised of 28 employees, 21 direct reports (4 high-level).

2012 – 2016 Senior Director of Contract Services – Goodwill Industries
Oversight of Workforce Development Department - Contracts - (Alameda, Contra Costa and Solano counties) Provide overall supervision, training of management team, confer with the CEO and board members to discuss organizational issues, operating budget of 11M comprised of 52 employees, 5 direct reports.

Fiscally responsible, analyze and maintain budgetary information, financial planning, revenue forecasts P&L oversight of 32M budget, expand agency revenue; ensure maximization of funds, develop new contracts and funding opportunities, grant writing, staff supervision, contract negotiation, RFP proposal preparation and final selection process, project planning and start-up, direct and ensure compliance of contract services and guidelines, establish and maintain alliances with County, State, local government and community-based partnerships, public speaking, program development, redesign and corrective operational processes, ensured contract outcomes, performance levels and deadlines, public presentations and departmental training, leadership development and motivational speaking, develop outcome based and narrative reports, development and submission of funding reports, payment requirements, financial audit of all payroll, billing, program records and process for all cost centers within workforce development.

- *Awards: 2015 CAL PIA Community Partnership award, 2015 Community Service 3-year contract, 2014 Job Services 3-year contract, 2014 F.A.M.E. Welfare-to-Work 3-year contract, 2013 AB109 Bridges-to-Work 3-year contract, 2015 & 2012 STEP-UP 3-year contract and received the CEO award, 2013, 2014 and in 2015 agency stopped giving out this award.*

2011 – 2013 Executive Director – Second Step Sober Living, Lodi CA
Participated on the Second Step Living (Sober living home for men) committee, conferred with committee and board members to discuss project issues, ccoordinated activities, resolved problems, collaboratively planned, ensured compliance organizational goals, objectives, mission and strategic planning and execution, established policies, procedures and guidelines, project planning and start-up operational oversight, fiscally responsible, analyze and maintain budgetary information, financial planning, revenue forecasts P&L oversight, expand revenue collaboratively established strategies to maximize returns on investments, increase productivity and explore/pursue new funding opportunities, *letter of recommendation available.*

2010 – 2012 Intervention Services Departmental Manager – STAND, Concord, CA
Provide overall supervision, training and management of the Intervention Services Department comprised of contracts with the Richmond Police Department, Antioch Police Department, Concord Police Department, Pittsburg Health Clinic, EHSD Contra Costa County, Chevron, Junior League, Cal-Ema, (Collaborative LGBTQ Rainbow Community Center, Victims of Crime, Community Violence Solutions), and HUD, direct and *oversee operations of "transitional housing".*

Fiscally responsible, analyzed and maintained budgetary information, financial planning, revenue forecasts P&L oversight, expand agency revenue; develop new contracts and funding opportunities, grant writing, contract negotiation, RFP proposal preparation and final selection process, project planning and start-up, direct and ensure compliance of contract services and guidelines, establish and maintain alliances with County, State, local government and community-based partnerships, program development, redesign and corrective operational processes, ensured contract outcomes, performance levels and deadlines, public presentations and departmental training, staff oversight, training and development, supervision and staff evaluation, leadership and career development and motivational speaking, develop outcome based and narrative reports, development and submission of funding reports, payment requirements, financial audit of all payroll. Chaired Cultural Competency Committee,

member of and presented on several partnering committees: Coalition for Human Trafficking, Home base committee, Homeless/HUD, Contra Costa Employment committee, Rainbow committee.

- *Awards: 2010 LGBTQ STAND-In-Pride 5-year contract, 2010 Domestic Violence EHSD 3-year contract, Pittsburg Health Clinic 1-year pilot project, MOVE Transitional housing*
- *Achievement/s: Designed and started a volunteer trauma-based vocational drop-in center for domestic violence survivor, this center also included on-site children's activity center*

2007 – 2010 Program Coordinator/Contract Manager – Goodwill, Antioch CA
Provided overall supervision, training and management to the Welfare-to-Work (WEX) contract, contract negotiation, RFP proposal preparation and final selection process, lead on taskforce with the Executive Team, planned, directed and ensured compliance of contract services and guidelines implemented alliances and acted as a liaison between County and community-based partnerships, ensured contract outcomes, performance levels and deadlines for multiple contracts, hired and provided training and supervision of program staff, fiscally responsible, analyzed, and maintained budgetary information, developed, revenue reports, reviewed and maintained annual financial plans, monitored, profit and loss statements, submitted purchase order requests, developed outcome based and narrative reports development and submission of funding reports, payment requirements, program site reviews, *reference letters from community partners are available.*

- *Awards: 2010 Work Experience 3-year contract, received the CEO Award in 2009 and 2010.*

2004 – 2007 G.I.F.T. Program Director, Livermore Housing Authority, Livermore CA
Provide overall supervision, training and management of three (3) contracts – G.I.F.T Program, Family Self-Sufficiency, and Section 8 Home Ownership HUD

Planned, directed and ensured compliance of contract services and guidelines, supervised staff and the maintenance crew, program design and start-up, ensured contract outcomes, performance levels and deadlines for multiple contracts, planned, coordinated and implemented activities, created alliances and acted as a liaison between County, City, State and community-based partnership, operational oversight, provided direct services to domestic violence survivors, low-income, unemployed, mental health consumers, reentry, fiscally Responsible, developed outcome based reports to HUD for all contracts, completed all property management duties, walk-thru, inspections HUD Code, rent collection and evictions, *received two (2) promotions during my employment.*

2002 – 2003 5150 Designee/Case Manager – Volunteers of America, Sacramento CA
Served, screened and treated Mental Health consumers, ensured contract outcomes, performance levels and deadlines, planned, coordinated and implemented activities for participants, crisis intervention and deflection, case planning, provided 5150 assessments under the supervision of a clinician for clients in crisis, medication management, medication administration, case management

1995 – 1998 Counselor/Case Manager I/II & Shift Leader– Turning Point, Sacramento CA
Served, screened and treated Developmentally Disabled Mental Health consumers, One-on-One counseling sessions, group therapy and ILS workshops, planned, acted as an advocate and liaison between clients and community-base organizations, crisis intervention and deflection,

EDUCATION/CERTIFICATION:

2015	OMB Supercircular Cost Principles	Solano County, CA
2014	Non-Profit – OMB 122 Cost Principles	Solano County, CA
2004	Nan McKay University – Certified Family Specialist	Las Vegas, NA
2001	Diablo Valley College – Psychology/Philosophy	Pleasant Hill, CA

Workforce Development Board Contra Costa County

BOARD MEMBERS
PUBLIC ROSTER

Name	Seat #	Appointment Date	District # (Resident)	Term Start Date	Term End Date	Title	Entity	District # (Employment)	Committee
Michael McGill	1	6/23/2020	District #2	7/1/2020	6/30/2024	Chairperson/Engineer	MMS Design Associates	District #2	EXEC/YOUTH
Joshua Aldrich	2	10/9/2018	District #3	10/1/2018	6/30/2022	CEO	Del Sol NRG. Inc.	District #3	BED
Yolanda Vega	3	6/23/2020	District #2	7/1/2020	6/30/2024	Principal	Peak Performance Corporate Training	District #2	EXEC
Terry Curley	4	10/9/2018	District #2	10/1/2018	6/30/2022	Executive Vice President	United Business Bank	District #4	EXEC/BED
Tom Guarino	5	7/14/2020	District #X	7/1/2020	6/30/2024	Government Relations, East Bay Public Affairs	PG&E	Disttict #4	BED
Jose Carrascal	6	8/11/2020	District #3	7/1/2020	6/30/2024	Director of Site Operations	Corteva Agriscience	District #5	YOUTH
Stacey Marshall	7	6/23/2020	District #1	7/1/2020	6/30/2024	Manager Human Resources	American Sugar Refining, Inc.	District #5	BED
Carolina Herrera	8	7/14/2020	District #4	7/1/2020	6/30/2024	Manager, Community & Government Relations	Kaiser Permanente	District #4	BED
Robert Muller	9	3/12/2019	District #5	3/1/2019	6/30/2023	Learning Manager	PBF Energy	District #5	YOUTH
Laura Trevino	10	7/14/2020	District #5	7/1/2020	6/30/2024	Business Profile Account Manager	Coast Personal Services	District #5	YOUTH
Stephanie Rivera	11	7/14/2020	District #4	7/1/2020	6/30/2024	Director, Community Health Improvement	John Muir Health	District #4	BED
Monica Magee	12	8/11/2020	District #5	7/1/2020	6/30/2024	Director of Marketing	Bishop Ranch	District #2	BED
Corry Kennedy	13	7/14/2020	District #4	7/1/2020	6/30/2024	Human Resource Manager	Chevron	District #2	
Name	**Seat #**	**Appointment Date**	**District # (Resident)**		**Term End Date**	**Title**	**Entity**		
Thomas Hansen	1	10/17/2017	District #X	10/1/2017	6/30/2021	Business Manager	IBEW Local 302	District #5	EXEC
Joshua Anijar	2	12/10/2019	District #X	12/1/2019	6/30/2023	Executive Director	Centra Labor Council Contra Costa County	District #5	EXEC
VACANT	3		District #X		6/30/20XX			District #X	
VACANT	4		District #X		6/30/20XX			District #X	
VACANT	5		District #X		6/30/20XX			District #X	
Name	**Seat #**	**Appointment Date**	**District # (Resident)**		**Term End Date**	**Title**	**Entity**		
G. Vittoria Abbate	1	10/17/2017	District #2	10/1/2017	6/30/2021	Director, College & Career & Adult Education	Mt. Diablo Unified School District	District #4	YOUTH
Kelly Schelin	2	7/14/2020	District #5	7/1/2020	6/30/2024	Associate Vice Chancellor, Educational Services	Contra Costa College	District #1	BED
Name	**Seat #**	**Appointment Date**	**District # (Resident)**		**Term End Date**	**Title**	**Entity**		
Carol Asch	1	6/23/2020	District #X	7/1/2020	6/30/2024	Rehabilitation Act of 1973/District Administrator	California Department of Rehabilitation	District #4	YOUTH
Richard Johnson	2	6/23/2020	District #4	7/1/2020	6/30/2024	Employment Service/Employment Prog.Manager ll	California Employment Development Department	District #4	BED
Kwame Reed	3	6/23/2020	District #X	7/1/2020	6/30/2024	Economic Development Director	City of Antioch	District #3	EXEC/BED
Name	**Seat #**	**Appointment Date**	**District # (Resident)**		**Term End Date**	**Title**	**Entity**		
Leslay Choy	1	7/14/2020	District #1	7/1/2020	6/30/2024	Executive Director	San Pablo Economic Development	District #1	BED
DeVonn Powers (Pending Approval)	2		District #X		6/30/2024	**Founder Chief Exec.Officer**	**Humanity Way, Inc.**	District #X	

	BUSINESS
	WORKFORCE & LABOR
	EDUCATION AND TRAINING
	GOVERNMENTAL AND ECONOMIC AND COMMUNITY DEVELOPMENT
	FLEX ADDITIONAL MEMBERS
	PENDING APPROVAL/CONFIRMATION
	VACANT SEAT
	TERM END DATE

COMMITTEE	
Exec	EXECUTIVE COMMITTEE
BED	BUSINESS ECONOMIC & DEV.
Youth	YOUTH COMMITTEE
N/A	NOT ASSIGNED

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **4. f.**

Meeting Date:	11/23/2020
Subject:	Appointments to the Local Planning and Advisory Council for Early Care and Education (LPC)
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	25
Referral Name:	Child Care Planning/Development Council Membership
Presenter:	N/A **Contact:** Dennis Bozanich 925-655-2050

Referral History:

The review of applications for appointments to the Contra Costa Local Planning Council for Child Care and Development was originally referred to the Family and Human Services Committee by the Board of Supervisors on April 22, 1997.

The Local Planning and Advisory Council for Early Care and Education (LPC) coordinates programs and services affecting early child care and education, including recommendations for the allocation of federal funds to local early child care and education programs.

The LPC consists of 20 members: 4 consumer representatives - a parent or person who receives or has received child care services in the past 36 months; 4 child care providers - a person who provides child care services or represents persons who provide child care services; 4 public agency representatives - a person who represents a city, county, city and county, or local education agency; 4 community representatives - a person who represents an agency or business that provides private funding for child care services or who advocates for child care services through participation in civic or community based organizations; and 4 discretionary appointees - a person appointed from any of the above four categories or outside of those categories at the discretion of the appointing agencies.

Terms of appointment are 3 years.

Referral Update:

The County Superintendent of Schools for Contra Costa County has reviewed the applications, determined that the applicants meet the eligibility requirements and requests that the Committee recommends appointment to the Board of Supervisors.

Recommendation(s)/Next Step(s):

RECOMMEND to the Board of Supervisors the appointments of Stacey Norman to the vacant Community Representative - Central/South 2 seat and Liliana Gonzalez to the vacant Public Agency - Central/South 2 seat on the Local Planning and Advisory Council for Early Care and Education, as recommended by the County Office of Education.

Fiscal Impact (if any):

There is no fiscal impact.

Attachments

Contra Costa County Office of Education
77 Santa Barbara Road, Pleasant Hill, CA 94523 • (925) 942-3388
Lynn Mackey, Superintendent of Schools

November 5, 2020

Family Human Services Committee
Contra Costa County Board of Supervisors
651 Pine Street, Suite 107
Martinez, CA 94553

Subject: Appointment of LPC Members

Dear County Board of Supervisors:

I have reviewed the memoranda and member applications submitted by the Contra Costa Local Planning and Advisory Council for Early Care and Education (LPC). I recommend approval to appoint Stacey Norman to the vacant seat of Community Representative —Central/South 2 and Liliana Gonzalez to the vacant seat of Public Agency — Central/South 2 County Representatives.

Based on the applicants' education, background, and current employment, I have determined that Ms. Norman and Ms. Gonzalez meet the eligibility definition for Public Agency seats in Contra Costa County as defined by the LPC Membership Structure.

Ms. Norman has spent her entire career focusing on education. Ms. Norman has a Master's Degree in Early Childhood Education, and she has had positions serving as a preschool teacher, Kindergarten teacher, and an adjunct instructor of early childhood studies. In addition, she has a passion for teaching future early childhood educators. Ms. Norman will prove an asset to the LPC with her expertise in all areas of teacher training – advocacy, resource development, allocation of funds, and overall support in the field. I vote to approve the recommendation submitted by the LPC.

Ms. Gonzalez possesses relevant experience and knowledge about the early care and education system. Her education is in early childhood education, and she has had positions in the classroom, as an education manager, and as a home visitor. In addition, she has worked closely with families of young children with disabilities and special needs, supporting their navigation of the early intervention system. She understands the diverse needs of children and families through her work experience in the community. I vote to approve the recommendation submitted by the LPC.

I extend my welcome to Stacey Norman and Liliana Gonzalez and thank them for their interest in contributing their knowledge and expertise for the improvement of early care and education in Contra Costa County through community service on the LPC.

Thank you,

Lynn Mackey
Superintendent of Schools
Contra Costa County

SJ:kg

cc:

Susan K. Jeong, LPC Coordinator
Crystal McClendon-Gourdine, LPC Interim Chair

CONTRA COSTA COUNTY
Office of Education
learn • lead • achieve

LPC Contra Costa County
Local Planning and Advisory Council
for Early Care and Education

MEMORANDUM

DATE: November 5, 2020

TO: Contra Costa County Board of Supervisors
Family and Human Services Committee
Supervisor John Gioia, District I, Chair
Supervisor Candace Andersen, District II, Vice Chair

Contra Costa County Office of Education
Lynn Mackey, Contra Costa County Superintendent of Schools

FROM: Susan Jeong, LPC Coordinator/Manager, Educational Services

SUBJECT: LPC APPOINTMENTS
Contra Costa County Local Planning and Advisory Council for Early Care and Education (LPC)

RECOMMENDATION(S):

1) APPOINT the following new members to the Contra Costa Local Planning and Advisory Council for Early Care and Education, as recommended by the LPC:

Name	Seat	Area
Liliana Gonzalez	Public Agency 2	Central/South County
Stacey Norman	Community Representative 2	Central/South County

REASON/S FOR RECOMMENDATION:

The Contra Costa County Local Planning Council for Child Care and Development (LPC) was established in April 1998. Required by AB 1542, which was passed in 1993, thirty members of the LPC were appointed by the County Board of Supervisors and the County Superintendent of Schools. Childcare consumers and providers, public agency representatives, and community representatives each comprise 20% of the LPC. The remaining 20% are discretionary appointees. Membership is for a three-year term. On January 7, 2003, membership was decreased from 30 to 25 members, due to the difficulty being experienced in filling all of the seats.

On September 19, 2012 membership was decreased from 25 to 20, due to continued difficulty to fill vacant seats. Official reduction of appointed seats provides flexibility to ensure quorum is met in order to conduct Council business.

Membership consists of the following:

- Four consumer representatives - a parent or person who receives or has received child care services in the past 36 months;

- Four child care providers - a person who provides child care services or represents persons who provide child care services;
- Four public agency representatives - a person who represents a city, county, city and county, or local education agency;
- Four community representatives - a person who represents an agency or business that provides private funding for child care services or who advocates for child care services through participation in civic or community based organizations;
- Four discretionary appointees - a person appointed from any of the above four categories or outside of those categories at the discretion of the appointing agencies.

Appointments to the Contra Costa County Local Planning and Advisory Council for Early Care and Education (LPC) are subject to the approval of the Board of Supervisors and County Superintendent of Schools, Lynn Mackey. The Board of Supervisors designated the Family and Human Services Committee to review and recommend appointments on their behalf.

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CLERK BOARD OF SUPERVISORS
CONTRA COSTA CO.

Print Form

Contra Costa County

Please return completed applications to:
Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553
or email to: ClerkofTheBoard@cob.cccounty.us

BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Liliana

Last Name Gonzalez

Home Address - Street [redacted]

City Vallejo

Zip Code 94591

Phone (best number to reach you) [redacted]

Email [redacted]

Resident of Supervisorial District:

EDUCATION *Check appropriate box if you possess one of the following:*

☑ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
Mills College	B.A. Research Psychology	☑ Yes ☐ No
Mills College	M.A. Infant Mental Health	☑ Yes ☐ No
		☐ Yes ☐ No

Other Training Completed:

Board, Committee or Commission Name Local Planning Council

Seat Name Public Agency Representative

Have you ever attended a meeting of the advisory board for which you are applying?

☐ No ☑ Yes If yes, how many? 2

Please explain why you would like to serve on this particular board, committee, or commission.

It is both my personal and professional endeavor to advocate and take action towards ensuring that the children in our community receive the best start early in their lives. My passion aligns directly with that of the Local Planning Council which is to support the sustainability and growth of a quality early childcare infrastructure and system. The most rapid development of the brain takes place in the early years of an individual's life; it is critical that communities support access to quality early child care for all children in order to support their development and readiness for adolescence and adulthood.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

My educational background is in early childhood development and infant mental health. I have a strong service background in early childhood education having worked both in the classroom, as an education manager, and home visitor. I also have worked closely with families of young children with disabilities and special needs supporting their navigation of the early intervention system. These experiences have fostered in me a deep appreciation the experiences of educators, parents, and young children; they provide me with a strong lens to better understand and reflect on larger early childhood system of care.

I am including my resume with this application:
Please check one: ☑ Yes ☐ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.
Please check one: ☐ Yes ☑ No

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Print Form

Contra Costa County

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Martinez, CA 94553
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BOARDS, COMMITTEES, AND COMMISSIONS APPLICATION

First Name Stacey

Last Name Norman

Home Address - Street [redacted]

City Pleasant Hill

Zip Code 94523

Phone (best number to reach you) [redacted]

Email [redacted]

Resident of Supervisorial District: Yes

EDUCATION *Check appropriate box if you possess one of the following:*

☑ High School Diploma ☐ CA High School Proficiency Certificate ☐ G.E.D. Certificate

Colleges or Universities Attended	Course of Study/Major	Degree Awarded
Sonoma State University	MA, Early Childhood Education	■ Yes ☐ No
California State University, East Bay	LIberal Studies, Human Development	■ Yes ☐ No
Diablo Valley College	Liberal Studies	☐ Yes ■ No

Other Training Completed:

Board, Committee or Commission Name LPC

Seat Name

Have you ever attended a meeting of the advisory board for which you are applying?

☐ No ■ Yes If yes, how many? 1

Please explain why you would like to serve on this particular board, committee, or commission.

I am an adjunct instructor of Early Childhood Studies at Diablo Valley College in Pleasant Hill, Contra Costa County. My passion is teaching future early childhood educators, and as such, it is important that I stay relevant in all areas of teacher training - advocacy, resource development, allocation of funds, and overall support in the field.

Describe your qualifications for this appointment. (NOTE: you may also include a copy of your resume with this application)

I currently hold a Master's Degree in Early Childhood Education. I have been a preschool teacher, Kindergarten teacher, and more recenlty, an adjunct instructor of early childhood studies. I also conduct professional development trainings for different schools in the Bay Area.

I am including my resume with this application:

Please check one: ■ Yes ☐ No

I would like to be considered for appointment to other advisory bodies for which I may be qualified.

Please check one: ■ Yes ☐ No

Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ☐ Yes ■ No

List any volunteer and community experience, including any boards on which you have served.

I am a CASA (Court Appointed Special Advocate) for foster youth in Contra Costa County.

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

I CERTIFY that the statements made by me in this application are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I acknowledge and understand that all information in this application is publicly accessible. I understand and agree that misstatements and/or ommissions of material fact may cause forfeiture of my rights to serve on a board, committee, or commission in Contra Costa County.

Signed: _____ **Date:** 2/4/20

Submit this application to: Clerk of the Board of Supervisors
651 Pine St., Room 106
Martinez, CA 94553

Questions about this application? Contact the Clerk of the Board at (925) 335-1900 or by email at ClerkofTheBoard@cob.cccounty.us

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2. All members of appointed bodies are required to take the advisory body training provided by Contra Costa County.

3. Members of certain boards, commissions, and committees may be required to: 1) file a Statement of Economic Interest Form also known as a Form 700, and 2) complete the State Ethics Training Course as required by AB 1234.

4. Meetings may be held in various locations and some locations may not be accessible by public transportation.

5. Meeting dates and times are subject to change and may occur up to two (2) days per month.

6. Some boards, committees, or commissions may assign members to subcommittees or work groups which may require an additional commitment of time.

7. As indicated in Board Resolution 2011/55, a person will not be eligible for appointment if he/she is related to a Board of Supervisors member in any of the following relationships: mother, father, son, daughter, brother, sister, grandmother, grandfather, grandson, granddaughter, great-grandfather, great-grandmother, aunt, uncle, nephew, niece, great-grandson, great-granddaughter, first-cousin, husband, wife, father-in-law, mother-in-law, daughter-in-law, stepson, stepdaughter, sister-in-law, brother-in-law, spouse's grandmother, spouse's grandfather, spouse's granddaughter, and spouses' grandson, registered domestic partner, relatives of a registered domestic partner as listed above.

8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

Stacey Higgins Norman
Curriculum Vitae

[redacted]
Pleasant Hill, CA 94523

Phone: [redacted]
Email: [redacted]

EDUCATION

M.A., Early Childhood Education, Sonoma State University, Rohnert Park, 2008

B.A., Liberal Studies, California State University – East Bay, Hayward, 2006

Minor, Human Development, California State University – East Bay, Hayward, 2006

FOREIGN STUDY

International Study Abroad, C.L.I. Dante Alighieri School, Florence, Italy, 2003

ACADEMIC / TEACHING EXPERIENCE

Associate Professor, Diablo Valley College, Pleasant Hill, CA, 2019 – Present
- Teach Advanced Curriculum Development and Child Development & Psychology to classes averaging 30 students.
- Write course materials such as syllabi, handouts, and homework assignments in alignment with current state Student Learning Objectives (SLO).
- Mentor and provide support for students in career pathways and development.

Professional Development Coach & Consultant, Little Bridges School, 2019 – 2020
- Reframed teacher language to reflect developmentally appropriate practices in infant, toddler, and preschool classrooms.
- Supported teachers in developing relationships with the children in their care.
- Conducted workshops for "circle time" activities.
- Advocated for self-care in the workplace.

Professional Development Coach & Consultant, The Seven Hills School, 2017 – 2019
- Provided support and instruction for teachers in an onsite Reggio Emilia preschool.
- Assisted teachers in the creation and implementation of pedagogical documentation and assessment.
- Supported and reinforced best practices in emergent curriculum.

Associate Professor, Ohlone College, Fremont, CA, 2013 – 2019

- Taught Introduction to Childhood Growth and Development; Principles and Practices; Child, Family, and Community; Health, Safety and Nutrition; Music and Movement; Art for the Young Child; Literacy Development in the Early Childhood Classroom; Infant and Toddler Development; and Literature for the Young Child to classes averaging 25 students.
- Wrote course materials such as syllabi, handouts, and homework assignments in alignment with current state Student Learning Objectives (SLO).
- Mentored and provided support for students in the Umoja Mentoring Program – an organization dedicated to enhancing the cultural and educational experiences of African American students.
- Sat on the Scholarship Evaluation Committee, Spring semester, 2016.

Kindergarten Teacher, Bentley School, 2010-2012

- Used multimodal teaching strategies to teach literacy, social studies, science, and mathematics to a classroom of 18 Kindergarten children.
- Served on the Inclusivity and Multiculturalism (IAM) Committee.

Assistant Professor, Sonoma State University, Extended Education , Fall semester 2009

- Taught course on Introduction to Attachment Theory under the mentorship of Dr. Dorothy Stewart, Ed.D.

Developmental Kindergarten Teacher (Pre-K), Old Firehouse School, 2008-2010

- Developed a physical, cognitive, social, and emotional foundation for future academic success through emergent curriculum and project-based learning.
- Successfully practiced observation, documentation, and authentic assessment.
- Designed classrooms according to the NAEYC and ECERS standards of emergent classroom environments.

PUBLICATIONS

Hart, L. & Caven, K. (2013). *The Bullying Antidote: Superpower Your Kids for Life*, pg. 106-107. Center City, Minnesota: Hazelden.

Bentley School's Kindergarten promotional video:
http://youtu.be/xr27s9AhiCU or http://www.youtube.com/watch?v=xr27s9AhiCU .

GUEST SPEAKING

Multicultural Identity in Independent Schools: A Panel Discussion, Bentley School, Lafayette, 01/13/11.

The Chemistry Project: Emergent Curriculum and Project Work in the Pre-K Classroom. Presented at the Innovative Teacher Project, Reggio Roundtable, Old Firehouse School, Walnut Creek, 06/12/10.

ECE 130: Child, Family and Community, Professor Deya Brashears, Diablo Valley College, Pleasant Hill, 02/09.

CERTIFICATIONS

State of California, Emergency Teaching Credential

California Basic Educational Skills Test (CBEST)

Positive Guidance & Discipline Teacher Trainer

Handwriting Without Tears

Reader's & Writer's Workshop

Cardiopulmonary Resuscitation (CPR) and First Aid

MEMBERSHIPS

National Association for the Education of Young Children (NAEYC)

Community College Consortium of Early Childhood Educators (CCCECE)

Positive Guidance & Discipline Association of America

PROFESSIONAL DEVELOPMENT

Kimochi Training, Dr. Kate Raher, San Rafael, CA, May 17, 2019

Trauma Informed Care, Child Care Links, Pleasanton, CA, August 1, 2018

Early Intervention and Inclusion Conference – Inclusive Practices that Support All Learners, Skyline College, San Bruno, CA, May 5, 2018

Anji Play Summer Institute, Saint Mary's College, Moraga, CA, July 14-16, 2016.

Inclusion Symposium, Early Care & Education Planning Council, Hayward, CA March 19, 2016.

Positive Discipline in the Classroom, Solana Beach, November 5-6, 2011.

I Teach K!, Sands Expo and Convention Center, Las Vegas , July 11-13, 2011.

CAIS Northern Regional Meeting Conference, Head-Royce School, Oakland, March 7, 2011.

The Innovative Teacher Project, Roundtable, Old Firehouse School, Walnut Creek, June 12, 2010.

Learning & The Brain: Using Brain Research to Enhance Learning, Attention, and Memory, Fairmont Hotel, San Francisco, February 7-9, 2010.

CAEYC Annual Conference and Expo, Sacramento Convention Center, Sacramento, March 27-28, 2009.

Are you currently or have you ever been appointed to a Contra Costa County advisory board?

Please check one: ■ Yes ☐ No

List any volunteer and community experience, including any boards on which you have served.

I was an at large member of the Contra Costa County Commission for Women.
I am currently serving on the CSB Head Start Policy Council.
I am a part of the Contra Costa Oral Health Collaborative.

Do you have a familial relationship with a member of the Board of Supervisors? (Please refer to the relationships listed below or Resolution no. 2011/55)

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

Do you have any financial relationships with the county, such as grants, contracts, or other economic relationships?

Please check one: ☐ Yes ■ No

If Yes, please identify the nature of the relationship:

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Signed: _____ **Date:** 2/20/2020

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8. A person will not be eligible to serve if the person shares a financial interest as defined in Government Code §87103 with a Board of Supervisors Member.

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Liliana P. Gonzalez

[redacted] ♦ Vallejo, CA, 94591 ♦ [redacted]

EDUCATION

Master of Arts in Infant Mental Health — Mills College, Oakland, CA. *May 2013*
Bachelor of Arts in Research Psychology — Mills College, Oakland, CA. *May 2012*

CERTIFICATON/TRAINING

- Certified CLASS Observer (Pre-K & Infant/Toddler)
- Circle of Security Facilitator
- Parent Interacting With Infant (PIWI)
- CSEFEL Teaching Pyramid
- Play Based Curriculum

WORK EXPERIENCE

Help Me Grow Program Coordinator — *July 2016 – Present*
First 5 Contra Costa, Concord, CA.

- Coordinate planning and implementation of Help Me Grow System
- Identify system gaps and challenges and recommend strategies to address system needs
- Develop and maintain collaborative relationships with community partners
- Maintain and synthesis information, data, and records to evaluate and report on the effectiveness of current programs & projects

Disabilities and Home-based Program Coordinator — *March 2014 –July 2016*
The Unity Council Head Start & Early Head Start, Concord, CA.

- Supervise the coordinator of the Oakland EHS Home Visiting and Prenatal Program.
- Coordinate and collaborate with the various service areas in order to ensure the effective delivery of educational and social services to all families in the program.
- Supervise, train, and coach a team of five home visitors to ensure they have the adequate resources to provide home visits to a case load of 12 families.
- Collaborate with parents and staff in monitoring the development of all children across three sites and establishing and implementing appropriate development goals for their children. Responsible for the developmental screening of all 274 children in the program.
- Support the navigation of resource referrals of parents of children with special needs in working closely with Local Education Agencies and staff in order to individualize curriculum to meet needs of children.

Home Visitor/Family Advocate — *July 2013 –March 2014*
The Unity Council, Concord, CA.

- Manage a caseload of 12 infants and their families by providing comprehensive services and empowering them by connecting them to appropriate resources in the community.
- Promote and support the growth and development of 12 infants and their families by conducting weekly home visits and a weekly socialization group for infants 0-36 months old.
- Collaborate with parents in monitoring the development of infants and establishing and implementing appropriate development goals for their children every 3 months.

Early Intervention Intern — *Aug. 2012 –May 2013*
Epiphany Center, San Francisco, CA.

- Observed and fostered social and emotional development for infants and children ages 0 – 36 months conducting narrative observations twice a month per child while facilitating a Spanish Speaking support group for 4 mothers once a month.
- Provided consultation and recommendations to primary caregivers in developing goals and early intervention for infants and mothers based on observations.
- Developed, implemented and facilitated the Play/Art Therapy curriculum in addition to teaching the Nurturing Skills for Healthy Families curriculum on infant development and parenting for 10 students twice a week.
- Facilitated a Spanish Speaking support group for 4 mothers once a month.

Senior Resident Assistant for the Summer Academic Workshop *July 2012 –Aug. 2012*
Mills College, Oakland, CA

- Worked efficiently in collaboration with 2 other Resident Assistants successfully mentoring and tutoring 12 first generation college students through a four week academically rigorous course load.
- Organized and facilitated group discussions and team building exercises for students and 6 staff members
- Developed and implemented dynamic educational and community focused programs such as cultural excursion to the Oakland History Museum and community farmers market.
- Received one week intensive social justice training on how to lead and facilitate discussions on issues regarding class, race, sexuality, disability, dynamics of power & privilege, and more.

Teacher Assistant at the Mills College Children's School *Aug. 2011 –Dec. 2012*
Mills College, Oakland, CA

- Supported 8 children in their social and emotional development by providing childcare throughout the day and assisting them through daily transitions of meal time, nap time, activity time, and more.
- Developed, implemented, and facilitated a week-long music curriculum to promote positive social development of infants for 4 days a week over the course of 4 months.
- Conducted a case study for the purpose of providing consultation to parents and teachers, and recommendations for how to better support the social and emotional needs of 36 month old children.

Extra

At-Large Commissioner, Contra Costa County Commission for Women *July 2015 – July 2017*
Contra Costa County

- As acting Treasure: take down minutes of all meetings and phone conferences; assist in the management and maintenance of the commission's website and public calendar; manage the commission's email account.
- Assist in the planning and execution of commission events, fundraisers, trainings and networking events relating to the social and economic conditions of women.
- Collaborate in the development of the commission's strategic plan.

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **5.**

Meeting Date:	11/23/2020
Subject:	CONSIDER accepting In Home Supportive Services Public Authority Registry Temporary Policy Changes
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	NA
Referral Name:	NA
Presenter:	Elizabeth Dondi **Contact:** Elizabeth Dondi; 3-6671

Referral History:

The In Home Supportive Services Public Authority Advisory Council received a report from the Executive Director on the challenges facing the Public Authority's Registry including shortages of providers. Some challenges have always existed with recruiting and qualifying individuals for the registry. COVID has made those challenges even more daunting.

This item outlines recommended temporary flexibilities for Registry applicants.

Referral Update:

In the proposed modifications, providers interested in joining the Registry will be required to complete a written application, including listing at least one (1) work reference and one (1) personal reference. *(The regular criteria is at least two (2) work reference and one (1) personal reference).* Applicant providers will be required to complete a face-to-face interview with Registry Staff and complete the Registry Orientation.

They will also be required to complete the State Mandated requirements, which include:

- Complete and pass a Department of Justice background check;
- Complete the State provider orientation; and
- Complete Form SOC 426.

Recommendation(s)/Next Step(s):

CONSIDER accepting and submitting for approval by the Board of Supervisors modifications to the IHSS Public Authority Registry Policies and Procedures.

Fiscal Impact (if any):

None

Attachments

Staff Summary of IHSS PA Registry Policy Changes
Registry Policy and Procedures with Temporary Flexibilities
REDLINE - Registry Policy and Procedures with Temporary Flexibilities

Temporary Flexibilities for IHSS Registry Recruitment

The Registry has always had many challenges recruiting providers for West County. The challenges are compounded by the COVID-19 crisis and shortage of providers is now being experienced in the Central and East County.

The flexibilities the Public Authority is requesting will expand the Registry's ability to recruit outside the perimeters in place currently for a temporary period of 12 months and therefore, increase the number of available providers to assist the IHSS consumers in all parts of the County.

The following in blue color is a summary of the Temporary Flexibilities Public Authority is requesting.

Temporary Provider Application and Intake

Providers interested in joining the Registry will be required to complete a written application, including listing at least one (1) work reference and one (1) personal reference. *(The regular criteria is at least two (2) work reference and one (1) personal reference)*. Applicant providers will be required to complete a face-to-face interview with Registry Staff and complete the Registry Orientation.

They will also be required to complete the State Mandated requirements, which include:

- Complete and pass a Department of Justice background check
- Complete the State provider orientation
- Complete Form SOC 426

Temporary Provider References Policy and Procedure

Policy:

The Registry will require one (1) positive work references and one (1) positive personal reference before considering a potential provider for the Registry.

Procedure:

Registry staff will:

1. Require potential providers to provide references;

2. Ask potential providers to supply one(1) work reference and one(1) personal reference;

3. Check the references;

4. Require one (1) positive work references and one (1) positive personal reference before considering a potential provider for the Registry;

5. Accept a family member reference for an IHSS provider who has worked for family only and who family is the only work reference(s) they have and this is verifiable in CMIPS; (*we have been turning down this group of applicants and yet they are the majority in IHSS Program*)

6. Perform a reference check with current employer (IHSS consumer), Once a provider joins the Registry, is referred for work, is hired and working relationship last 3 months; thereby enabling the provider to meet the regular Registry reference criteria.

7. Give direct access to the Registry for providers listed on another County Registry, who have worked for IHSS consumer(s) and are verifiable/active in CMIPS.

Public Authority Operating Policies
Policy 1 Centralized Registry

- That the Registry be centralized and operated "in-house" by the Public Authority.
- That the Registry provide a sufficient number of off-site stations to accommodate provider intakes, interviews and orientation.
- That the Registry serve only IHSS consumers and providers.
- That the Registry use registry software and forms previously developed by the County, with the understanding that once the Public Authority Registry begins operating, needed software modifications may be identified.

Public Authority Operating Policies
Policy 2 Provider Recruitment

Provider Recruitment Policy and Procedure

Policy: The Registry will endeavor to recruit a sufficient number of providers to meet local consumer needs.

Procedure:

1. As specifically as possible, identify the tasks/days/hours consumers require; and identify cultural/language and geographic needs and consumer preferences.

Note: Making these decisions in advance will narrow the focus of recruitment efforts.

2. Recruit providers who meet the tasks/days/hours, cultural/language and geographic needs and consumer preferences that have been identified.

Caution: The first inclination will be to recruit as many providers as possible. Be careful; this requires balance. If the Registry doesn't recruit enough providers, it will not be able to meet consumer requests. However, if the Registry recruits too many providers, they will go without work, become discouraged, drop off the Registry, and word of mouth will hurt future recruitment.

3. Depending on recruitment goals one or more of the following recruitment strategies may be helpful:

- Utilizing county list of all current IHSS providers and consumers, do an outreach/recruitment mailing;
- Asking SEIU to assist in outreach/recruitment of potential providers;
- Scheduling informational meetings for potential providers;
- Advertise in major newspapers, local weekly, and ethnic newspapers;
- Public Service Announcements on major television and radio stations, cable stations, and ethnic stations;
- Mailings to and posters in organizations providing services to the elderly and disabled;
- Posters in busses and trains;
- Outreach/recruitment through GAIN, CalWORKs, etc.;
- Listing Registry with Employment Development Department;
- Outreach/recruitment through churches; and
- Outreach/recruitment through colleges.

Provider Application and Intake

Providers interested in being placed on the Registry are required to complete a written application, including a list of at least two employment references and two personal references.

- Purposes of the application include: 1) getting information needed to begin determining the appropriateness of the applicant for the Registry; and 2) getting information needed to make a match between the provider and consumer.

Application Procedure:

1. Applications can be obtained from the Public Authority Registry.

2. Upon completing and returning the application to the Registry, applicants are scheduled for a personal interview/orientation with Registry staff.

Provider Intake Process Policy:

All applicants to the Registry are required to participate in the provider intake process; no exceptions will be considered.

Intake Procedure:

The provider intake process includes the applicant:

1. Completing, signing and dating the provider application.

2. Showing proof of citizenship or any other legal document to work in the United States (Green Card or Work Permit from the Immigration Department), current and accurate picture identification and Social Security card. The names on the picture ID and Social Security card must match.

3. Signing and dating the signature page of the Provider Handbook, indicating the provider has read and understood the Handbook. A copy of the signed and dated signature page is to be kept in the provider's file.

4. Providing references that meet Registry references check criteria. The references must include names and telephone numbers of the individuals providing the references.

5. Participating in a face-to-face interview/orientation with Registry staff.

6. Providing documentation/certificates for any training (e.g., First Aid, CPR, CNA or any other training) claimed by the provider. Copies of training documentation/ certificates will be kept in provider's file.

7. Providing proof of valid driver's license if provider indicates a willingness to provide transportation services, a copy of driver's license will be kept in provider's file. Consumers will be advised that the Registry checks these documents only at the time the provider goes on the Registry, and that the Public Authority/Registry cannot guarantee that a provider has a valid driver's license at the time of referral. Providers will be informed that they may be liable if they drive a consumer; that the Public Authority accepts no liability related to a provider driving a consumer; and that the provider should consult with his/her insurance carrier before transporting a consumer.

8. Completing and passing a Department of Justice Background Check
9. Completing the State Manadated Provider Orientation.
10. Completing SOC 426 – Provider Enrollment Form

11. An individual file is to be kept on each applicant to the Registry. Applicants who do not meet the requirements for inclusion on the Registry are to be kept separate from active files, but all documents will be retained for six months.

    - The provider's file should contain, but may not be limited to:

        - ✓ Completed Registry application
        - ✓ Signed and dated Provider Handbook signature page
        - ✓ Completed reference check forms
        - ✓ Copies of training documentation/certificates
        - ✓ Copy of drivers license
        - ✓ Other pertinent information, e.g., if applicant is rejected by the Registry or if a provider is removed from the Registry, a copy of the letter informing applicant/provider of Registry action

Revised:6/06

Provider Screening - Employment Eligibility Policy and Procedure

Policy:

All Registry applicants will be required to provide copies of personal identification documents that will be included in the applicant's file.

- Government issued picture identification card
- Original Social Security Card
- Unexpired INS Employment Authorization (when necessary)

Procedure:

1. Copies of all documents must be placed in applicant's file.

2. If the applicant is between 14-17 years of age, she/he must also bring a valid School Work Permit.

Public Authority Operating Policies
Policy 5 Provider References

Provider References Policy and Procedure

Policy:

The Registry will require one positive work references and one positive personal reference before considering a potential provider for the Registry.

Procedure:

Registry staff will:

1. Require potential providers (including any providers on the Registry when the Public Authority begins operations) to provide references;

2. Ask potential providers to supply a total of two work references and two personal references;

3. Check references;

4. Require one positive work references and one positive personal reference before considering a potential provider for the Registry.

5. Accept a family member reference for an IHSS provider who has worked for family only and who family is the only work reference(s) they have and this is verifiable in the Case Management Information and Payroll System (CMIPS).
6. Perform a reverence check with current employer (IHSS consumer), once a provider joins the Registry, is referred for work, is hired and the working relationship last 3 months; thereby enabling the provider to meet the regular Registry reference criteria.
7. Give direct access to the Registry for providers listed on another County Registry, who have worked for IHSS consumer(s) and are verifiable as active in CMIPS.

Public Authority Operating Policies
Policy 6 Provider Interview/Orientation

Provider Interview/Orientation Policy and Procedure

Policy:

All Registry applicants will be required to participate in a face-to-face interview/orientation with Registry staff prior to being listed on the Registry.

Procedure:

1. Registry staff will schedule the interview/orientation with the Registry applicant. Interviews/orientation can be done individually or in a group session.

2. The interview/orientation will be utilized:

   - As an orientation to IHSS and Registry policies and procedures**,** e.g., Registry's nondiscrimination policy, what is and what is not allowable in IHSS, IHSS payroll and time sheets, ability of Registry to combine part-time assignments into full-time work;
   - To distribute and review the Provider Handbook;* and to have the provider sign and date the Handbook signature page indicating she/he has read and understood the Handbook;
   - To inform providers about provider and consumer rights and responsibilities;
   - To inform providers that they may be liable if they drive a consumer, that the Public Authority accepts no liability related to a provider driving a consumer and recommending that the provider consult with his/her insurance carrier;
   - To provide an understanding of the population the provider will be serving;
   - To stress the importance of reliability, dependability, flexibility, being a good listener and confidentiality;
   - As an opportunity for Registry staff to acquaint themselves with the provider;
   - To review the provider's work history;
   - To provide written orientation materials, including the Provider Handbook;
   - To assist the provider in understanding and completing the Registry Provider Application; and

3. The interview/orientation format should include visual, verbal and written presentation.

   * NOTE: The Provider Handbook should include, but may not be limited to:

   - ✓ Registry policies and procedures
   - ✓ Provider and consumer rights and responsibilities
   - ✓ Suggestions about what the provider might ask in an interview

- ✓ A list of phone numbers to call if provider has a question or is having a problem, e.g., Registry staff, IHSS staff, payroll

4. A copy of the signed and dated Handbook signature page will be kept in the provider's file.

5. The Handbook will be distributed to all newly enrolling IHSS providers, all providers applying to be listed on the Registry and to others upon request.

Public Authority Operating Policies
Policy 8 Provider Follow-Up

Provider Follow-up Policy and Procedure

Policy:

Providers must keep the Registry updated on their schedules, availability for work and other pertinent information. To remain actively listed on the Registry, providers must update their files at least every two weeks, and more often if there is a change in the provider's schedule, availability for work or other pertinent information.

Procedure:

1. Registry staff will inform providers that it is the provider's responsibility to update his/her file at least every two weeks, and more often if there is a change in the provider's schedule, availability for work or other pertinent information.

2. Registry staff will inform providers that if they fail to update their files, they will be put on inactive status and will not be referred for future jobs until the file is updated; and that continued non-compliance with the file update requirement will result in the provider's file being closed.

3. Registry staff will inform providers that information to be updated includes:

    - Change of provider address or telephone number
    - Changes in availability for work or work preferences, e.g., change in available hours, when a job has ended, when she/he becomes available for new or additional work assignments
    - Notifying Registry if there is an emergency, if he/she is sick or any other reason she/he will be unable to fulfill work assignments
    - Whenever possible giving two weeks notice if she/he will not be able to continue working her/his schedule

4. Registry staff will record provider update calls and will make appropriate changes in the provider file and Registry database.

5. Providers whose updates are current will be given priority for job referrals.

6. For providers who have been inactive in IHSS and on the Registry for two years will be required to re-apply to the Registry and complete an application listing references and attend an orientation in order to be re-instated on the Registry.

Public Authority Operating Policies
Policy 9 Provider Removal

Provider Removal from the Registry Policy and Procedure

General Policy:

- The Public Authority reserves the right to remove a provider from the Registry.

- The Public Authority may determine reasonable rules and regulations regarding the appointment to and removal of providers from the Registry.

- Complaints concerning a provider may be given verbally or in writing to Public Authority staff. Public Authority staff will document all complaints.

Policy - Minor Offenses:

The Public Authority will remove a provider from the Registry after two complaints of minor offenses that have been reported by one or more sources within a two year period and have been deemed valid by Public Authority staff. Minor offenses will include but not be limited to:

- Not appearing at scheduled interviews without notice
- Being late for work without reasonable cause
- Discourtesy, rudeness or inappropriate behavior toward consumer or consumer relatives or Public Authority staff
- Refusal to do the authorized tasks agreed to upon hire
- Not performing requested and authorized tasks during work hours
- Inadequate job performance
- Not returning consumer phone calls
- Not returning Registry phone calls
- Failure to update Registry files
- Quitting Registry assignment (without a good reason) without at least a two week notice

Policy - Major Offenses:

The Public Authority will remove a provider from the Registry after one complaint of a major offense that has been deemed valid by Public Authority staff. Major offenses will include but not be limited to:

- Theft
- Sexual/physical abuse
- Neglect
- Dishonesty or misrepresentation related to job duties
- Unauthorized disclosure of confidential information

- Being intoxicated or being under the influence or possession of any illegal substance while on duty
- Asking the consumer to supplement the allowable IHSS wage
- Absence from or leaving the job without notice
- Possession of a firearm or other dangerous weapon while on duty
- Conviction for a crime which indicates unfitness for the job
- Knowingly putting the consumer in jeopardy

Procedure:

1. Public Authority staff will evaluate the complaint and determine what action to take.

2. If the complaint regarding a first minor offense is determined to be valid, by Public Authority staff, the provider will be mailed a written statement listing the complaint, notifying the provider that a second complaint of a similar offense will constitute grounds for removal from the Registry, and informing the provider about the appeal process.

3. If a complaint regarding a second minor offense (within a two year period) or a complaint regarding a major offense is determined to be valid, by Public Authority staff, the provider will be removed from the Registry.

4. Within ten working days following the date of Registry removal, the provider will be mailed a written statement notifying the provider of the removal, the reason(s) for removal, and informing the provider about the appeal process.

Appeal Process:

1. The provider may appeal the Public Authority's action to the Public Authority Executive Director within ten working days of mailing of the removal notification letter.

   The appeal must be in writing and state why the provider believes the Public Authority's action was incorrect.

   The Executive Director has the discretion to extend the ten working days timeframe if she/he deems it appropriate and reasonable to do so.

2. The Executive Director will mail the provider written notification of his/her decision within ten working days of receipt of provider's appeal.

3. If the provider is not satisfied with the Executive Director's decision, the provider can bring the appeal, in writing, to the Advisory Committee or subcommittee of the Advisory Committee within thirty working days of mailing of Executive Director's decision.

4. The Advisory Committee or subcommittee will make the final decision regarding the appeal within thirty working days of receipt of provider's appeal.

   The thirty working days timeframe can be modified with the mutual consent of all parties.

5. Providers removed from the Registry will remain in an inactive Registry status (not being referred to jobs) until/unless the decision to remove is reversed through the appeal process.

Procedures for Investigating a Complaint:

The Public Authority follows procedures specified in the Policy on Removing a Provider from the Registry.

1. Receive Complaint – make written notes
2. Notify provider, as soon as possible, but no longer than 5 working days, that allegations have been made. Try to contact by phone, but if unable to reach, send a letter stating that PA needs to talk to him/her about allegations.
3. Obtain information from the provider – keep written notes.
4. Check the files to see if other complaints have been made. If indicated, check with social worker.
5. Speak separately with both parties (the consumer and provider) and any other involved in the dispute: i.e. social worker, APS, MSSP worker, family member(s).
6. Get specific facts from all parties: exactly what happened, when, the severity, frequency, what attempts have been made to resolve the problem. Observe any materials (time sheets, checks, receipts, records in the files, etc.).
7. Try to discover if there are other areas of concern.
8. When necessary, report suspected or reported abuse or neglect of elder or dependent adult to Adult Protective Services.
9. In an objective manner, try to discuss the issue with the parties to attempt to resolve the issue.
10. Based on information gathered, make a decision. Inform the parties. When necessary, send either a warning letter or a letter of termination to the provider.
11. Include a copy of the Removal Policy and Grievance Procedure with the letter to the provider.
12. Enter comments in "notes" section of the provider file in the computer.

Providers removed from the Registry will be placed in an "inactive" status until the decision to remove is reversed through the appeal process.

Public Authority Operating Policies
Policy 10 Referral of Consumers

Referral of Consumers to the Registry Policy and Procedure

Policy:

The Registry accepts referral of any Contra Costa County IHSS consumer from any referral source. Primary referral sources:

- Initial (first time) referrals generally come through County IHSS.
- Some initial referrals may come from others, e.g., family members, providers.
- Re-referrals (those who have been previously served) are most often direct self-referrals.

Procedure:

When a referral is received, Registry staff will:

1. Contact the consumer or consumer representative within three working days;
2. Confirm consumer's IHSS status; and
3. Begin the intake process

Public Authority Operating Policies
Policy 11 Consumer Intake

Consumer Intake Policy and Procedure

Policy:

A Consumer Profile will be entered in the Registry database for every consumer requesting services from the Registry.

- Purpose of the Consumer Profile to get information needed to match providers and consumers.

Procedure:

Once a referral is received, Registry staff will:

1. Contact the consumer or consumer representative within three working days;

2. Confirm consumer's IHSS status;

3. Describe how the Registry works; and inform the consumer that she/he is responsible for selecting a provider;

4. Inform the consumer that, within five working days, the Registry will provide a list of providers for the consumer to consider; and that in an emergency situation the Registry will refer the consumer to the Rapid Response Program;

5. Inform the consumer that she/he is not obligated to hire a provider from the Registry; that consumers have the right to seek providers from any source, including but not limited to referrals from the Registry; and, if appropriate, suggest other possible sources of providers, e.g., family member, friends, church;

6. Inform the consumer that she/he will need to respond to a series of questions in order to facilitate referrals from the Registry;

7. Complete the Consumer Profile in the Registry database, identifying, with the consumer, his/her most critical needs and most important preferences; and

8. Check the consumer's most current 293 form in CMIPS.

Public Authority Operating Policies
Policy 12 Generating Lists of Providers

Generating Consumer List of Providers Policy and Procedure

Policy:

- Consumers or consumer representatives will be given a list of providers from the Registry. The list will include a minimum of three and a maximum of six providers.

- The order of screening to determine which providers are placed on the list will be based on making an appropriate match between the consumer's needs and preferences, and the provider's willingness to perform tasks authorized by the social worker and the provider's availability and preferences.

- The Registry reserves the right to continue screening for consumer needs and preferences and provider preferences until the provider list consists of at least three and no more than six names.

Procedure:

1. Using information from the Consumer Profile, Registry staff will generate a list of providers by querying the Registry database for providers who match the consumer's needs and preferences;

2. Registry staff will also query for providers who are willing to perform tasks authorized by the social worker and who are available for work;

3. Registry staff will query such that the list will include a minimum of three and maximum of six providers; and

4. The list will include only providers who have completed the application process, including reference check, if applicable, provided training documentation or certification, proof of valid driver's license.

5. If the consumer needs a provider with special training (e.g., First Aid, CPR, CNA), Registry staff will assure that appropriate training documentation/certification is on file prior to including the provider on the list.

6. The list will include only providers who have indicated a willingness to perform the tasks/hours the consumer needs and, as much as possible, meet other preferences desired by the consumer.

Public Authority Operating Policies
Policy 13 Referral of Providers to Consumers

Referral of Providers to Consumer Policy and Procedure

Policy:

- The Registry will supply a list of providers to IHSS consumers following completion of the consumer intake process. The list will include a minimum of three and a maximum of six providers who have updated their availability with the Registry within the last two weeks. The order of screening to determine which providers are placed on the list will be based on making an appropriate match between the consumer's needs and preferences, and the provider's willingness to perform tasks authorized by the social worker and the provider's availability and preferences.

- The list will be communicated to the consumer or consumer representative. It is the consumer's (or person acting in the interest of the consumer) responsibility to choose which provider(s) if any, she/he will contact and/or hire from the list.

- The Registry will not "recommend" any provider(s).

- The consumer is the employer for the purposes of hiring, supervising and firing his/her provider. The Registry is not the employer for these functions.

Procedure:

1. The Registry will send additional material to consumers with the first list that will include but not be limited to:

    - Information on how the Registry operates, including what the Registry does and does not do;
    - IHSS recipient and provider rights and responsibilities;
    - Other relevant printed materials.

2. Registry staff will inform the consumer that she/he should call the Registry to let staff know if she/he has hired a provider or is having any problems with the process.

3. Registry staff will inform the consumer that the provider must call the Public Authority Senior Benefits Clerk to begin the provider enrollment process.

Public Authority Operating Policies
Policy 14 Consumer Follow-up

Consumer Follow-up Policy and Procedure

Policy:

The Registry will provide regular follow-up on all consumers receiving a list of providers from the Registry. Follow-ups will be conducted by placing telephone calls to the consumer or consumer representative. Follow-up telephone calls will be made at least every ten days and will continue until the consumer case is closed, e.g., consumer found Registry provider or found own provider, consumer hospitalized, institutionalized, withdrew or was withdrawn from IHSS or deceased.

- Purposes of follow-up include, but are not limited to: assessing consumer's progress in finding a provider; and determining if the consumer is having any particular problems in utilizing Registry services, if consumer needs have changed, if consumer needs a new list, or if consumer needs additional support services.

Procedure:

1. Once the list of providers has been mailed to the consumer and the appropriate information entered into the Registry Tracking database, the database will automatically indicate the date for the first follow-up call.

2. On the date indicated for the first follow-up call, place a phone call to the consumer to determine the consumer's progress in finding a provider, if the consumer is having any particular problems in utilizing Registry services, if the consumer's needs have changed, if the consumer needs a new list, if the consumer needs additional support services, etc.

   Additional support services include, but are not necessarily limited to:

   - Assisting the consumer and provider with understanding employer/employee roles, rights and responsibilities;
   - Understanding how to interview and hire providers;
   - Calling providers and setting up interviews;
   - Being present at interviews;
   - Assisting with resolution of conflict between provider and consumer;
   - Developing provider schedules and tracking of provider's hours;
   - Understanding payroll, time sheets and share of cost payments;
   - Trouble-shooting payroll and share of cost problems; and
   - Referring consumers to the Social Worker if there is a significant change in the consumer's condition.

3. After completing the follow-up call, Registry staff will consult with the social worker and take whatever steps are appropriate to address issues/problems identified while speaking with the consumer.

4. The next step is to enter the appropriate information (follow-up notes) into the Registry database, the database will automatically indicate the date for the next follow-up call.

5. The final step is to print out two copies of the 10-day follow up form: i.e., one for the Program Manager and one to be used during the next follow-up call.

6. After a case is closed, the consumer will be asked to respond to a Consumer Satisfaction Survey. The survey will be conducted over the phone by Registry staff. Written copies of completed surveys will be kept on file. The surveys will be used as a tool for assessing Registry performance and progress toward meeting Public Authority Performance Measures, for identifying needed program improvements and for reporting to the Advisory Committee and Board.

7. After a Registry provider has been on the job for 60 days (the match has lasted 60 days) the consumer will be asked to respond to a survey to assess the quality of their provider's work. The survey will be conducted over the phone by the Registry staff. Written copies of completed surveys will be kept on file. The surveys will be used as a tool for assessing Registry performance and progress toward meeting Public Authority Performance Measures, identifying provider training needs and for reporting to the Advisory Committee and Board.

Public Authority Operating Policies
Policy 15 Consumer and Provider Support Services

Consumer and provider support services policy

- The Public Authority will provide supportive services;
- Support services will be provided to any Registry consumer or provider upon request, and determination of need by Authority staff;
- Methods for provision of services would include phone consultation, written materials, inclusion in consumer/provider orientation and training and home visits.

Supportive services will include, but not necessarily be limited to:

- Assisting the consumer and provider with understanding employer/employee roles, rights and responsibilities;
- Understanding how to interview and hire providers;
- Calling providers and setting up interviews;
- Being present at interviews;
- Assisting with resolution of conflict between provider and consumer;
- Developing provider schedules and tracking of provider's hours;
- Understanding payroll, time sheets and share of cost payments;
- Trouble-shooting payroll and share of cost problems; and

Public Authority Operating Policies
Policy 16 Consumer and Provider Training

Consumer and Provider Training Policy and Procedure

Policy:

Training services will be made available to all IHSS consumers and providers; training will be provided upon request and determination of need by Public Authority staff; training will be voluntary and at no cost to consumers or providers; training and training materials will be provided in English and other appropriate languages.

A stipend will be paid to enrolled Contra Costa County IHSS providers and active Registry providers for attending group-training sessions.

Procedure - Consumer Training:

- Consumers receive training/orientation to IHSS and Registry services during the intake process and through printed materials.

- Consumer training will be done one-on-one and in group sessions; and training topics will include, but may not be limited to clarification regarding IHSS, consumer/provider rights, roles and responsibilities, how to be an employer, e.g., hiring, firing, supervising, scheduling, timecards, dealing with employee problems. (One-on-one training usually takes place in the consumer's home.)

- A record is to be kept of all one-on-one and group training received by consumers.

Procedure – Provider Training:

- Providers receive training/orientation to IHSS and Registry services during the intake (interview/orientation) process and through printed materials.

- Provider training sessions will be offered. Training sessions will:

  - ✓ Be in a group setting; 25-30 participants per session;
  - ✓ Be scheduled at different locations throughout the County; at different times of day and evening; and
  - ✓ Training topics will be general, e.g., Universal Precautions, back care, transferring, CPR, First Aid, adaptive equipment use.

- A record is to be kept of providers attending group and/or individual training; and completion of training is to be noted in the provider's Registry database file.

Public Authority Operating Policies

Policy 17 Consumer Refusal of Service

Consumer - Refusal of Service Policy & Procedure

General Policies:

1. The Public Authority reserves the right to refuse Registry services to a consumer.

2. The Public Authority may determine reasonable rules and regulations regarding the refusal of Registry services to a consumer.

3. Complaints concerning a consumer may be made verbally or in writing to Public Authority staff. Public Authority staff will document all complaints and respect confidentiality.

4. Prior to taking any action regarding denial of Registry services, Public Authority staff will attempt to resolve the situation by consulting with the consumer, the consumer's IHSS Social Worker and other interested persons.

Policy - Minor Offenses:

The Public Authority will refuse Registry services to a consumer after two complaints of minor offenses that have been reported by one or more sources within a two-year period; that have been deemed reasonable and valid by Public Authority staff; and that have not been resolved by consultation or referral (see general policy # 4). Minor offenses will include but not be limited to:

- Discourtesy, rudeness or inappropriate behavior toward the provider or registry staff
- Repeated pattern of not following through with registry process, e.g., not calling providers on list in a timely manner, not being available for scheduled interviews, canceling interviews without notifying scheduled providers
- Repeated pattern of hiring and then discharging registry providers without valid, work-related justification
- Calling provider names – making racist remarks
- Refusing to sign legitimate timesheets
- Refusing to pay required share of cost

- Not being available when provider arrives for scheduled work; not informing provider of change in plans
- Insisting that provider perform tasks not authorized by the IHSS Social Worker, e.g.,:
  - performing services for anyone other than the authorized consumer, such as other family members
  - taking care of pets, such as shampooing, making special food, exercising, taking for walks
  - cleaning whole house when consumer lives with own family
  - doing yard work, such as cutting the lawn, trimming the roses, weeding the flower beds
  - washing the car
  - unauthorized heavy cleaning, moving furniture, climbing ladders
  - driving to other than medical appointments, essential shopping or errands
  - insisting that provider stay late, i.e. to run an errand or take shopping

Policy - Major Offenses:

The Public Authority will refuse Registry services to a consumer after one complaint of a major offense that has been deemed reasonable and valid by Public Authority staff and that has not been resolved by consultation or referral (see general policy # 4). Major offenses will include but not be limited to:

- Theft, forgery, dishonesty or misrepresentation related to being the employer of the provider, e.g., hiring relative as provider, signing time card, and keeping money; insisting provider work less hours than approved, then claiming total hours on time sheet and "splitting the check"
- Inappropriate contact with provider's family
- Sexual harassment or sexual abuse of provider
- Physically abusing or assaulting provider
- Knowingly putting the provider in jeopardy
- Displaying a firearm or other dangerous weapon in a threatening manner

Procedure:

1. Public Authority staff will evaluate the complaint and determine what action to take.

2. Public Authority staff will attempt to resolve the situation by consulting with the consumer, the consumer's IHSS Social Worker and other appropriate individuals.

3. If the complaint regarding a first minor offense is determined to be reasonable and valid by Public Authority staff and the complaint has not been resolved through Step 2 (above), the consumer will be notified verbally and in a written statement listing the complaint, informing the consumer that a second complaint of a similar offense will constitute grounds for refusal of Registry services, and notifying the consumer about the appeal process.

4. If a complaint regarding a second minor offense (within a two-year period) or a complaint regarding a major offense is determined to be reasonable and valid, by Public Authority staff and the complaint has not been resolved through Step 2 (above), the consumer will be refused Registry services.

5. Within ten working days following the date of refusal of Registry services, the consumer will be notified verbally and in a written statement informing the consumer of the refusal of Registry services, the reason(s) for refusal, and notifying the consumer about the appeal process. A copy of the notification statement will be sent to the consumer's social worker.

Appeal Process:

1. The consumer may appeal the Public Authority's action to the Public Authority Executive Director within ten working days of mailing of the refusal of Registry services notification letter.

   The appeal may be verbal or in writing and state why the consumer believes the Public Authority's action was incorrect.

   The Executive Director has the discretion to extend the ten working days timeframe if she/he deems it appropriate and reasonable to do so.

2. The Executive Director will mail the consumer written notification of his/her decision within ten working days of receipt of consumer's appeal.

3. If the consumer is not satisfied with the Executive Director's decision, the consumer can bring the appeal, verbally or in writing, to the Advisory Committee or subcommittee of the Advisory Committee within thirty working days of mailing of the Executive Director's decision.

4. The Advisory Committee or subcommittee will make the final decision regarding the appeal within thirty working days of receipt of consumer's appeal.

The thirty working days timeframe can be modified with the mutual consent of all parties.

5. Refusal of Registry services will remain in effect until/unless the decision to refuse services is reversed through the appeal process.

AC adopted 10/11/01

Public Authority Operating Policies
Policy 1 Centralized Registry

- That the Registry be centralized and operated "in-house" by the Public Authority.
- That the Registry provide a sufficient number of off-site stations to accommodate provider intakes, interviews and orientation.
- That the Registry serve only IHSS consumers and providers.
- That the Registry use registry software and forms previously developed by the County, with the understanding that once the Public Authority Registry begins operating, needed software modifications may be identified.

Public Authority Operating Policies
Policy 2 Provider Recruitment

Provider Recruitment Policy and Procedure

Policy: The Registry will endeavor to recruit a sufficient number of providers to meet local consumer needs.

Procedure:

1. As specifically as possible, identify the tasks/days/hours consumers require; and identify cultural/language and geographic needs and consumer preferences.

Note: Making these decisions in advance will narrow the focus of recruitment efforts.

2. Recruit providers who meet the tasks/days/hours, cultural/language and geographic needs and consumer preferences that have been identified.

Caution: The first inclination will be to recruit as many providers as possible. Be careful; this requires balance. If the Registry doesn't recruit enough providers, it will not be able to meet consumer requests. However, if the Registry recruits too many providers, they will go without work, become discouraged, drop off the Registry, and word of mouth will hurt future recruitment.

3. Depending on recruitment goals one or more of the following recruitment strategies may be helpful:

- Utilizing county list of all current IHSS providers and consumers, do an outreach/recruitment mailing;
- Asking SEIU to assist in outreach/recruitment of potential providers;
- Scheduling informational meetings for potential providers;
- Advertise in major newspapers, local weekly, and ethnic newspapers;
- Public Service Announcements on major television and radio stations, cable stations, and ethnic stations;
- Mailings to and posters in organizations providing services to the elderly and disabled;
- Posters in busses and trains;
- Outreach/recruitment through GAIN, CalWORKs, etc.;
- Listing Registry with Employment Development Department;
- Outreach/recruitment through churches; and
- Outreach/recruitment through colleges.

Provider Application and Intake

Providers interested in being placed on the Registry are required to complete a written application, including a list of at least two employment references and two personal references.

- Purposes of the application include: 1) getting information needed to begin determining the appropriateness of the applicant for the Registry; and 2) getting information needed to make a match between the provider and consumer.

Application Procedure:

1. Applications can be obtained from the Public Authority Registry.

2. Upon completing and returning the application to the Registry, applicants are scheduled for a personal interview/orientation with Registry staff.

Provider Intake Process Policy:

All applicants to the Registry are required to participate in the provider intake process; no exceptions will be considered.

Intake Procedure:

The provider intake process includes the applicant:

1. Completing, signing and dating the provider application.

2. Showing proof of citizenship or any other legal document to work in the United States (Green Card or Work Permit from the Immigration Department), current and accurate picture identification and Social Security card. The names on the picture ID and Social Security card must match.

3. Signing and dating the signature page of the Provider Handbook, indicating the provider has read and understood the Handbook. A copy of the signed and dated signature page is to be kept in the provider's file.

4. Providing references that meet Registry references check criteria. The references must include names and telephone numbers of the individuals providing the references.

5. Participating in a face-to-face interview/orientation with Registry staff.

6. Providing documentation/certificates for any training (e.g., First Aid, CPR, CNA or any other training) claimed by the provider. Copies of training documentation/ certificates will be kept in provider's file.

7. Providing proof of valid driver's license if provider indicates a willingness to provide transportation services, a copy of driver's license will be kept in provider's file. Consumers will be advised that the Registry checks these documents only at the time the provider goes on the Registry, and that the Public Authority/Registry cannot guarantee that a provider has a valid driver's license at the time of referral. Providers will be informed that they may be liable if they drive a consumer; that the Public Authority accepts no liability related to a provider driving a consumer; and that the provider should consult with his/her insurance carrier before transporting a consumer.

8. Completing and passing a Department of Justice Background Check
9. Completing the State Manadated Provider Orientation.
10. Completing SOC 426 – Provider Enrollment Form

11. An individual file is to be kept on each applicant to the Registry. Applicants who do not meet the requirements for inclusion on the Registry are to be kept separate from active files, but all documents will be retained for six months.

    - The provider's file should contain, but may not be limited to:

        - ✓ Completed Registry application
        - ✓ Signed and dated Provider Handbook signature page
        - ✓ Completed reference check forms
        - ✓ Copies of training documentation/certificates
        - ✓ Copy of drivers license
        - ✓ Other pertinent information, e.g., if applicant is rejected by the Registry or if a provider is removed from the Registry, a copy of the letter informing applicant/provider of Registry action

Revised:6/06

Provider Screening - Employment Eligibility Policy and Procedure

Policy:

All Registry applicants will be required to provide copies of personal identification documents that will be included in the applicant's file.

- Government issued picture identification card
- Original Social Security Card
- Unexpired INS Employment Authorization (when necessary)

Procedure:

1. Copies of all documents must be placed in applicant's file.

2. If the applicant is between 14-17 years of age, she/he must also bring a valid School Work Permit.

Public Authority Operating Policies
Policy 5 Provider References

Provider References Policy and Procedure

Policy:

The Registry will require one positive work references and one positive personal reference before considering a potential provider for the Registry.

Procedure:

Registry staff will:

1. Require potential providers (including any providers on the Registry when the Public Authority begins operations) to provide references;

2. Ask potential providers to supply a total of two work references and two personal references;

3. Check references;

4. Require one positive work references and one positive personal reference before considering a potential provider for the Registry.

5. Accept a family member reference for an IHSS provider who has worked for family only and who family is the only work reference(s) they have and this is verifiable in the Case Management Information and Payroll System (CMIPS).
6. Perform a reverence check with current employer (IHSS consumer), once a provider joins the Registry, is referred for work, is hired and the working relationship last 3 months; thereby enabling the provider to meet the regular Registry reference criteria.
7. Give direct access to the Registry for providers listed on another County Registry, who have worked for IHSS consumer(s) and are verifiable as active in CMIPS.

Public Authority Operating Policies
Policy 6 Provider Interview/Orientation

Provider Interview/Orientation Policy and Procedure

Policy:

All Registry applicants will be required to participate in a face-to-face interview/orientation with Registry staff prior to being listed on the Registry.

Procedure:

1. Registry staff will schedule the interview/orientation with the Registry applicant. Interviews/orientation can be done individually or in a group session.

2. The interview/orientation will be utilized:

   - As an orientation to IHSS and Registry policies and procedures**,** e.g., Registry's nondiscrimination policy, what is and what is not allowable in IHSS, IHSS payroll and time sheets, ability of Registry to combine part-time assignments into full-time work;
   - To distribute and review the Provider Handbook;* and to have the provider sign and date the Handbook signature page indicating she/he has read and understood the Handbook;
   - To inform providers about provider and consumer rights and responsibilities;
   - To inform providers that they may be liable if they drive a consumer, that the Public Authority accepts no liability related to a provider driving a consumer and recommending that the provider consult with his/her insurance carrier;
   - To provide an understanding of the population the provider will be serving;
   - To stress the importance of reliability, dependability, flexibility, being a good listener and confidentiality;
   - As an opportunity for Registry staff to acquaint themselves with the provider;
   - To review the provider's work history;
   - To provide written orientation materials, including the Provider Handbook;
   - To assist the provider in understanding and completing the Registry Provider Application; and

3. The interview/orientation format should include visual, verbal and written presentation.

   * NOTE: The Provider Handbook should include, but may not be limited to:

   - ✓ Registry policies and procedures
   - ✓ Provider and consumer rights and responsibilities
   - ✓ Suggestions about what the provider might ask in an interview

- ✓ A list of phone numbers to call if provider has a question or is having a problem, e.g., Registry staff, IHSS staff, payroll

4. A copy of the signed and dated Handbook signature page will be kept in the provider's file.

5. The Handbook will be distributed to all newly enrolling IHSS providers, all providers applying to be listed on the Registry and to others upon request.

Public Authority Operating Policies
Policy 8 Provider Follow-Up

Provider Follow-up Policy and Procedure

Policy:

Providers must keep the Registry updated on their schedules, availability for work and other pertinent information. To remain actively listed on the Registry, providers must update their files at least every two weeks, and more often if there is a change in the provider's schedule, availability for work or other pertinent information.

Procedure:

1. Registry staff will inform providers that it is the provider's responsibility to update his/her file at least every two weeks, and more often if there is a change in the provider's schedule, availability for work or other pertinent information.

2. Registry staff will inform providers that if they fail to update their files, they will be put on inactive status and will not be referred for future jobs until the file is updated; and that continued non-compliance with the file update requirement will result in the provider's file being closed.

3. Registry staff will inform providers that information to be updated includes:

    - Change of provider address or telephone number
    - Changes in availability for work or work preferences, e.g., change in available hours, when a job has ended, when she/he becomes available for new or additional work assignments
    - Notifying Registry if there is an emergency, if he/she is sick or any other reason she/he will be unable to fulfill work assignments
    - Whenever possible giving two weeks notice if she/he will not be able to continue working her/his schedule

4. Registry staff will record provider update calls and will make appropriate changes in the provider file and Registry database.

5. Providers whose updates are current will be given priority for job referrals.

6. For providers who have been inactive in IHSS and on the Registry for two years will be required to re-apply to the Registry and complete an application listing references and attend an orientation in order to be re-instated on the Registry.

Public Authority Operating Policies
Policy 9 Provider Removal

Provider Removal from the Registry Policy and Procedure

General Policy:

- The Public Authority reserves the right to remove a provider from the Registry.

- The Public Authority may determine reasonable rules and regulations regarding the appointment to and removal of providers from the Registry.

- Complaints concerning a provider may be given verbally or in writing to Public Authority staff. Public Authority staff will document all complaints.

Policy - Minor Offenses:

The Public Authority will remove a provider from the Registry after two complaints of minor offenses that have been reported by one or more sources within a two year period and have been deemed valid by Public Authority staff. Minor offenses will include but not be limited to:

- Not appearing at scheduled interviews without notice
- Being late for work without reasonable cause
- Discourtesy, rudeness or inappropriate behavior toward consumer or consumer relatives or Public Authority staff
- Refusal to do the authorized tasks agreed to upon hire
- Not performing requested and authorized tasks during work hours
- Inadequate job performance
- Not returning consumer phone calls
- Not returning Registry phone calls
- Failure to update Registry files
- Quitting Registry assignment (without a good reason) without at least a two week notice

Policy - Major Offenses:

The Public Authority will remove a provider from the Registry after one complaint of a major offense that has been deemed valid by Public Authority staff. Major offenses will include but not be limited to:

- Theft
- Sexual/physical abuse
- Neglect
- Dishonesty or misrepresentation related to job duties
- Unauthorized disclosure of confidential information

- Being intoxicated or being under the influence or possession of any illegal substance while on duty
- Asking the consumer to supplement the allowable IHSS wage
- Absence from or leaving the job without notice
- Possession of a firearm or other dangerous weapon while on duty
- Conviction for a crime which indicates unfitness for the job
- Knowingly putting the consumer in jeopardy

Procedure:

1. Public Authority staff will evaluate the complaint and determine what action to take.

2. If the complaint regarding a first minor offense is determined to be valid, by Public Authority staff, the provider will be mailed a written statement listing the complaint, notifying the provider that a second complaint of a similar offense will constitute grounds for removal from the Registry, and informing the provider about the appeal process.

3. If a complaint regarding a second minor offense (within a two year period) or a complaint regarding a major offense is determined to be valid, by Public Authority staff, the provider will be removed from the Registry.

4. Within ten working days following the date of Registry removal, the provider will be mailed a written statement notifying the provider of the removal, the reason(s) for removal, and informing the provider about the appeal process.

Appeal Process:

1. The provider may appeal the Public Authority's action to the Public Authority Executive Director within ten working days of mailing of the removal notification letter.

   The appeal must be in writing and state why the provider believes the Public Authority's action was incorrect.

   The Executive Director has the discretion to extend the ten working days timeframe if she/he deems it appropriate and reasonable to do so.

2. The Executive Director will mail the provider written notification of his/her decision within ten working days of receipt of provider's appeal.

3. If the provider is not satisfied with the Executive Director's decision, the provider can bring the appeal, in writing, to the Advisory Committee or subcommittee of the Advisory Committee within thirty working days of mailing of Executive Director's decision.

4. The Advisory Committee or subcommittee will make the final decision regarding the appeal within thirty working days of receipt of provider's appeal.

   The thirty working days timeframe can be modified with the mutual consent of all parties.

5. Providers removed from the Registry will remain in an inactive Registry status (not being referred to jobs) until/unless the decision to remove is reversed through the appeal process.

Procedures for Investigating a Complaint:

The Public Authority follows procedures specified in the Policy on Removing a Provider from the Registry.

1. Receive Complaint – make written notes
2. Notify provider, as soon as possible, but no longer than 5 working days, that allegations have been made. Try to contact by phone, but if unable to reach, send a letter stating that PA needs to talk to him/her about allegations.
3. Obtain information from the provider – keep written notes.
4. Check the files to see if other complaints have been made. If indicated, check with social worker.
5. Speak separately with both parties (the consumer and provider) and any other involved in the dispute: i.e. social worker, APS, MSSP worker, family member(s).
6. Get specific facts from all parties: exactly what happened, when, the severity, frequency, what attempts have been made to resolve the problem. Observe any materials (time sheets, checks, receipts, records in the files, etc.).
7. Try to discover if there are other areas of concern.
8. When necessary, report suspected or reported abuse or neglect of elder or dependent adult to Adult Protective Services.
9. In an objective manner, try to discuss the issue with the parties to attempt to resolve the issue.
10. Based on information gathered, make a decision. Inform the parties. When necessary, send either a warning letter or a letter of termination to the provider.
11. Include a copy of the Removal Policy and Grievance Procedure with the letter to the provider.
12. Enter comments in "notes" section of the provider file in the computer.

Providers removed from the Registry will be placed in an "inactive" status until the decision to remove is reversed through the appeal process.

Public Authority Operating Policies
Policy 10 Referral of Consumers

Referral of Consumers to the Registry Policy and Procedure

Policy:

The Registry accepts referral of any Contra Costa County IHSS consumer from any referral source. Primary referral sources:

- Initial (first time) referrals generally come through County IHSS.
- Some initial referrals may come from others, e.g., family members, providers.
- Re-referrals (those who have been previously served) are most often direct self-referrals.

Procedure:

When a referral is received, Registry staff will:

1. Contact the consumer or consumer representative within three working days;
2. Confirm consumer's IHSS status; and
3. Begin the intake process

Public Authority Operating Policies
Policy 11 Consumer Intake

Consumer Intake Policy and Procedure

Policy:

A Consumer Profile will be entered in the Registry database for every consumer requesting services from the Registry.

- Purpose of the Consumer Profile to get information needed to match providers and consumers.

Procedure:

Once a referral is received, Registry staff will:

1. Contact the consumer or consumer representative within three working days;

2. Confirm consumer's IHSS status;

3. Describe how the Registry works; and inform the consumer that she/he is responsible for selecting a provider;

4. Inform the consumer that, within five working days, the Registry will provide a list of providers for the consumer to consider; and that in an emergency situation the Registry will refer the consumer to the Rapid Response Program;

5. Inform the consumer that she/he is not obligated to hire a provider from the Registry; that consumers have the right to seek providers from any source, including but not limited to referrals from the Registry; and, if appropriate, suggest other possible sources of providers, e.g., family member, friends, church;

6. Inform the consumer that she/he will need to respond to a series of questions in order to facilitate referrals from the Registry;

7. Complete the Consumer Profile in the Registry database, identifying, with the consumer, his/her most critical needs and most important preferences; and

8. Check the consumer's most current 293 form in CMIPS.

Generating Consumer List of Providers Policy and Procedure

Policy:

- Consumers or consumer representatives will be given a list of providers from the Registry. The list will include a minimum of three and a maximum of six providers.

- The order of screening to determine which providers are placed on the list will be based on making an appropriate match between the consumer's needs and preferences, and the provider's willingness to perform tasks authorized by the social worker and the provider's availability and preferences.

- The Registry reserves the right to continue screening for consumer needs and preferences and provider preferences until the provider list consists of at least three and no more than six names.

Procedure:

1. Using information from the Consumer Profile, Registry staff will generate a list of providers by querying the Registry database for providers who match the consumer's needs and preferences;

2. Registry staff will also query for providers who are willing to perform tasks authorized by the social worker and who are available for work;

3. Registry staff will query such that the list will include a minimum of three and maximum of six providers; and

4. The list will include only providers who have completed the application process, including reference check, if applicable, provided training documentation or certification, proof of valid driver's license.

5. If the consumer needs a provider with special training (e.g., First Aid, CPR, CNA), Registry staff will assure that appropriate training documentation/certification is on file prior to including the provider on the list.

6. The list will include only providers who have indicated a willingness to perform the tasks/hours the consumer needs and, as much as possible, meet other preferences desired by the consumer.

Public Authority Operating Policies
Policy 13 Referral of Providers to Consumers

Referral of Providers to Consumer Policy and Procedure

Policy:

- The Registry will supply a list of providers to IHSS consumers following completion of the consumer intake process. The list will include a minimum of three and a maximum of six providers who have updated their availability with the Registry within the last two weeks. The order of screening to determine which providers are placed on the list will be based on making an appropriate match between the consumer's needs and preferences, and the provider's willingness to perform tasks authorized by the social worker and the provider's availability and preferences.

- The list will be communicated to the consumer or consumer representative. It is the consumer's (or person acting in the interest of the consumer) responsibility to choose which provider(s) if any, she/he will contact and/or hire from the list.

- The Registry will not "recommend" any provider(s).

- The consumer is the employer for the purposes of hiring, supervising and firing his/her provider. The Registry is not the employer for these functions.

Procedure:

1. The Registry will send additional material to consumers with the first list that will include but not be limited to:

    - Information on how the Registry operates, including what the Registry does and does not do;
    - IHSS recipient and provider rights and responsibilities;
    - Other relevant printed materials.

2. Registry staff will inform the consumer that she/he should call the Registry to let staff know if she/he has hired a provider or is having any problems with the process.

3. Registry staff will inform the consumer that the provider must call the Public Authority Senior Benefits Clerk to begin the provider enrollment process.

Public Authority Operating Policies
Policy 14 Consumer Follow-up

Consumer Follow-up Policy and Procedure

Policy:

The Registry will provide regular follow-up on all consumers receiving a list of providers from the Registry. Follow-ups will be conducted by placing telephone calls to the consumer or consumer representative. Follow-up telephone calls will be made at least every ten days and will continue until the consumer case is closed, e.g., consumer found Registry provider or found own provider, consumer hospitalized, institutionalized, withdrew or was withdrawn from IHSS or deceased.

- Purposes of follow-up include, but are not limited to: assessing consumer's progress in finding a provider; and determining if the consumer is having any particular problems in utilizing Registry services, if consumer needs have changed, if consumer needs a new list, or if consumer needs additional support services.

Procedure:

1. Once the list of providers has been mailed to the consumer and the appropriate information entered into the Registry Tracking database, the database will automatically indicate the date for the first follow-up call.

2. On the date indicated for the first follow-up call, place a phone call to the consumer to determine the consumer's progress in finding a provider, if the consumer is having any particular problems in utilizing Registry services, if the consumer's needs have changed, if the consumer needs a new list, if the consumer needs additional support services, etc.

   Additional support services include, but are not necessarily limited to:

   - Assisting the consumer and provider with understanding employer/employee roles, rights and responsibilities;
   - Understanding how to interview and hire providers;
   - Calling providers and setting up interviews;
   - Being present at interviews;
   - Assisting with resolution of conflict between provider and consumer;
   - Developing provider schedules and tracking of provider's hours;
   - Understanding payroll, time sheets and share of cost payments;
   - Trouble-shooting payroll and share of cost problems; and
   - Referring consumers to the Social Worker if there is a significant change in the consumer's condition.

3. After completing the follow-up call, Registry staff will consult with the social worker and take whatever steps are appropriate to address issues/problems identified while speaking with the consumer.

4. The next step is to enter the appropriate information (follow-up notes) into the Registry database, the database will automatically indicate the date for the next follow-up call.

5. The final step is to print out two copies of the 10-day follow up form: i.e., one for the Program Manager and one to be used during the next follow-up call.

6. After a case is closed, the consumer will be asked to respond to a Consumer Satisfaction Survey. The survey will be conducted over the phone by Registry staff. Written copies of completed surveys will be kept on file. The surveys will be used as a tool for assessing Registry performance and progress toward meeting Public Authority Performance Measures, for identifying needed program improvements and for reporting to the Advisory Committee and Board.

7. After a Registry provider has been on the job for 60 days (the match has lasted 60 days) the consumer will be asked to respond to a survey to assess the quality of their provider's work. The survey will be conducted over the phone by the Registry staff. Written copies of completed surveys will be kept on file. The surveys will be used as a tool for assessing Registry performance and progress toward meeting Public Authority Performance Measures, identifying provider training needs and for reporting to the Advisory Committee and Board.

Public Authority Operating Policies
Policy 15 Consumer and Provider Support Services

Consumer and provider support services policy

- The Public Authority will provide supportive services;
- Support services will be provided to any Registry consumer or provider upon request, and determination of need by Authority staff;
- Methods for provision of services would include phone consultation, written materials, inclusion in consumer/provider orientation and training and home visits.

Supportive services will include, but not necessarily be limited to:

- Assisting the consumer and provider with understanding employer/employee roles, rights and responsibilities;
- Understanding how to interview and hire providers;
- Calling providers and setting up interviews;
- Being present at interviews;
- Assisting with resolution of conflict between provider and consumer;
- Developing provider schedules and tracking of provider's hours;
- Understanding payroll, time sheets and share of cost payments;
- Trouble-shooting payroll and share of cost problems; and

Public Authority Operating Policies
Policy 16 Consumer and Provider Training

Consumer and Provider Training Policy and Procedure

Policy:

Training services will be made available to all IHSS consumers and providers; training will be provided upon request and determination of need by Public Authority staff; training will be voluntary and at no cost to consumers or providers; training and training materials will be provided in English and other appropriate languages.

A stipend will be paid to enrolled Contra Costa County IHSS providers and active Registry providers for attending group-training sessions.

Procedure - Consumer Training:

- Consumers receive training/orientation to IHSS and Registry services during the intake process and through printed materials.

- Consumer training will be done one-on-one and in group sessions; and training topics will include, but may not be limited to clarification regarding IHSS, consumer/provider rights, roles and responsibilities, how to be an employer, e.g., hiring, firing, supervising, scheduling, timecards, dealing with employee problems. (One-on-one training usually takes place in the consumer's home.)

- A record is to be kept of all one-on-one and group training received by consumers.

Procedure – Provider Training:

- Providers receive training/orientation to IHSS and Registry services during the intake (interview/orientation) process and through printed materials.

- Provider training sessions will be offered. Training sessions will:

  - ✓ Be in a group setting; 25-30 participants per session;
  - ✓ Be scheduled at different locations throughout the County; at different times of day and evening; and
  - ✓ Training topics will be general, e.g., Universal Precautions, back care, transferring, CPR, First Aid, adaptive equipment use.

- A record is to be kept of providers attending group and/or individual training; and completion of training is to be noted in the provider's Registry database file.

Public Authority Operating Policies

Policy 17 Consumer Refusal of Service

Consumer - Refusal of Service Policy & Procedure

General Policies:

1. The Public Authority reserves the right to refuse Registry services to a consumer.

2. The Public Authority may determine reasonable rules and regulations regarding the refusal of Registry services to a consumer.

3. Complaints concerning a consumer may be made verbally or in writing to Public Authority staff. Public Authority staff will document all complaints and respect confidentiality.

4. Prior to taking any action regarding denial of Registry services, Public Authority staff will attempt to resolve the situation by consulting with the consumer, the consumer's IHSS Social Worker and other interested persons.

Policy - Minor Offenses:

The Public Authority will refuse Registry services to a consumer after two complaints of minor offenses that have been reported by one or more sources within a two-year period; that have been deemed reasonable and valid by Public Authority staff; and that have not been resolved by consultation or referral (see general policy # 4). Minor offenses will include but not be limited to:

- Discourtesy, rudeness or inappropriate behavior toward the provider or registry staff
- Repeated pattern of not following through with registry process, e.g., not calling providers on list in a timely manner, not being available for scheduled interviews, canceling interviews without notifying scheduled providers
- Repeated pattern of hiring and then discharging registry providers without valid, work-related justification
- Calling provider names – making racist remarks
- Refusing to sign legitimate timesheets
- Refusing to pay required share of cost

- Not being available when provider arrives for scheduled work; not informing provider of change in plans
- Insisting that provider perform tasks not authorized by the IHSS Social Worker, e.g.,:
  - performing services for anyone other than the authorized consumer, such as other family members
  - taking care of pets, such as shampooing, making special food, exercising, taking for walks
  - cleaning whole house when consumer lives with own family
  - doing yard work, such as cutting the lawn, trimming the roses, weeding the flower beds
  - washing the car
  - unauthorized heavy cleaning, moving furniture, climbing ladders
  - driving to other than medical appointments, essential shopping or errands
  - insisting that provider stay late, i.e. to run an errand or take shopping

Policy - Major Offenses:

The Public Authority will refuse Registry services to a consumer after one complaint of a major offense that has been deemed reasonable and valid by Public Authority staff and that has not been resolved by consultation or referral (see general policy # 4). Major offenses will include but not be limited to:

- Theft, forgery, dishonesty or misrepresentation related to being the employer of the provider, e.g., hiring relative as provider, signing time card, and keeping money; insisting provider work less hours than approved, then claiming total hours on time sheet and "splitting the check"
- Inappropriate contact with provider's family
- Sexual harassment or sexual abuse of provider
- Physically abusing or assaulting provider
- Knowingly putting the provider in jeopardy
- Displaying a firearm or other dangerous weapon in a threatening manner

Procedure:

1. Public Authority staff will evaluate the complaint and determine what action to take.

2. Public Authority staff will attempt to resolve the situation by consulting with the consumer, the consumer's IHSS Social Worker and other appropriate individuals.

3. If the complaint regarding a first minor offense is determined to be reasonable and valid by Public Authority staff and the complaint has not been resolved through Step 2 (above), the consumer will be notified verbally and in a written statement listing the complaint, informing the consumer that a second complaint of a similar offense will constitute grounds for refusal of Registry services, and notifying the consumer about the appeal process.

4. If a complaint regarding a second minor offense (within a two-year period) or a complaint regarding a major offense is determined to be reasonable and valid, by Public Authority staff and the complaint has not been resolved through Step 2 (above), the consumer will be refused Registry services.

5. Within ten working days following the date of refusal of Registry services, the consumer will be notified verbally and in a written statement informing the consumer of the refusal of Registry services, the reason(s) for refusal, and notifying the consumer about the appeal process. A copy of the notification statement will be sent to the consumer's social worker.

Appeal Process:

1. The consumer may appeal the Public Authority's action to the Public Authority Executive Director within ten working days of mailing of the refusal of Registry services notification letter.

   The appeal may be verbal or in writing and state why the consumer believes the Public Authority's action was incorrect.

   The Executive Director has the discretion to extend the ten working days timeframe if she/he deems it appropriate and reasonable to do so.

2. The Executive Director will mail the consumer written notification of his/her decision within ten working days of receipt of consumer's appeal.

3. If the consumer is not satisfied with the Executive Director's decision, the consumer can bring the appeal, verbally or in writing, to the Advisory Committee or subcommittee of the Advisory Committee within thirty working days of mailing of the Executive Director's decision.

4. The Advisory Committee or subcommittee will make the final decision regarding the appeal within thirty working days of receipt of consumer's appeal.

The thirty working days timeframe can be modified with the mutual consent of all parties.

5. Refusal of Registry services will remain in effect until/unless the decision to refuse services is reversed through the appeal process.

AC adopted 10/11/01

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **6.**

Meeting Date:	11/23/2020
Subject:	CONSIDER recommending bylaw revisions for the Advisory Council on Aging
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	NA
Referral Name:	NA
Presenter:	Anthony Macias **Contact:** Anthony Macias, 925.602.4175

Referral History:

The Board of Supervisors sanctioned the Advisory Council on Aging (ACOA) as the County-wide Coordinating Committee in 1969. Under the Older Americans Act (Title III of the Older Americans Comprehensive Services Amendment of 1973), the Contra Costa Area Agency on Aging was established October 1, 1975, with the Advisory Council on Aging as the representative group which advises the Board of Supervisors on the Contra Costa Area Plan and its implementation.

Referral Update:

Explanation of the changes to ACOA Bylaws:

1. The elimination of the second vice president was based on two issues: First, that there were no meaningful duties for the office and, Second, there have been problems persuading people to seek the office.
2. Combining the Secretary and Treasurer positions since the Secretary's only job is to call the roll and the Treasurer's only job is to collect the donations to the Refreshment Fund.
3. The creation of vetted Alternate Members grew out of having to cancel several Council Meetings for lack of a quorum and frequently waiting for enough members to arrive to make a quorum. ACOA has 40 members and a quorum is 21 members. It is not unusual for 11 or 12 people to be absent for valid reasons during certain times of the year. Other counties have used alternate members to help meet quorum requirements.

Recommendation(s)/Next Step(s):

CONSIDER accepting and submitting for approval to the Board of Supervisors modifications to the Advisory Council on Aging Bylaws.

Fiscal Impact (if any):

None

Attachments

Recommended ACOA Bylaw Revisions

REDLINE - Recommended ACOA Bylaw Revisions

CONTRA COSTA COUNTY
ADVISORY COUNCIL ON AGING

ADVISORY COUNCIL ON AGING
BYLAWS INDEX

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CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING

BYLAWS

April 30, 2020

PREAMBLE

In recognition of the problems of the older people of Contra Costa County and the need for concerted community action to help resolve these problems, this non-sectarian, non-partisan organization was formed in 1962.

ARTICLE I – NAME

1.1 The name of this organization shall be "CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING", which shall hereinafter be referred to as "The Council". *

**The Board of Supervisors sanctioned the Council as the County-wide Coordinating Committee in 1969. Under the Older Americans Act (Title III of the Older Americans Comprehensive Services Amendment of 1973), the Contra Costa Area Agency on Aging was established October 1, 1975, with the Advisory Council on Aging as the representative group which advises the Board of Supervisors on the Contra Costa Area Plan and its implementation.*

ARTICLE II – PURPOSE

2.1 Planning for Older Residents
The Council shall provide a means for county-wide planning, cooperation and coordination for individuals and groups interested in improving and developing services and opportunities for the older residents of this County.

2.2 Leadership and Advocacy
The Council shall provide leadership and advocacy on behalf of older persons and serve as a channel of communication and information on aging.

2.3 Advise on Area Plan
The Council shall advise the Area Agency on Aging (AAA), the Aging and Adult Services Bureau of the Contra Costa County Employment and Human Services Department (hereinafter referred to as "Aging and Adult Services") and the Board of Supervisors on the Four-Year Area Plan. This is based on the unmet needs and priorities of older per-

sons as determined by surveys of local committees (commissions) and coalitions on aging, and results of public hearings held in conjunction with Aging and Adult Services.

ARTICLE III - MEMBERSHIP

3.1 Composition of Council

Including the officers, the Council shall have not more than 40 members. These members shall consist of the designated representatives of the local municipalities [nineteen (19)], and one (1) Senior Nutrition Program Council representative. The remainder will be Members-at-Large (20.) The Council will strive to achieve membership that reflects the ethnic, economic and geographic balance of the senior population of the County. The Council will make every effort to achieve a membership where one-fourth of the Council is made up of actual consumers of services under the Area Plan, and at least one member will represent the interests of people with disabilities. The ACOA may recommend for appointment up to four (4) alternate Member-at-Large (MAL) members, who shall serve and vote in place of members (City or MAL) who are absent from, or who are disqualifying themselves from participating in a meeting of the ACOA.

Alternates must meet the same requirements as a regular member-at-large. Alternates may also be reimbursed for travel expenses.

3.2 Membership Status

The County Board of Supervisors appoints Members-at-large seat, following their standard policies and procedures for such appointments. Local municipalities and the Senior Nutrition Program Council select a representative as their designated liaison to the Council.

3.3 Members' Terms of Office

The County Board of Supervisors shall approve members for an approximate two (2) year term. All terms expire on September 30th. Accordingly, an appointment made on a date other than October 1 will have a term adjusted to expire on the September 30 prior to the two-year anniversary date. When applicable, any vacant seat shall be filled for the unexpired term remaining for that seat.

3.4 Residency and Age Requirement

All members, including alternates, shall reside in Contra Costa County. Change of residence to outside of Contra Costa County will automatically terminate membership on the Council. All members shall be at

least eighteen (18) years of age.

3.5 Ex-Officio Members

Contra Costa County members of the California Commission on Aging, the California Senior Legislature and representatives of other groups from Contra Costa County concerned with aging may be invited by the Council to join it as ex-officio, non-voting members. Such ex-officio memberships shall be outside of, and in addition to the number of regular memberships established by Section 3.1 of these bylaws.

3.6 Past Council Presidents

All past presidents who are no longer members of the Advisory Council on Aging shall be considered members ex-officio after their terms of office have been completed. Such memberships shall be non-voting.

3.7 Emeritus Members

To honor past exemplary service to the Council, any member of the Council may nominate an Emeritus Member. Emeritus Members will be appointed upon a majority vote of a quorum. Such appointment is an honorary lifetime title. Emeritus members may not vote, nor does their membership factor into the quorum determination.

3.8 Appointments of Members

When a vacancy occurs, the Membership Committee shall recommend a replacement for approval by the Council and possible appointment by the Board of Supervisors

3.9 Attendance

For the purposes of attendance, a membership year is January through December. Due to the inability of the Council to carry out its business when a quorum is not met, attendance at all required meetings is of the utmost importance.

All members are required to attend meetings on a regular basis.

A member who is absent from four (4) regularly scheduled meetings in a membership year shall be deemed to have voluntarily resigned from the Council. If that occurs, the former Council member's status will be noted at the next scheduled Council meeting and shall be recorded in the Council's minutes. The President shall, without further direction from the Executive Committee, inform Board of Supervisors of the member's resignation and request the appointment of a replacement.

3.10 Leaves of Absence

A member may request a Leave of Absence. Requests for a Leave of Absence must be in writing and: (1) include the beginning date; (2) the anticipated ending date; and (3) the reason for the leave request. Examples of acceptable reasons for leaves include: bereavement, family and medical leaves, jury and witness duty, or a personal leave for another reason. The Executive Committee will determine if the leave is granted or denied and the President will notify the member. If approved, the member's attendance will not be tallied during the leave period and their seat will not be declared vacant.

3.11 Resignation

All members must submit a written resignation when vacating membership. The President shall then submit the resignation to the Board of Supervisors.

3.12 Removal of Members

After three meetings following appointment to the Council, each member shall be subject to removal for cause. Any member who believes a member should be removed from the Council must provide a written request to the Membership Committee for evaluation and recommendation to the full Council for a vote on the removal request. In the case of municipal appointments, a recommended removal may also occur at any time the municipality withdraws their approval or sponsorship. As the Contra Costa County Board of Supervisors is the appointing authority for the Advisory Council on Aging, recommended removals are subject to the ratification of the Board of Supervisors.

ARTICLE IV – MEMBERSHIP MANDATES

4.1 Commitment

Incoming members are to be active, contributing members as evidenced by, but not limited to, attendance at the regular monthly Council meetings and each member is required to participate in the activities of at least one of the Council's committees or designated work groups. All members must choose a committee or work group within six (6) months of appointment and notify Membership Chair and Staff of that choice. Any subsequent change requires the same notification. A member must satisfy the attendance requirements of any organization which they have been assigned to represent the Council.

4.2 Ethics Training

All members, including alternates, of the Advisory Council on Aging are required to take formal ethics training (AB1234) every two (2) years. New members have up to three (3) months to fulfill their obligation for the first training. Verification of completion must be provided immediately to Staff. Members not in compliance will be referred to the Membership Committee. If needed, may be referred to the Board of Supervisors for appropriate action.

4.3 Disclosure of Financial Interests

All Advisory Council members, including alternates, must annually complete and file California Form 700 – Statement of Economic Interests and also upon leaving the Council. The members are only required to disclose those financial interests that are set forth in the Employment and Human Services Department Conflict of Interest Code. Members not in compliance will be referred to the Membership Committee. If needed, may be referred to the Board of Supervisors for appropriate action.

4.4 Perception of Conflict

The Advisory Council has developed its own document addressing the perception of conflict. Its purpose is to strongly encourage all members to recuse themselves from any discussion or vote which could be interpreted as constituting a conflict of interest, be construed as a clash of loyalties or be perceived as self-serving in any way.

ARTICLE V – OFFICERS

5.1 Council Officers

Officers of the Advisory Council on Aging shall be as follows: President, Vice-President, and Secretary/Treasurer.

5.2 Officers' Terms of Office

The above-named officers shall hold office for one (1) year or until their successors are elected or appointed. The officers may serve no more than two (2) consecutive terms of one year each in the same position.

5.3 Officers' Duties

The duties of the respective officers shall be those regularly associated with such titles except that the President may assign special duties to a specific officer at any time.

5.4 Representation on TACC

The President of the Contra Costa County Advisory Council on Aging, as chair of the Advisory Council, shall be the Council's representative to the Triple A Council of California (TACC.) The Vice President serves as a TACC alternate director (member.)

5.5 Succession Protocol - President

In the event that the President does not complete his/her term, the Vice-President shall move into the presidency and serve out the unexpired term. The newly appointed President shall select a member of the Council to serve the unexpired term of the Vice-President. The President can choose to request input from the Nominating Committee (or Membership Committee as applicable).

5.6 Succession Protocol - All Other Officers

Vacancy in mid-term of the Vice President or Secretary/Treasurer will be filled by the Nominating Committee (or Membership Committee if Nominating is not in session) recommending to the Council the name of a Council Member. If, however, the vacated officer's position has less than three (3) months duration remaining, the President shall appoint a member of the current Council to serve the unexpired balance of the term. In either case, the Council shall approve or disapprove the appointments.

5.7 Termination of Officers

Officers may be removed for just cause by a majority vote of the full Advisory Council on Aging when 90% of all appointed members are present, or at a special meeting convened for that purpose at which a quorum is present. Any officer removed ceases to hold the office once the vote has been tallied and announced. Succession shall be as outlined in Sections 5.5 and 5.6.

5.8 Director of Aging & Adult Services

The Director of Aging and Adult Services shall serve as a consultant to the Council. The Director, or designated representative, shall submit a monthly report to the Council at the regular meetings. Special reports may be given at the December annual meeting.

ARTICLE VI – MEETINGS, COMMITTEES, WORK GROUPS

6.1 Regular Meetings

There shall be at least eight (8) meetings a year, at such time and place as agreed upon.

6.2 Special Meetings

The President shall call a special meeting of the Council at any time upon the written request of at least five (5) members of the Council. Also, the President may call a special meeting of the Council at any time an emergency meeting is felt to be imperative.

6.3 Executive Committee

There shall be an Executive Committee of the Council composed of the elected officers, the immediate past president, chair of standing committees and chairs of designated county-wide work groups (designated by the Council), if they are also members of the Advisory Council. Only members of the Executive Committee shall have voting rights at Executive Committee. Other members of the Advisory Council may be invited to give reports or recommendations at the Executive Committee meetings.

6.4 Annual Meeting

At the December meeting, the council will render to the public a report of the Council's activities and accomplishments of the past year and shall install new officers for the coming year.

6.5 Committee and Work Group Structure

The President of the Council, upon taking office, shall appoint the Chairs of each Committee and Work Group. Work Group Chairs or one of the two Co-Chairs, shall be members of the Council. Chairs of Work Groups who are also Council members are also voting members of the Executive Committee.

Committees may take action consistent with the Advisory Council on Aging's policies and procedures. Work Groups must bring action items to the Executive Council for determination if the item will move forward for final action of the Council in full.

6.6 Committee Quorums

A majority of a committee shall constitute a quorum. The act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee. Unless otherwise provided in

the resolution of the Advisory Council on Aging, work groups and ad hoc committees shall act under the direction of their respective Chairs without any requirement for a quorum.

6.7 Committees and Work Groups

Each committee or work group shall have a chairperson. The President of the Advisory Council shall be an ex-officio member of all committees of the Advisory Council and shall be notified of all meetings. Committee and work group meeting notices, agendas and minutes shall be mailed, e-mailed, and/or personally given, approximately one work week in advance of the meeting date to all members of the committee. Each committee and work group Chair shall maintain a list of Council members, and their attendance, for each meeting and copies given to the Advisory Council staff person.

6.8 Task Force or Ad Hoc Committees

In the implementation of the Area Plan, the Council shall develop task forces or ad hoc committees, where needed, in the accomplishment of specific objectives. The Chair of the Advisory Council may designate or solicit participation for ad hoc committees. Ad hoc committees are not subject to the Brown Act, but are subject to the County's Better Government Ordinance (C.C.C. Ord. Code, § 25-2.)

6.9 Standing Committees and Work Groups

The following shall be the Standing Committees and Work Groups of the Council: Executive Committee, Planning Committee, Membership Committee, Health Work Group, Housing Work Group, Legislative Work Group, Marketing Work Group and Transportation Work Group.

ARTICLE VII – CONDUCT OF MEETINGS

7.1 Order of Business

The President or a majority vote of the Council may change the order of business as may be required.

7.2 Council Quorum

A quorum for the transaction of business by the Council shall consist of a majority (one more than half) of the total number of seats of the Council. Membership of the Council shall be evidenced by the list of authorized seats approved by the Board of Supervisors at the time of roll call. Ex-officio or emeritus members of the Council under sections 3.5, 3.6 and 3.7 shall not be counted when establishing a quorum under this section.

7.3 Quorum Declaration

After a quorum is declared to exist, all transactions of business can proceed, regardless whether enough attendees leave to decrease the members present below the quorum requirement. In such an event, any motions for action will be determined by a majority vote of the members then present.

7.4 Meetings in the Absence of a Quorum

A quorum is not required in order to conduct a meeting, with the exception that no motions may be introduced or voted upon. Discussion can take place, with the item carried forward to the next meeting. All other non-action items of business of the Council may proceed without a quorum present. If sufficient members arrive after roll call to make up a quorum, the meeting may proceed without restrictions.

ARTICLE VIII - NOMINATING COMMITTEE

8.1 The nominating committee shall normally be chosen after installation of new officers but no later than August of each year. The Nominating Committee is a Sub-Committee of the Membership Committee.

8.2 The nominating committee shall be chosen annually for the purpose of presenting an annual slate of officers for election or filling vacant officer positions that occur while the Nominating Committee is in session.

8.3 The nominating committee shall have five members elected by caucus of advisory council members from each of the five supervisorial districts.

8.4 The nominating committee shall present a slate of officers at a council meeting prior to the Annual Meeting in December and will also request additional nominations from the floor. Election of new officers shall take place at the annual meeting in December.

8.5 The nominating committee members may serve two (2) consecutive terms of one (1) calendar year for the applicable months the committee is in session. The nominating committee at its first meeting following election of its members shall choose one of its members as chair.

ARTICLE IX– AMENDMENTS

9.1 The Bylaws may be amended by a majority vote of the total membership of the Council present at any regular meeting or special meeting called

for that purpose, provided that each member of the Council has been notified, in writing of the wording of the proposed amendment(s) at least ten (10) days in advance of the meeting.

9.2 These Bylaws must not conflict with the Board of Supervisors' Ordinances regarding Advisory Councils. The Council may adopt such Bylaws as shall seem appropriate and necessary for the functioning of the Council.

Approved and adopted by the Contra Costa County Board of Supervisors as evidenced by passage of Board Order:

Board Agenda Item Number _____On_____, 2020

CONTRA COSTA COUNTY
ADVISORY COUNCIL ON AGING

ADVISORY COUNCIL ON AGING
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CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING

BYLAWS

April 30, 2020

PREAMBLE

In recognition of the problems of the older people of Contra Costa County and the need for concerted community action to help resolve these problems, this non-sectarian, non-partisan organization was formed in 1962.

ARTICLE I – NAME

1.1 The name of this organization shall be "CONTRA COSTA COUNTY ADVISORY COUNCIL ON AGING", which shall hereinafter be referred to as "The Council". *

**The Board of Supervisors sanctioned the Council as the County-wide Coordinating Committee in 1969. Under the Older Americans Act (Title III of the Older Americans Comprehensive Services Amendment of 1973), the Contra Costa Area Agency on Aging was established October 1, 1975, with the Advisory Council on Aging as the representative group which advises the Board of Supervisors on the Contra Costa Area Plan and its implementation.*

ARTICLE II – PURPOSE

2.1 Planning for Older Residents
The Council shall provide a means for county-wide planning, cooperation and coordination for individuals and groups interested in improving and developing services and opportunities for the older residents of this County.

2.2 Leadership and Advocacy
The Council shall provide leadership and advocacy on behalf of older persons and serve as a channel of communication and information on aging.

2.3 Advise on Area Plan
The Council shall advise the Area Agency on Aging (AAA), the Aging and Adult Services Bureau of the Contra Costa County Employment and Human Services Department (hereinafter referred to as "Aging and Adult Services") and the Board of Supervisors on the Four-Year Area Plan. This is based on the unmet needs and priorities of older per-

sons as determined by surveys of local committees (commissions) and coalitions on aging, and results of public hearings held in conjunction with Aging and Adult Services.

ARTICLE III - MEMBERSHIP

3.1 Composition of Council

Including the officers, the Council shall have not more than 40 members. These members shall consist of the designated representatives of the local municipalities [nineteen (19)], and one (1) Senior Nutrition Program Council representative. The remainder will be Members-at-Large (20.) The Council will strive to achieve membership that reflects the ethnic, economic and geographic balance of the senior population of the County. The Council will make every effort to achieve a membership where one-fourth of the Council is made up of actual consumers of services under the Area Plan, and at least one member will represent the interests of people with disabilities. The ACOA may recommend for appointment up to four (4) alternate Member-at-Large (MAL) members, who shall serve and vote in place of members (City or MAL) who are absent from, or who are disqualifying themselves from participating in a meeting of the ACOA.

Alternates must meet the same requirements as a regular member-at-large. Alternates may also be reimbursed for travel expenses.

3.2 Membership Status

The County Board of Supervisors appoints Members-at-large seat, following their standard policies and procedures for such appointments. Local municipalities and the Senior Nutrition Program Council select a representative as their designated liaison to the Council.

3.3 Members' Terms of Office

The County Board of Supervisors shall approve members for an approximate two (2) year term. All terms expire on September 30th. Accordingly, an appointment made on a date other than October 1 will have a term adjusted to expire on the September 30 prior to the two-year anniversary date. When applicable, any vacant seat shall be filled for the unexpired term remaining for that seat.

3.4 Residency and Age Requirement

All members, including alternates, shall reside in Contra Costa County. Change of residence to outside of Contra Costa County will automatically terminate membership on the Council. All members shall be at least eighteen (18) years of age.

3.5 Ex-Officio Members

Contra Costa County members of the California Commission on Aging, the California Senior Legislature and representatives of other groups from Contra Costa County concerned with aging may be invited by the Council to join it as ex-officio, non-voting members. Such ex-officio memberships shall be outside of, and in addition to the number of regular memberships established by Section 3.1 of these bylaws.

3.6 Past Council Presidents

All past presidents who are no longer members of the Advisory Council on Aging shall be considered members ex-officio after their terms of office have been completed. Such memberships shall be non-voting.

3.7 Emeritus Members

To honor past exemplary service to the Council, any member of the Council may nominate an Emeritus Member. Emeritus Members will be appointed upon a majority vote of a quorum . Such appointment is an honorary lifetime title. Emeritus members may not vote, nor does their membership factor into the quorum determination.

3.8 Appointments of Members

When a vacancy occurs, the Membership Committee shall recommend a replacement for approval by the Council and possible appointment by the Board of Supervisors

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For the purposes of attendance, a membership year is January through December. Due to the inability of the Council to carry out its business when a quorum is not met, attendance at all required meetings is of the utmost importance.

All members are required to attend meetings on a regular basis.

A member who is absent from four (4) regularly scheduled meetings in a membership year shall be deemed to have voluntarily resigned from the Council. If that occurs, the former Council member's status will be noted at the next scheduled Council meeting and shall be recorded in the Council's minutes. The President shall, without further direction from the Executive Committee, inform Board of Supervisors of the member's resignation and request the appointment of a replacement.

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3.11 Resignation

All members must submit a written resignation when vacating membership. The President shall then submit the resignation to the Board of Supervisors.

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After three meetings following appointment to the Council, each member shall be subject to removal for cause. Any member who believes a member should be removed from the Council must provide a written request to the Membership Committee for evaluation and recommendation to the full Council for a vote on the removal request. In the case of municipal appointments, a recommended removal may also occur at any time the municipality withdraws their approval or sponsorship. As the Contra Costa County Board of Supervisors is the appointing authority for the Advisory Council on Aging, recommended removals are subject to the ratification of the Board of Supervisors.

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4.1 Commitment

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are required to take formal ethics training (AB1234) every two (2) years. New members have up to three (3) months to fulfill their obligation for the first training. Verification of completion must be provided immediately to Staff. Members not in compliance will be referred to the Membership Committee. If needed, may be referred to the Board of Supervisors for appropriate action.

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The above-named officers shall hold office for one (1) year or until their successors are elected or appointed. The officers may serve no more than two (2) consecutive terms of one year each in the same position.

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The duties of the respective officers shall be those regularly associated with such titles except that the President may assign special duties to a specific officer at any time.

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The President of the Contra Costa County Advisory Council on Aging, as chair of the Advisory Council, shall be the Council's representative

to the Triple A Council of California (TACC.) The Vice President serves as a TACC alternate director (member.)

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In the event that the President does not complete his/her term, the Vice-President shall move into the presidency and serve out the unexpired term. The newly appointed Presidentshall select a member of the Council to serve the unexpired term of the Vice-President. The President can choose to request input from the Nominating Committee (or Membership Committee as applicable).

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Council.

Approved and adopted by the Contra Costa County Board of Supervisors as evidenced by passage of Board Order:

Board Agenda Item Number_____On_____, 2020

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **7.**

Meeting Date: 11/23/2020

Subject: Healthcare for the Homeless Annual Update

Submitted For: David Twa, County Administrator

Department: County Administrator

Referral No.: FHS #5

Referral Name: Continuum of Care/Healthcare for the Homeless

Presenter: Lavonna Martin, Health, Housing and Homeless Services **Contact:** Jaime Jenett (925) 608-6716

Referral History:

Since 1990, the Health Care for the Homeless (HCH) Program has provided health care services to the homeless population in Contra Costa County through mobile clinics, stationary health centers, the Concord Medical Respite facility, street medical outreach clinics and the medication-assisted treatment program. Health care services provided by the HCH team include routine physical assessments, basic treatment of primary health problems such as minor wounds and skin conditions, respiratory problems, TB screening, acute communicable disease screening, coordination and referrals for follow up treatment of identified health care needs, dental services, health education, behavioral health services, medication assisted treatment for opioid addiction, and outreach and enrollment services. A significant portion of the homeless patients seen by the HCH team have chronic diseases, including asthma, hypertension, diabetes, and mental health/substance abuse issues. They also have disproportionately more dental, substance abuse and mental health needs than the general population.

In past reports, Dr. Joseph Mega, presented the staff report on health care services for the homeless, including opioid addiction treatment, and the number of clients and encounters with clients. The data showed that homeless Medi-Cal patients were more than twice as likely to have a chronic health condition and drastically more likely to visit hospital emergency than general Medi-Cal patients.

Referral Update:

The attached memo and presentation includes program updates from the last report, including goals and strategies for 2021 as well as accomplishments for 2020.

Recommendation(s)/Next Step(s):

1. Accept this report from the Health Services Department; and

2. Forward this report to the Board of Supervisors for acceptance; and

3. Direct staff to continue to report on a quarterly basis to the FHS Committee regarding health status of the homeless population in Contra Costa County by the Health Care for the Homeless Program.

Fiscal Impact (if any):

No fiscal impact.

Attachments

Staff Memo
Staff Report Presentation
COVID System Modeling

ANNA ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR
LAVONNA MARTIN, MPH, MPA
HEALTH, HOUSING AND HOMELESS SERVICES DIRECTOR

CONTRA COSTA
HEALTH SERVICES

Contra Costa
Health, Housing and
Homeless Services
ADMINISTRATION
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Date: November 23, 2020
To: Family and Human Services Committee
Supervisor John Gioia, District I, Chair
Supervisor Candace Anderson, District II, Co-Chair
From: Lavonna Martin, Director, Health, Housing and Homeless Services Division
CC: Anna Roth, RN, MS, MPH Health Services Director
Subject: Annual Update on Homelessness Continuum of Care

As directed in the November 13, 2019 Family and Human Services Committee meeting, Health Housing and Homeless Services would like to provide a report regarding progress on the effort to end homelessness and the activities of Contra Costa Council on Homelessness.

While the primary focus since March 2020 has been coordinating a collective homelessness system response to the COVID-pandemic, the Continuum of Care and Council on Homelessness were able to achieve progress on achieving goals outlined in the 2020 Priority Plan. This Priority Plan outlines the priority areas, goals and strategies that the Continuum of Care, Contra Costa Health, Housing and Homeless Services (H3), and partner stakeholders determined at the beginning of the year. The plan is grounded in the goals and strategies of the Contra Costa Continuum of Care's 2014 Strategic Plan, Forging Ahead, which emphasized two key goals and three strategies:

- Goals: Permanent Housing and Prevention
- Strategies: Coordinated Entry (CE), Performance Standards, Communication

GOALS

1) **Permanent Housing:** Increase outflow (permanent housing) by:
   a. Adding temporary housing capacity,
   b. Adding Permanent Supportive Housing, and
   c. Enhancing prioritization (Coordinated Entry Phase III – integrating shelters)

   2020 Accomplishments:
   - Implemented a community approved prioritization process to move individuals and families out of the temporary hotels and into permanent housing.
   - Temporarily added 183 more shelter beds to the system of care through funding provided by Project Roomkey.
   - Added an East County Temporary Shelter facility of approximately 170 units
   - Secured emergency COVID-19 funding for limited supply of rental assistance to support exits from COVIC-19 temporary shelters into permanent housing placements.

2) **Prevention:** Reduce inflow (prevention) by:
   1) Scaling rapid resolution

   2020 Accomplishments:

- Scaled Rapid Resolution by developing and implementing a triage tool for widespread use by the homeless service providers.

STRATEGIES

1) Coordinated Entry/Enhancing prioritization (triage and assessment tools)

2020 Accomplishments:

- Enhance prioritization by adding a prioritization strategy for COVID-19 hotel exits into permanent housing
- Coordinated among stakeholders to implement coordinated approaches to homeless services for projects and funding, including Project Roomkey, Project Homekey, ESG-CV, CESH, and HHAP.

2) Bolstering and utilizing Housing Security Fund

2020 Accomplishments:

- Allocated funding from state competitive funding (California Emergency Solutions Housing (CESH) program) to bolster Housing Security Fund for flexible assistance, including rental assistance and utility payments

3) Performance Standards

2020 Accomplishments:

- Renewed participation in Built for Zero Initiative and engaged other technical assistance to learn strategies and techniques to implement Continuous Quality Improvement processes to enhance ability to identify relevant performance metrics and create and maintain data reliability.
- Completed multiple data analyses which enhance understanding and ability to develop system performance standards, service costs, and consumer and system needs:
    - HMIS Analysis (for internal review and system improvements)
    - Contra Costa County CoC Homeless Program Utilization Analysis
    - All Home Regional Contra Costa COVID-19 Homeless System Housing Intervention Modeling
- Data quality: Started developing the process to analyze data for data quality and to create a data quality monitoring plan for the community.

4) Communication

- Developed priorities around enhancing transparency through communication improvements.
- Developed Toolkit, video and organized a CoC Learning Hub in November to promote Homelessness Awareness Month.
- Engaged Executive Directors and homeless service providers through monthly provider meetings and an Executive Directors Meetings.
- Developed a 2021 calendar for activities, training and events to promote transparency and planning and increase participation in meetings, trainings, and events.
- Regularly communicated trainings, events, upcoming meetings, provider updates and funding opportunities in monthly newsletters.

OTHER ACCOMPLISHMENTS

1) **Expanded Diverse Composition of Council on Homelessness:** Approved adding Workforce Development seat and Youth Representative to the Council; updated Council membership application and review process to ensure diversity, equity, and inclusion and broader diversity of representatives.

2) **Compliance:** Improved system and project compliance with federal and state regulations by developing and implementing a Monitoring Plan for homeless service agencies.
3) **Advocacy:** Engaged in advocacy opportunities and promotion of policy needed to support the County's homeless service efforts by meeting with the County lobbyists and submitting letters of support to the County Administrator's Office on state and federal legislation in alignment with the Board of Supervisors policy platform.
4) **Education & Expertise:** Participated in five (5) federally funded technical assistance workshops to support COVID-19 system and project performance, data quality and coordinated entry improvements.
5) **Collaborate on Local Housing Strategies:** Staff to Council participated in drafting and revision of Consolidated Plan, grant applications for DCD administered funding to address homelessness, and local planning for Living Contra Costa, Value Mapping, and other local strategies impacting homelessness.

Looking forward, in 2021 the Council on Homelessness and the Continuum of Care will be participating in a number of initiatives including:

- Continuous Quality Improvement, including refining the Work Plan to include strategies around our foundational principles of equity, transparency, and data informed decision making
- Various Equity initiatives as part of the larger homeless system Equity Strategy, including the Racial Equity Action Lab, rollout of integrated online map tool, and broad translation of updated consumer content to promote increased access to resources and important information
- Participation in All Home and Homebase Regional Work
- Annual homeless Point in Time Count
    - A comprehensive single day point-in-time count of families and individuals experiencing homelessness, conducted at the end of January. PIT data is used for local, regional, and federal strategic planning, decision making, allocation of resources, and advocacy to prevent and end homelessness in Contra Costa County.

Future communications from the Council on Homelessness and the CoC will include:

- An Annual Report
- Quarterly written reports from the Council on Homelessness to the Family and Human Services as a way to keep the Committee and Board of Supervisors updated on the activities and priorities of the Council and homeless continuum of care throughout the year.

Please see the attached Contra Costa COVID-19 Homeless System Housing Intervention Modeling.

Recommendation(s)/Next Step(s):

1. Accept this report from the Health Services Department; and
2. Forward this report to the Board of Supervisors for acceptance; and
3. Direct Staff to **report on a quarterly basis** to the FHS Committee regarding progress of the effort to end homelessness and the activities of Contra Costa Council on Homelessness.

Contra Costa Homeless System of Care Annual Update

Lavonna Martin, Director
Health, Housing and Homeless Services

Journey Today…

1. Data snapshot
2. Homeless system response to address the COVID-19 crisis
3. COVID-19 Recovery Plan
4. Opportunities for 2021

2020

Contra Costa County: Annual Point in Time Count Report

CONTRA COSTA
HEALTH HOUSING
& HOMELESS SERVICES
A Division of Contra Costa Health Services

Research, Evaluation, and Data (RED) Team
Contra Costa Health Services: Health, Housing, and Homeless Services Division

250

2,277

- ❑ Persons in Shelter – 707
- ❑ Persons Unsheltered – 1,570
- ❑ 5% Households were Families

https://cchealth.org/h3/coc/pdf/PIT-report-2020.pdf

COVID-19 Response in Homeless System of Care

March

April

May

June

- Developed guidelines for service providers
- Distributed PPE, other supplies and educational materials to providers and consumers
- Shifted from congregate shelters to non-congregate settings (hotels)
- Discouraged the displacement of homeless encampments
- Procured handwashing stations and portable restrooms for persons living outside

July

August

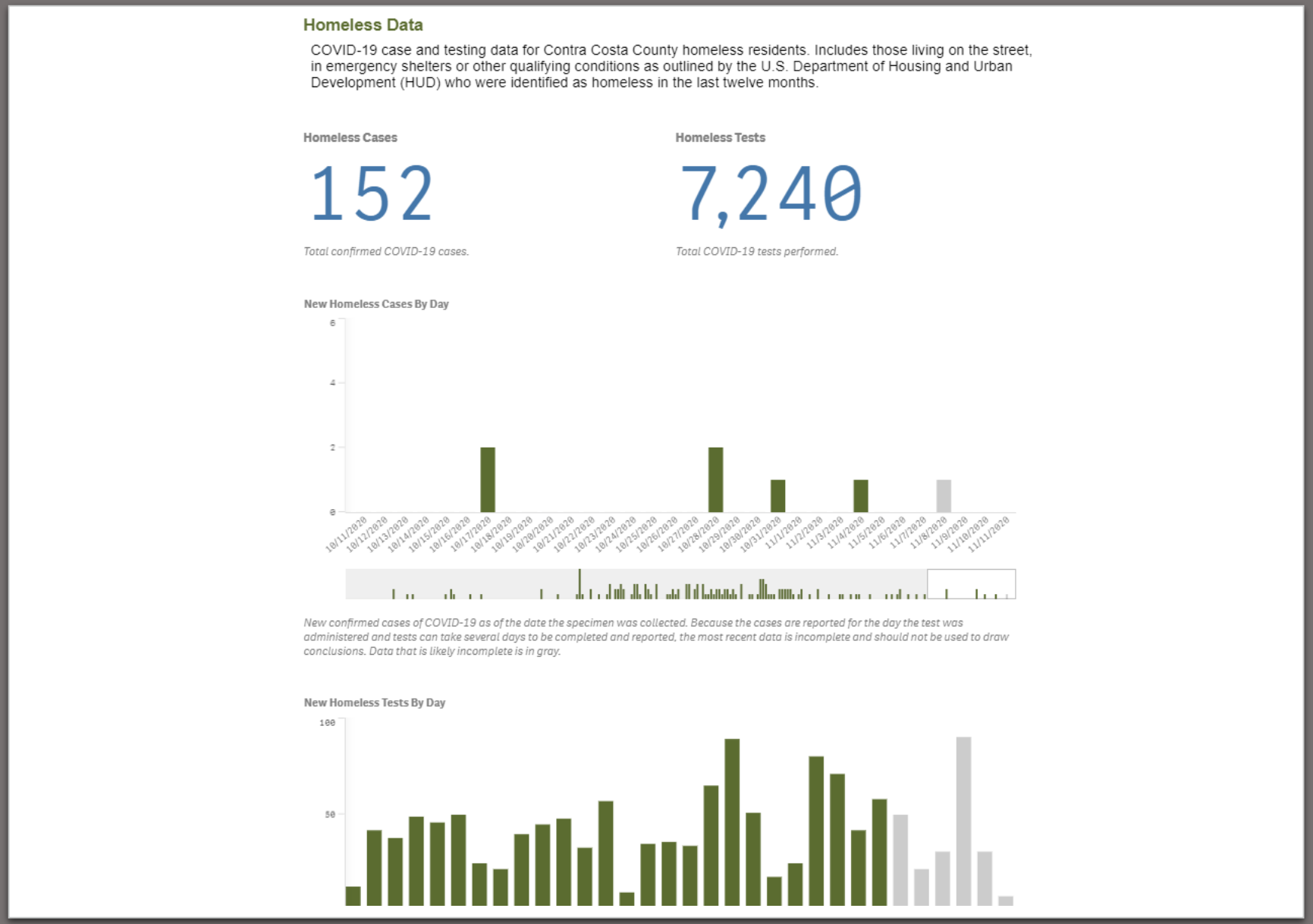
September

October

- Leased additional hotel rooms
- Submitted Project Homekey application
- Hotel prioritization process finalized
- “Contra Costa Homeless System of Care Response to the COVID-19 Pandemic” Meeting Series
- Began to admit new consumers to single room shelters

Project Roomkey Hotel Program

- 105 rooms for +/PUI
- 494 rooms for high-risk
- Utilization rate: 99%
- >1400 residents served to date



COVID-19 Homeless Dashboard

https://www.coronavirus.cchealth.org/homeless

Focus on What's Ahead

1	Re-opening services while protecting health
2	Maintaining bed capacity gained
3	Accelerating long-term housing placements

256

Contra Costa County

CONTRA COSTA HEALTH SERVICES

COVID-19 Recovery Plan for the Homeless System of Care

	Support Basic Health and Safety Needs	Maintain non-congregate shelter	Safely re-open existing shelters	Accelerate permanent housing placement
Fall 2020	**CARE Centers** Centers in Richmond and Walnut Creek are open for showers, meals, and laundry. *Now Open*		**Single room occupancy shelters** Re-start admissions to shelters with single rooms. *Now Open*	**Housing Navigation Services** Prioritize current hotel residents for housing navigation services. *Now Available*
	Portable restrooms and hand-washing Partner w/ cities to reduce transmission of COVID-19 in encampments. *Now Available*			
Winter 2020-2021	**Safe Parking Program** Temporary safe parking programs will begin for residents living in vehicles and RV's. *January 2021*	**Purchase hotel** Add 174 room hotel as lasting resource of emergency interim housing in East County. *December 2020*	**Winter Shelters** Admissions to seasonal indoor "camping-style" shelter programs can begin. *Nov '20-June '21*	
Spring 2021		**Lease non-congregate hotel** Extend ~100 hotel rooms for up to one year to transition persons to housing. *Spring 2021*	**Modified Congregate Shelter** Establishing ~100 modular sleep stations within county-operated shelter system. *February 2021*	**Rapid rehousing and permanent supportive housing** Distribute ~$4M in financial assistance with short or long-term supports in permanent housing. *January 2021*
TBD			**Traditional shelters** Re-opening 200 beds in congregate shelters with shared sleeping areas. *TBD*	**Mainstream Vouchers** Target any mainstream housing choice vouchers allocated to CoC to residents in hotels. *TBD*

**All dates are anticipated and may change based on funding availability and/or County tier level based on COVID-19 test positivity rate.*

Project Roomkey to Homekey

Opportunities for 2021

- Continuous Quality Improvement
- All Home regional work
- Point in Time Count
- Annual Report
- Quarterly reports to FHS

Contra Costa County Housing Intervention Modeling

Current Capacity vs. Immediate Need

		Current	Optimal	Gap/Need
Exits	RRH	172	1,041	869
	PSH	541	1,750	1209
	Vouchers	35	857	822
Entry (Temporary Beds)	Emergency Shelter	630	1,430	617
	Interim Shelter (Hotel)	183		
	Transitional Housing	194	194	
Homelessness Prevention & Rapid Resolution	Prevention/Rapid Resolution	1,243	1,780	537
	Total	2,998	7,052	4,054

Population Baseline: 6,900

5800 households were sheltered and unsheltered in Contra Costa.

Approximately 47% (3,250) consumers are at risk of COVID-19.

Total COVID Funds: ~$40M

- Federal ESG $403k
- Federal ESG-CV1 $1.3M
- Federal ESG-CV2 $9.2M
- State ESG-CV $1M
- State ESG-CV2 $5M
- Project Roomkey $1.7M
- Project Homekey* $21.4M
- CRF HCFC COVID $858k

ALL HOME

Racial Equity Action Lab

Addressing Anti-Black Racism and Racial Disparities in Bay Area Homelessness Response

Sponsored by BARHII, Homebase, All Home, and the Federal Reserve Bank of San Francisco

Council on Homeless Member Recommendations

Recommendations For Open Council on Homelessness Seats

Seat	Recommendation	# of applicants
Affordable Housing Developer	Iman Novin, Consultant Novin Development Consulting	2
Behavioral Health	Margaret Schiltz, Program Manager Portia Bell Hume Center's West County FSP program	6
City Government	Teri House, CDBG Manager City of Antioch	5
Consumer	Jo Bruno Consumer	3 (consumer) 4 (consumer advocate)
Educational/Vocational	Alejandra Chamberlain, Homeless Liaison Contra Costa Office of Education	1
ESG	Gabriel Lemus, Administrator Department of Conservation and Development	1
Healthcare Provider	Linea Altman, Public Health Program Specialist II Community Connect & Health Care for the Homeless	1
Homeless Service Provider	Deanne Pearn, Executive Director Hope Solutions	4
Public Safety #1	Manjit Sappal, Chief of Police City of Martinez	1
Veteran Services	Misaki Hiriyama, Coordinated Entry Specialist Northern California VA Healthcare System	1
Workforce Development	Maureen Nelson, Administrator One Stop Consortium	2
Youth	Renee Hedrick, Member Youth Action Council	1

For more information

Jaime Jenett, MPH

Community Engagement Specialist

Health, Housing and Homeless Services (H3)

Jaime.jenett@cchealth.org

952-464-0152 cell

Contra Costa County Housing Intervention Modeling

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- Project Homekey* $21.4M
- CRF HCFC COVID $858k

ALL HOME

Estimated Cost to Reach Optimal Capacity

INTERVENTION	COST PER UNIT/HH PER YEAR	NUMBER NEEDED	TOTAL (PER YEAR)
RRH	$19,980	869	$17.4 M
PSH	$24,000	1209	$29.0 M
Vouchers	$17,858	822	$14.7 M
Emergency and Interim Shelter	$10,950-$52,560	617	$6.7 M – $32.4 M
Transitional Housing	$43,070	0	$0
Homelessness Prevention/Rapid Resolution	$4,480	537	$2.4 M
Total		**4,054**	**$70.2 M – 95.9 M**

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **8.**

Meeting Date: 11/23/2020
Subject: Public Mental Health Care System
Submitted For: David Twa, County Administrator
Department: County Administrator
Referral No.: 115/116
Referral Name: Public Mental Health Care System
Presenter: Matthew P. White, M.D.; Suzanne Tavano, PH.D; Barbara Serwin, Chair, Mental Health Commission
Contact: Warren Hayes (925) 957-2616

Referral History:
On October 30, 2017 the Family and Human Services Committee (FHS) accepted the report from the Health Services Department addressing various mental health service issues and concerns raised by the FHS, the Board of Supervisors, the Mental Health Commission's White Paper, the Civil Grand Jury, and members of the public. These issues and concerns centered upon the difficulty in accessing mental health care, particularly for children and youth experiencing serious emotional disturbances. Indicative to this lack of access was the 1) increase in Psychiatric Emergency Services visits, 2) long wait times to access care, and 3) shortage of clinical staff, especially psychiatrists. The Health Services Department report addressed these issues and concerns, and reported upon the initiatives and progress made to date.

The FHS asked the Department to provide an update to the Mental Health Commission in six months, and to the FHS annually thereafter. The last status report made to FHS was on September 23, 2019.

Referral Update:
The attached report includes the updated Mental Health Services Three Year Program and Expenditure Plan for review by the committee and referral to the Board of Supervisors for acceptance and authorization to communicate approval to the California Department of Health Care Services.

Recommendation(s)/Next Step(s):
ACCEPT the updated Mental Health Services Act Three Year Plan, REFER to the Board of Supervisors for consideration.

Fiscal Impact (if any):

There is no fiscal impact.

Attachments

MHSA Three Year Plan 2020-23
Staff Presentation for MHSA Three Year Plan
Innovation Annual Report - 2018-19
PEI Evaluation Report 2018-19

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Fiscal Years 2020-2023

The PhotoVoice Empowerment Project

Each year, artwork from the PhotoVoice Empowerment Project is selected to be included in the Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan or Annual Update. The PhotoVoice Empowerment Project enables peers/clients/consumers to produce artwork; that is personal and allows for expression through poetry and narrative. The artwork speaks to the prejudice and discrimination that some people with lived behavioral health and/or wellness experience face.

The PhotoVoice Empowerment Project also empowers peers/clients/consumers with lived behavioral health and/or wellness experience or lived experience to record and reflect their community's strengths or concerns; while promoting critical dialogue about personal and community issues to reach policymakers and effect change. Special thanks to PhotoVoice participants for sharing their experience and artwork.

Overcoming Obstacles

Throughout time we are stigmatized for skin color whether we are Black, Mexican, Asian or White. I wanted to symbolize how I was stigmatized throughout my life and that has caused insecurities within myself. My photo is my mother in front of the American flag because she has been a huge factor in making me proud of my culture and being an American citizen and overcoming obstacles like she did throughout my life.

- *Angela Navarro*

Executive Summary

We are pleased to present Contra Costa Behavioral Health Services (CCBHS) Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan (Three Year Plan) for fiscal years 2020-23. This Three-Year Plan starts July 1, 2020 and will be updated annually in fiscal years 2021-22 and 2022-23.

The Three-Year Plan describes programs that are funded by the MHSA, what they will do, and how much money will be set aside to fund these programs. The Three-Year Plan includes the components of Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities/ Information Technology (CF/TN). Also, the Three-Year Plan describes what will be done to evaluate plan effectiveness and ensure that all MHSA funded programs meet the intent and requirements of the Mental Health Services Act.

California approved Proposition 63 in November 2004, and the Mental Health Services Act became law. The Act provides significant additional funding to the existing public mental health system and combines prevention services with a full range of integrated services to treat the whole person. With the goal of wellness, recovery and self-sufficiency, the intent of the law is to reach out and include those most in need and those who have been traditionally underserved. Services are to be consumer driven, family focused, based in the community, culturally and linguistically responsive, and integrated with other appropriate health and social services. Funding is to be provided at sufficient levels to ensure that counties can provide each child, transition age youth, adult and senior with the necessary mental health services and supports set forth in their treatment plan. Finally, the Act requires the Three-Year Plan be developed with the active participation of local stakeholders in a Community Program Planning Process (CPPP).

Program Changes and Updates. The 2020-23 Three Year Plan was prepared in response to a community program planning process that took place in 2019 and early 2020. The plan was then posted for a 30-day public comment period on March 1, 2020. With the onset of COVID-19 in ensuing weeks, the Public Hearing was postponed and a request for extension was made to the Department of Health Care Services (5510 Form) in order to allow time to respond to the economic impact of the global pandemic. The Three-Year Plan was subsequently revised with stakeholder input to incorporate new fiscal realities, while also maintaining vital existing programs and services. Foremost among prioritized service and support needs are a variety of supportive housing strategies that increase the ability of persons most challenged by serious mental illness to live in the community:

- Expansion of Full Service Partnership (FSP) capacity by serving 40 additional adults, and services to include housing flex funds (pages 30-31).

- An update to the County's participation in the State initiative "No Place Like Home" for increasing permanent supportive housing units for persons experiencing serious mental illness and who are homeless or at risk of chronic homelessness (page 35).
- Increased funding to provide on-site behavioral health care for persons residing in CCBHS sponsored permanent supportive housing units (page 35).
- Increasing case management service and housing support capacity to the county operated adult mental health clinics by adding Mental Health Specialists with lived experience as a consumer or family member of a consumer (page 40).

Additional prioritized service needs that have been added to the Three-Year Plan include:

- Support to expand Mobile Crisis Response Team which serves adults across the County who are experiencing a mental health crisis (page 41)
- Providing outreach, education and linkage to treatment for families with very young children experiencing serious emotional disorders (page 46).
- Providing dedicated staff to provide countywide suicide prevention education and training (page 52-53).
- Financially supporting County or contract workforce to be more culturally and linguistically responsive via the locally funded MHSA Loan Repayment Program in the behavioral health field and retention in the workforce (page 62-63).

Funding. Fiscal Year 2020-21 sets aside up to $61.6 million in budget authority; a $7 million annual increase from the previous Three-Year Plan (page 67). This increase in budget authority is significantly smaller than anticipated pre-COVID-19 and is primarily identified to fund a variety of supportive housing strategies, such as flexible housing funds, increasing the number of temporary and permanent supportive housing beds and units, and fielding additional staff dedicated to assisting individuals to get and keep their housing. Funding has also been added in response to the most recent Community Program Planning Process which recommended more support for early childhood mental health and suicide prevention training, as well as in support of building upon existing community crisis response strategies. In addition, MHSA funds have been used to address shortfalls in Realignment funds throughout the Behavioral Health Services system of care in order to preserve vital supports and services.

Outcomes. Performance indicators for the County's Full Service Partnership Programs (pages 27-28) and Prevention and Early Intervention component (pages 43-44) were updated in Fiscal Year 2018-19. In addition, Appendix B contains individual program profiles of MHSA programs and plan elements and includes FY 18-19 performance outcomes.

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Vision

The Mental Health Services Act serves as a catalyst for the creation of a framework that calls upon members of our community to work together to facilitate change and establish a culture of cooperation, participation and innovation. We recognize the need to improve services for individuals and families by addressing their complex behavioral health needs. This is an ongoing expectation. We need to continually challenge ourselves by working to improve a system that pays particular attention to individuals and families who need us the most and may have the most difficult time accessing care.

Our consumers, their families and our service providers describe behavioral health care that works best by highlighting the following themes:

Access. Programs and care providers are most effective when they serve those with behavioral health needs without regard to Medi-Cal eligibility or immigration status. They provide a warm, inviting environment, and actively and successfully address the issues of transportation to and from services, wait times, availability after hours, services that are culturally and linguistically competent, and services that are performed where individuals live.

Capacity. Care providers are most appreciated when they are able to take the time to determine with the individual and his or her family the level and type of care that is needed and appropriate, coordinate necessary health, behavioral health and ancillary resources, and then are able to take the time to successfully partner with the individual and his or her family to work through the behavioral health issues.

Integration. Behavioral health care works best when health and behavioral health providers, allied service professionals, public systems such as law enforcement, education and social services, and private community and faith-based organizations work as a team. Effective services are the result of multiple services coordinated to a successful resolution.

We honor this input by envisioning a system of care that supports independence, hope, and healthy lives by making accessible behavioral health services that are responsive, integrated, compassionate and respectful.

Suzanne K. Tavano, PHN, Ph. D
Behavioral Health Services Director

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Needs Assessment

Introduction

In 2019 CCBHS conducted a triennial quantitative and qualitative needs assessment of public mental health needs in preparation for developing the Fiscal Year 2020-23 MHSA Three Year Plan. This data driven analysis complements the CPPP, where interested stakeholders provided input on priority needs and suggested strategies to meet these needs. Data was obtained to determine whether CCBHS was doing the following: a) reaching the people it is mandated to serve, b) appropriately allocating its resources to provide a full spectrum of care, and c) experiencing any significant workforce shortfalls.

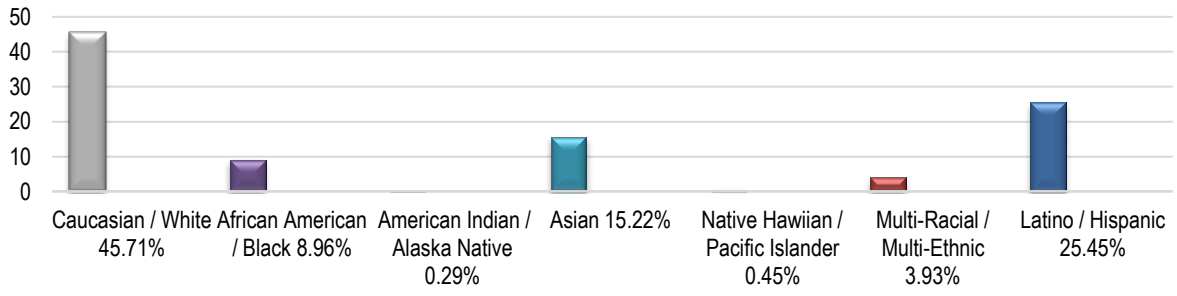
In 2019 Contra Costa Health Services (CCHS) also launched its Envision Health planning process to understand, think about, deliver and support health in Contra Costa County to collectively address changing realities. As part of this process CCBHS is working with the community and partners in planning for health realities for 10, 20 and even 30 years into the future.

Contra Costa County Population Summary

According to the most recent 2018 U.S. Census Bureau estimates, the population size in Contra Costa County was estimated at 1,150, 215. It's estimated that about 9% of people in Contra Costa County are living in poverty and about 30% of the non-institutionalized residents have public health coverage, however with the passing of the Affordable Care Act the numbers of people eligible are foreseen to grow as Medi-Cal eligibility is considered for some cases to be up to 322% Federal Poverty Level (FPL). Information released by the State of California's Department of Finance projects that population size is expected to grow. Latino/Hispanic and Asian/ Pacific Islander communities will see larger population growth.

An estimate of current racial/ethnic demographic data is illustrated below in Figure 1. In addition, more than half of the population is 18 or older, with about 30% of the population being children. About a quarter of Contra Costa County residents are foreign born.

Figure 1: Contra Costa County 2019 Projected Racial/ Ethnic Populations



Method

The data collected and used in this Needs Assessment included quantitative and qualitative data studies collected from various County sources, as well as State and other reports referenced in the report. The following areas of inquiry were identified in analyzing the information presented in this Needs Assessment:

1) The populations in Contra Costa County CCBHS intends to serve and which populations are being served.
2) The demographic composition of the Contra Costa County population.
3) How CCBHS is aligning its resources to provide a full spectrum of services at the appropriate level, while also being culturally and linguistically responsive.
4) How CCBHS is developing its workforce to address and implement identified service needs.
5) Identified service gaps and how CCBHS addresses these service gaps.

Findings

Data analysis supports that overall, CCBHS is serving most clients/consumers/peers and families requiring services, and that CCBHS serves more eligible clients than most counties in California. This is based upon prevalence estimates and ***penetration rates*** (meaning proportion of people being served in CCBHS in comparison to total Medi-Cal eligible population in the County) of economically under privileged children with serious emotional disturbance and adults with a serious mental illness, as compared with other counties. Whether consumers are appropriately served (in ways that align with their cultural values and linguistic needs) is an issue that has been raised by community stakeholders and advocates and is something that warrants on-going assessment and evaluation. This has become even more relevant during the pandemic, as existing social and racial inequities have been exacerbated.

Particular findings revealed through this Needs Assessment include the following:

1) Persons who identify as Asian/Pacific Islander, and very young children are slightly under-represented when considering penetration rates in comparison to other demographic groups within Contra Costa County.
2) There continues to be an ongoing shortage of affordable housing and housing supports for those individuals and families affected by serious mental illness.
3) Based on data analysis and stakeholder input, there is a need to strengthen services that can support children, youth and adults who are most severely challenged by emotional disturbances or mental illness.
4) Suicide prevention, awareness, and training is needed throughout the County, with special consideration for youth and young adults.
5) Workforce analysis indicates a continued shortage of staff capable of prescribing psychotropic medications.
6) There are minimal career progression opportunities for the classifications of peer specialists and family partners.
7) Staff capacity for communicating in languages other than English continues to be a need, specifically for Spanish and Asian/Pacific Islander languages.

8) Persons identifying as LatinX / Hispanic and Asian/Pacific Islander are under-represented in the CCBHS workforce.
9) CCBHS is lacking a state-of-the-art electronic data management system to support more effective decision-making, evaluation of services and communication with stakeholders.

Recommendation

CCBHS recognizes the importance of fielding programs and services that are responsive to clients and their families as well as the development of a workforce that can support and respond to the needs of those served. Input gathered through this data driven analysis complements the CPPP, where stakeholders, to include clients, family members, service providers, allied health and social service agencies and the community in general provide input in various methods to prioritize needs.

The above findings are addressed in this MHSA Three Year Program and Expenditure Plan for FY 2020-23. It is recommended that CCBHS work together with all stakeholders to make the very best of the resources provided by this Three-Year Plan.

The full Needs Assessment Report can be found at:
https://cchealth.org/mentalhealth/mhsa/pdf/2019-Needs-Assessment-Report.pdf

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Impact of COVID-19 on the Three-Year Program and Expenditure Plan

In late summer 2020, a thorough revision process took place with stakeholder involvement in order to address significant COVID-19 related budget shortfalls, while also maintaining the most vital services and supports. The March 2020 version of the Plan included significant expansion, particularly in the areas of housing, early childhood mental health, suicide prevention training and upgrading FSP's (ACT to fidelity). Ultimately, all existing contracts were renewed. Cuts were primarily made in the areas of planned future expansion. The below table highlights necessary changes made to the previously posted 2020-23 Three Year Program and Expenditure Plan draft, in light of the fiscal and community impact of COVID-19.

2020-23 COVID-19 Related Plan Revision Summary	
Additional FSP ACT Enhancement	Removed
Permanent Supportive Housing and Housing Supports	Increased funding (at lower level)
Suicide Prevention Training	Increased funding (at lower level)
Early Childhood Mental Health Outreach	Increased funding (at lower level)
CSS Contracts (with blended MHSA & Realignment funding)	Increased MHSA funding portion in order to address Realignment shortfall
Community Crisis Response	Increased staffing

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The Community Program Planning Process

Each year CCBHS utilizes a Community Program Planning Process (CPPP) to accomplish the following:

- Identify issues related to mental illness that result from a lack of mental health services and supports
- Analyze mental health needs
- Identify priorities and strategies to meet these mental health needs

CPAW. CCBHS continues to seek counsel from its ongoing stakeholder body, entitled the Consolidated Planning Advisory Workgroup (CPAW). Over the years CPAW members, consisting of consumers, family members, service providers and representative community members, have provided input to the Behavioral Health Services Director as each Three-Year Plan and yearly Plan Update has been developed and implemented. CPAW has recommended that the Three-Year Plan provide a comprehensive approach that links MHSA funded services and supports to prioritized needs, evaluates their effectiveness and fidelity to the intent of the Act, and informs future use of MHSA funds. CPAW has also recommended that each year's Community Program Planning Process build upon and further what was learned in previous years. Thus, the Three-Year Plan can provide direction for continually improving not only MHSA funded services, but also influencing the County's entire Behavioral Health Services Division. In addition, CPAW utilizes part of its monthly meeting time to be the planning and implementation resource for fielding each year's Community Forums.

Community Forums Informing Fiscal Year 2020-21
Since 2018, Community Forums have each focused on a unique theme, identified by stakeholders as a priority issue, and developed in collaboration with our CBO partners. In the past year, approximately 371 individuals of all ages participated in the community program planning process by attending the forums described below.

- July 18, 2019 (San Pablo – West County) – Supportive Housing
- September 12, 2019 (San Ramon - South County) – Suicide Prevention
- November 2, 2019 (Pittsburg – East County) – Early Childhood Mental Health

Supportive Housing Community Forum – West County (San Pablo)

7/18/19 - Event sponsored in partnership with Contra Costa Interfaith Housing

Total Present	Ethnicity	Affiliation	Age	Gender	Keynote Speaker Topics
110	White: 41%	Consumer/ Family Member: 32%	Under 25: 10%	Female: 66%	• What is supportive housing (vs other types of housing)? • Consumer perspective – Personal Story
	African American/ Black: 28%	Service Provider 26%	26-59: 67%	Male: 29%	
	Hispanic: 13%	CCBHS Staff: 16%	Over 60: 20%	Other: 5%	
	API: 13%	Other 15%			
	Native American/ Alaskan Native: 4%				
	Other: 9%				

Small Group Discussions. The following questions were discussed in small break-out groups. The top issues brought up by participants are summarized below:

Question 1: What kind of housing assistance is most helpful?

- Case managers with cultural humility
- Help with money management / budgeting
- Life skills training
- On-site nutritional counseling & activities
- Employment and educational support
- Linkages to food and other community resources
- Legal assistance / tenants' rights advocacy
- Substance use disorder support
- Clarity on public housing policies and procedures
- More housing, housing first model
- Parenting support
- Flex funds – help with move in costs
- Transportation
- Conflict resolution / safety

Question 2: What qualities make a good case manager?

- Empathy / compassion
- Cultural humility

- Bilingual / bicultural
- Flexibility
- Patience
- Trust / rapport
- Good communication
- Reliable, follows through
- Lived experience – share their story
- Employers should give smaller caseloads, address burnout & compassion fatigue to reduce employee turnover

Question 3: How should support be made available?

- As needed, 24/7
- On-site
- Culturally appropriate
- Peer to peer
- Accessible in all regions
- Improve transportation
- Home visits
- Case management “teams”

Question 4: Other comments?

- Explore alternative housing options – i.e. tiny homes, co-housing
- What happens when caregivers of mentally ill people die (i.e. elderly parents)?
- More step-down options from IMD’s; IMD’s should be local
- Tenant Advisory Board
- Transportation – agencies should have vans, provide vouchers
- ACT team approach
- More money for housing
- Prison Re-Entry

Suicide Prevention Community Forum – South County (San Ramon

9/12/19 - Event sponsored in partnership with Contra Costa Crisis Center

Total Present	Ethnicity	Affiliation	Age	Gender	Keynote Speaker Topics
110	White 50 (54%)	Consumer/ Family Member: 25 (27%)	Under 25: 7 (8%)	Female: 62 (67%)	• Suicide Data – Contra Costa County • Youth Suicide Epidemic • Suicide Prevention Skills and Resources
	Hispanic: 15 (16%)	Service Provider: 52 (57%)	26-59: 69 (75%)	Male: 27 (29%)	
	African American / Black: 10 (11%)	CCBHS Staff: 16 (17%)	Over 60: 17 (19%)	Other: 3 (3%)	
	API: 9 (10%)	Other 12 (13%)			
	Native American/ Alaskan Native: 0%				
	Other: 12 (13%)				

Small Group Discussions. The following questions were discussed in small break-out groups. The top issues brought up by participants are listed below in order of popularity.

Question 1: What resources exist in your community for those affected by suicide?

- Participants were able to identify 45 unique resources that ranged from CBO's, faith-based groups, crisis services, county programs, school based and law enforcement related services.

Question 2: What resources/services do you want to see more of?

- Language services – more language hotlines other than Spanish, more printed materials, more beyond interpretation, work force that reflects community – more bilingual/bicultural staff, more trainings in other languages
- Training for school communities
- Peer support
- Training for law enforcement (including training during police academy) and first responders
- Normalize mental health by starting conversations in early childhood – destigmatize
- More housing, explore modular housing
- Family support/advocacy
- Family training and education around suicide prevention
- Commitments to serve regardless of "eligibility requirements"

Question 3: What are some practices in your community or culture that promote health and wellness?

- Spirituality / Church / Prayer
- Law enforcement – crisis intervention services, peer support ream, first responders, community events
- Exercise / Sports
- Outdoor activity / Nature
- Mindfulness / yoga / meditation
- Inclusivity

Question 4: Any other thoughts or ideas to share related to this topic?

- More education / outreach / cultural exchange
- More scholarships / low cost opportunities for minorities and low-income people to get therapy
- Promote more mental health resources online
- More community events on suicide prevention & general prevention, especially in schools
- Staff – more providers of color, more care for staff to prevent burnout, promote empathy & compassion
- More peer respite models

Early Childhood (0-5) Mental Health Community Forum – East County (Pittsburg)

11/2/19 - Event sponsored in partnership with First Five Contra Costa and the Early Childhood Prevention and Intervention Coalition

Total Present	**Ethnicity**	**Affiliation**	**Age**	**Gender**	**Key-Note Speaker Topics**
151 Total *116 Participants, 28 Children, 7 Child Care Providers* **Children were entertained in an adjacent activity room and did not complete demographic forms. They are represented in total number only.*	White: 39%	Consumer / Family Member: 15%	**Children Under 18:* *19%*	Female: 93%	• Early Childhood Mental Health Overview • Early Childhood Provider Presentations • Understanding and Healing Early Childhood Trauma
	Hispanic: 30%	Service Provider: 54%	18-25: 5%	Male: 6%	
	African American/ Black: 18%	CCBHS Staff: 10%	26-59: 85%	Other: 1%	
	API: 11%	Other: 23%	Over 60: 10%		
	Native American / Alaskan Native: 4%				
	Other: 8%				

Small Group Discussions. Participants actively discussed via small groups topical

issues that were developed by CPAW representatives, CBO partners and an electronic survey prior to the forums. Highlights of small group input include:

Question 1: What would help reduce the stigma associated with "mental health" and increase understanding that early childhood mental health means supporting healthy social-emotional development in babies and young children?

- Improve messaging around mental health
- Re-brand, create a jingle, use celebrity advocates, social media
- Educate around behavioral health as an illness, remove blame/shame
- Person first language – you are not your illness
- Workshops
- Change the narrative around mental health
- Understand the impact of trauma, including intergenerational trauma
- Role of the pediatrician/medical provider is key – establish trust/rapport
- Pediatricians to focus on behavioral health, not just physical, screen for ACES, improve cultural sensitivity, ask the right questions without judgement
- Increase general community knowledge of mental health and normal development
- Build community – enhance natural supports, utilize peers, let people know they're not alone
- Access & Quality of care
- Early Intervention

Question 2: What types of support are most helpful for parents of babies and young children?

- Welcoming & Inclusive spaces
- Strength-based approach to working with parents
- Use faith leaders and trusted members of the community
- Community connections to those with similar experiences
- Free events / support groups
- Support for new parents, including home visits
- More general information / education
- School based mental health services and teacher education around mental health
- Reduce barriers such as childcare, transportation, basic needs
- Include and empower fathers, build on natural supports
- Community agencies

Question 3: Who is providing Early Childhood Mental Health services in Contra Costa?

- First 5, We Care, Lynn Center, ECMHS, Regional Center, Coco Kids, ABCD Clinic, 211 – Help Me Grow, MOPS (mothers of preschoolers), Lincoln Child Center, Seneca, Fred Finch, Seneca, Head Start, Kinship Support Services, parents, community advocates, county services, wrap around services, faith

communities, play groups, city parks and outdoor spaces.

- Barriers include childcare, fear in immigrant communities, healthcare should do better at promoting community resources, economics, generational gaps, inequity, transportation, de-centralized services

Question 4: What trainings do providers need to work with and to meet the needs of families with babies and young children?

- Trauma / Cultural Sensitivity trainings throughout community
- Workshops on stages of development, brain science, attachment/bonding
- Teacher trainings – development stages, cultural humility, early intervention
- General info on community resources – more use of technology to promote

Prioritizing Identified Unmet Needs. As part of each community forum, participants were asked to prioritize via applying dot markers to the following unmet needs identified through a needs assessment process and tracked over time. This provides a means for evaluating perceived impact over time of implemented strategies to meet prioritized needs. Thus, service needs determined to be unmet in previous years can drop in ranking as the system successfully addresses these needs. Unmet needs are listed in order of priority as determined by forum participants, with last year's Three-Year Plan rankings provided for comparison.

Current Year Rank	Topic	Previous Year Rank
1	More housing and homeless services	1
2	More support for family members and loved ones of consumers	3
3	Support for peer and family partner providers	11
4	Outreach to the underserved – provide care in my community, in my culture, in my language	2
5	Improved response to crisis and trauma	4
6	Connecting with the right service providers in your community when you need it	5
7	Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care	6
8	Children and youth in-patient and residential beds	9
9	Intervening early in psychosis	8
10	Getting to and from services	7
11	Serve those who need it the most	10
12	Care for the homebound frail and elderly	13
13	Increased psychiatry time	12
14	Assistance with meaningful activity	14

1. **More housing and homeless services.** (last year's rank: 1) The chronic lack of affordable housing makes this a critical factor that affects the mental health and well-

being of all individuals with limited means. However, it is especially deleterious for an individual and his/her family who are also struggling with a serious mental illness. A range of strategies that would increase housing availability include increasing transitional beds, housing vouchers, supportive housing services, permanent housing units with mental health supports, staff assistance to locate and secure housing in the community, and coordination of effort between Health, Housing and Homeless Services and CCBHS.

Relevant program/plan elements: Sufficient affordable housing for all consumers of CCBHS is beyond the financial means of the County's Behavioral Health Services budget. In 2019, it is estimated that nearly 2300 individuals in the County are homeless on any given night, which is a 43% increase since 2017. The MHSA funded Housing Services category of the Community Services and Supports component is coordinating staff and resources with the Health, Housing and Homeless Services Division in order to improve and maximize the impact of the number of beds and housing units available, shorten wait times, and improve mental health treatment and life skills supports needed for consumers to acquire and retain housing.

2. **More support for family members and loved ones of consumers.** (last year's rank: 3) Critical to successful treatment is the need for service providers to partner with family members and significant others of loved ones experiencing mental illness. Stakeholders continued to underscore the need to provide families and significant others with education and training, emotional support, and assistance with navigating the system.

   Relevant program/plan elements: Children's Services utilizes family partners to actively engage families in the therapeutic process, and fields the evidence-based practices of multi-dimensional family therapy and multi-systemic therapy, where families are an integral part of the treatment response. Adult Services is expanding their family advocacy services to all three of their Adult Mental Health Clinics. In the Prevention and Early Intervention component the County provides clinicians dedicated to supporting families experiencing the juvenile justice system due to their adolescent children's involvement with the law. Three programs provide family education designed to support healthy parenting skills. Project First Hope provides multi-family group therapy and psychoeducation to intervene early in a young person's developing psychosis. Rainbow Community Center has a family support component. The Workforce Education and Training Component funds NAMI's Family-to-Family training, where emotional support and assistance with how to navigate the system is provided, as well as the Family Volunteer Support Network, which is funded to recruit, train and develop family support volunteers to assist, educate and help families members to navigate services and enhance their capacity to participate in their loved ones' recovery.

3. **Support for peer and family partner providers.** (last year's rank: 11) CCBHS was acknowledged for hiring individuals who bring lived experience as consumers and/or family members of consumers. Their contributions have clearly assisted the County to move toward a more client and family member directed, recovery focused system of care. However, these individuals have noted the high incidence of turnover among their colleagues due to exacerbation of mental health issues brought on by work stressors, and lack of support for career progression. Individuals in recovery who are employed need ongoing supports that assist with career progression and normalize respites due to relapses.

   Relevant program/plan elements: CCBHS has strengthened its certification training for consumers who are preparing for a service provider role in the behavioral health system. Additional staff are funded to expand the SPIRIT curriculum to include preparing family members as well, provide ongoing career development and placement assistance, and develop ongoing supports for individuals with lived experience who are now working in the system.

4. **Outreach to the underserved – provide care in my community, in my culture, in my language.** (last year's rank: 2) Focus groups underscored that mental health stigma and non-dominant culture differences continue to provide barriers to seeking and sustaining mental health care. Emphasis should continue on recruiting and retaining cultural and linguistically competent service providers, training and technical assistance emphasis on treating the whole person, and the importance of providing on-going staff training on cultural-specific treatment modalities. Also, culture-specific service providers providing outreach and engagement should assist their consumers navigate all levels of service that is provided in the behavioral health system. Transition age youth, to include lesbian, gay, bi-sexual, transgender and questioning youth, who live in at-risk environments feel particularly vulnerable to physical harassment and bullying. Stakeholders continued to emphasize MHSA's role in funding access to all levels of service for those individuals who are poor and not Medi-Cal eligible.

   Relevant program/plan elements: All MHSA funded prevention and early intervention programs provide outreach and engagement to individuals and underserved populations who are at-risk for suffering the debilitating effects of serious mental illness. These programs are culture specific and will be evaluated by how well they assist individuals from non-dominant cultures obtain the cultural and linguistically appropriate mental health care needed. The training and technical assistance category of the Workforce Education and Training component utilizes MHSA funding to sensitize service providers to the issues impacting cultural awareness and understanding, and mental health access and service delivery for underserved cultural and ethnic populations. The Needs Assessment has indicated the underrepresentation of care provider staff who identify as Hispanic and Asian Pacific Islanders. Additional funds have been added to the Internship program to specifically recruit clinicians to address this underrepresentation.

5. **Improved response to crisis and trauma.** (last year's rank: 4) Response to crisis situations occurring in the community needs to be improved for both adults and children. Crisis response now primarily consists of psychiatric emergency services located at the Contra Costa Regional Medical Center (CCRMC). There are few more appropriate and less costly alternatives.

   Relevant program/plan elements: CCBHS should be part of a quality mental health response to traumatic violence experienced by the community. CCBHS has trained and certified a number of our mental health professionals to offer Mental Health First Aid training to community groups who have a special interest in responding to trauma events. A component of the training is strengthening the ability to identify the need for more intensive mental health care, as well as the ability to connect individuals to the right resources. Hope House, a crisis residential facility, and the Miller Wellness Center are two newer community resources. CCBHS was awarded state MHSA funding for a mobile, multi-disciplinary team for adults and older adults to partner with law enforcement to field a Mental Health Evaluation Team (MHET). Referrals are persons who have been in contact with the police on numerous occasions due to psychiatric issues and are at a high risk for hospitalization or incarceration. MHSA funds are used to augment and expand the capacity of CCBHS clinicians to assist law enforcement jurisdictions respond to persons experiencing psychiatric crises. Seneca Family of Agencies contracts with the County as part of the Children's Services full-service partnership program and provides a mobile response team for coordinating crisis support activities on behalf of youth and their families. Additional MHSA funding supports expanded hours of availability of Seneca's mobile crisis response team's capacity to respond to children and their families when in crisis. CCBHS also fields a countywide Mobile Crisis Response Team (MCRT) to support adult consumers experiencing mental health crises. MHSA also provides funding to the Contra Costa Crisis Center, which fields a 24/7 call center nationally certified by the American Association of Suicidology.

6. **Connecting with the right service providers in your community when you need it.** (last year's rank: 5) Mental health and its allied providers, such as primary care, alcohol and other drug services, housing and homeless services, vocational services, educational settings, social services and the criminal justice system provide a complexity of eligibility and paperwork requirements that can be defeating. Just knowing what and where services are can be a challenge. Easy access to friendly, knowledgeable individuals who can ensure connection to appropriate services is critical.

   Relevant program/plan elements: Family partners are stationed at the children's and adult County operated clinics to assist family members and their loved ones in navigating services. Clinicians are stationed at adult county operated clinics to assist consumers with rapid access and connectivity to services. The Workforce Education and Training Component funds NAMI's Family-to-Family training,

where emotional support and assistance with how to navigate the system is provided, as well as the Family Volunteer Support Network which recruits, trains and develops family support volunteers to support family members to navigate services and enhance their capacity to participate in their loved ones' recovery.

7. **Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care.** (last year's rank: 6) Integrating mental health, primary care, drug and alcohol, homeless services and employment services through a coordinated, multi-disciplinary team approach has been proven effective for those consumers fortunate to have this available. Often cited by consumers and their families was the experience of being left on their own to find and coordinate services, and to understand and navigate the myriad of eligibility and paperwork issues that characterize different service systems. Also cited was the difficulty of coordinating education, social services and the criminal justice systems to act in concert with the behavioral health system.

   Relevant Program/Plan Elements. The Three-Year Plan funds a number of multi-disciplinary teams that models effective integration of service providers for select groups of clients. However, this is a system issue that affects all programs and plan elements. The chapter entitled Evaluating the Plan describes the method by which every program and plan element will be evaluated as to the degree to which it communicates effectively with its community partners. The degree to which there is successful communication, cooperation and collaboration will be addressed in each written report, with program response and plan(s) of action required where attention is needed.

8. **Children and youth in-patient and residential beds.** (last year's rank: 9) In-patient beds and residential services for children needing intensive psychiatric care are not available in the county and are difficult to find outside the county. This creates a significant hardship on families who can and should be part of the treatment plan, and inappropriately strains care providers of more temporary (such as psychiatric emergency services) or less acute levels of treatment (such as Children's' clinics) to respond to needs they are ill equipped to address. Additional funding outside the Mental Health Services Act Fund would be needed to add this resource to the County, as in-patient psychiatric hospitalization is outside the scope of MHSA.

   Relevant Program/Plan Elements. In response to recent state legislation CCBHS will be offering the continuum of early and periodic screening, diagnosis and treatment (EPSDT) services to any specialty mental health service child and young adult who needs it. The Needs Assessment has indicated that seriously emotionally disturbed children ages 0-5 are slightly underrepresented in receiving care. This additional funding adds capacity for the Children's System of Care to serve more children ages 0-5. In addition, Assembly Bill 403 mandates statewide reform for care provided to foster care children, to include the County's responsibility to provide Therapeutic Foster Care (TFC) services. This expansion

of care responsibility enables the County to reduce the need for care in more restricted, locked facilities.

9. **Intervening early in psychosis.** (Previous rank: 8) Teenagers and young adults experiencing a first psychotic episode are at risk for becoming lifelong consumers of the public mental health system. Evidence based practices are now available that can successfully address this population by applying an intensive multi-disciplinary, family-based approach.

   Relevant program/plan elements: Project First Hope has expanded its target population from youth at risk for experiencing a psychotic episode to include those who have experienced a "first break".

10. **Getting to and from services.** (last year's rank: 7) The cost of transportation and the County's geographical challenges make access to services a continuing priority. Flexible financial assistance with both public and private transportation, training on how to use public transportation, driving individuals to and from appointments, and bringing services to where individuals are located, are all strategies needing strengthening and coordinating.

    Relevant program/plan elements: Transportation assets and flexible funds to assist consumers get to and from services are included in supports provided in Full-Service Partnerships. MHSA purchased vehicles to augment children, adult and older adult county operated clinic transportation assets, and additional staff are being hired through MHSA funding to drive consumers to and from appointments. The Innovative Project, Overcoming Transportation Barriers, has been implemented to provide a comprehensive, multi-faceted approach to transportation needs.

11. **Serve those who need it the most.** (last year's rank: 10) Through MHSA funding the County has developed designated programs for individuals with serious mental illness who have been deemed to need a full spectrum of services. These are described in the full-service partnership category of the Community Services and Supports component. In spite of these programs, stakeholders report that a number of individuals who have been most debilitated by the effects of mental illness continue to cycle through the costliest levels of care without success.

    Relevant program/plan elements: In February 2015, the Contra Costa Board of Supervisors passed a resolution authorizing $2.25 million of MHSA funds to be utilized on an annual basis for providing mental health treatment as part of an assisted outpatient treatment (AOT) program. The County implements the standards of an assertive community treatment team as prescribed by Assembly Bill 1421, and thus meet the acuity level of a full-service partnership. This program provides an experienced, multi-disciplinary team who provides around the clock mobile, out-of-office interventions to adults, a low participant to staff ratio, and provides the full spectrum of services, to include health, substance abuse, vocational and housing services. Persons deemed eligible for assisted

outpatient treatment are served, whether they volunteer for services, or are ordered by the court to participate.

12. **Care for the homebound frail and elderly.** (last year's rank: 13) Services for older adults continue to struggle with providing effective treatment for those individuals who are homebound and suffer from multiple physical and mental impairments. Often these individuals cycle through psychiatric emergency care without resolution.

    Relevant program/plan elements: MHSA funds the Older Adult Program, where three multi-disciplinary teams, one for each region of the County provide mental health services to older adults in their homes, in the community, and within a clinical setting. Lifelong Medical Care is funded in the Prevention and Early Intervention component to provide services designed to support isolated older adults. The Innovative Project, Partners in Aging, trains and fields in-home peer support workers to engage older adults who are frail, homebound and suffer from mental health issues. This innovative project is being implemented in response to the Needs Assessment, where older adults have been identified as underrepresented in the client population.

13. **Increased psychiatry time.** (last year: 12) Stakeholders reported long waiting periods before they could see a psychiatrist. This is confirmed by the quantitative workforce needs analysis that indicates a significant shortage of psychiatrists to fill authorized county and contract positions. This leads to a lack of needed psychotropic medication prescriptions, lack of time for psychiatrists to work as part of the treatment team, and a compromised ability to monitor and regulate proper dosages.

    Relevant program/plan elements: MHSA has supported the implementation of a County funded Loan Repayment Program that specifically addresses critical psychiatry shortages.

14. **Assistance with meaningful activity.** (last year's rank: 14) Stakeholders underscored the value of engaging in meaningful activity as an essential element of a treatment plan. Youth in high risk environments who are transitioning to adulthood were consistently noted as a high priority. For pre-vocational activities, suggested strategies include providing career guidance, assistance with eliminating barriers to employment, and assistance with educational, training and volunteer activities that improve job readiness. Stakeholders highlighted the need for better linkage to existing employment services, such as job seeking, placement and job retention assistance. For daily living skills, suggested strategies include assistance with money and benefits management, and improving health, nutrition, transportation, cooking, cleaning and home maintenance skill sets.

    Relevant program/plan elements: Putnam Clubhouse provides peer-based programming that helps individuals develop support networks, career development skills, and the self-confidence needed to sustain stable, productive

and more independent lives. The Prevention and Early Intervention programs of Contra Costa Interfaith Housing, Vicente Martinez Continuation High School, People Who Care and RYSE all have services to assist young people navigate school successfully and engage in meaningful activity.

Summary. The community program planning process identifies current and ongoing mental health service needs and provides direction for MHSA funded programs to address these needs. It also informs planning and evaluation efforts that can influence how and where MHSA resources can be directed in the future.

The full complement of MHSA funded programs and plan elements described in this document are the result of current as well as previous community program planning processes. Thus, this year's planning process builds upon previous ones. It is important to note that stakeholders did not restrict their input to only MHSA funded services but addressed the entire health and behavioral health system. The MHSA Three Year Program and Expenditure Plan operates within the laws and regulations provided for the use of the Mental Health Services Act Fund. Thus, the Three-Year Plan contained herein does not address all the prioritized needs identified in the community program planning process but does provide a framework for improving existing services and implementing additional programs as funding permits.

The following chapters contain programs and plan elements that are funded by the County's MHSA Fund, and will be evaluated by how well they address the Three-Year Plan's Vision and identified needs as prioritized by the Community Program Planning Process.

Community Services and Supports

Community Services and Supports is the component of the Three-Year Program and Expenditure Plan that refers to service delivery systems for mental health services and supports for children and youth, transition age youth (ages 16-25), adults, and older adults (over 60). Contra Costa County Behavioral Health Services utilizes MHSA funding for the categories of Full Service Partnerships and General System Development.

First approved in 2006 with an initial State appropriation of $7.1 million, Contra Costa's budget has grown incrementally to approximately $47.1 million for FY 2020-21 in commitments to programs and services under this component. The construction and direction of how and where to provide funding began with an extensive and comprehensive community program planning process whereby stakeholders were provided training in the intent and requirements of the Mental Health Services Act, actively participated in various venues to identify and prioritize community mental health needs, and developed strategies by which service delivery could grow with increasing MHSA revenues. The programs and services described below are directly derived from this initial planning process and expanded by subsequent yearly community program planning processes.

Full Service Partnerships
Contra Costa Behavioral Health Services both operates and contracts with mental health service providers to enter into collaborative relationships with clients, called Full Service Partnerships. Personal service coordinators develop an individualized services and support plan with each client, and, when appropriate, the client's family to provide a full spectrum of services in the community necessary to achieve agreed upon goals. Children (0 to 18 years) diagnosed with a serious emotional disturbance, transition age youth (16 to 25 years) diagnosed with a serious emotional disturbance or serious mental illness, and adults and older adults diagnosed with a serious mental illness are eligible. These services and supports include, but are not limited to crisis intervention/stabilization services, mental health and substance use disorder treatment, including alternative and culturally specific treatments, peer and family support services, access to wellness and recovery centers, and assistance in accessing needed medical, housing, educational, social, vocational rehabilitation and other community services, as appropriate. A qualified service provider is available to respond to the client/family 24 hours a day, seven days a week to provide after-hours intervention. As per statute requirements, these services comprise the majority of the Community Services and Supports budget.

Performance Indicators. The rates of in-patient psychiatric hospitalization and psychiatric emergency service (PES) episodes for persons participating in Full Service

Partnerships indicate whether Contra Costa's FSP programs promote less utilization of higher acute and more costly care. For FY 2018-19 data was obtained for 472 participants who were served by FSP programs. Use of PES and in-patient psychiatric hospitalization was compared before and after FSP participation, with the following results:

A 38.9% decrease in the number of PES episodes
A 60.1% decrease in the number of in-patient psychiatric hospitalizations
A 32.0% decrease in the number of in-patient psychiatric hospitalization days

The following full service partnership programs are now established:

Children. The Children's Full Service Partnership Program is comprised of four elements, 1) personal services coordinators, 2) multi-dimensional family therapy for co-occurring disorders, 3) multi-systemic therapy for juvenile offenders, and 4) county operated children's clinic staff.

1) Personal Service Coordinators. Personal service coordinators are part of a program entitled Short Term Assessment of Resources and Treatment (START). Seneca Family of Agencies contracts with the County to provide personal services coordinators, a mobile crisis response team, and three to six months of short-term intensive services to stabilize the youth in their community and to connect them and their families with sustainable resources and supports. Referrals to this program are coordinated by County staff on a countywide assessment team, and services are for youth and their families who are experiencing severe stressors, such as out-of-home placement, involvement with the juvenile justice system, co-occurring disorders, or repeated presentations at the County's Psychiatric Emergency Services.
2) Mobile Crisis Response. Additional MHSA funding supports the expansion of hours that Seneca's mobile crisis response teams are available to respond to children and their families in crisis. This expansion began in FY 2017-18 and includes availability to all regions of the county. Seneca has two teams available from 7:00 A.M. until 10:00 P.M. with on call hours 24/7 and the ability to respond to the field during all hours if indicated and necessary.
3) Multi-dimensional Family Therapy (MDFT) for Co-occurring Disorders. Lincoln Child Center contracts with the County to provide a comprehensive and multi-dimensional family-based outpatient program for adolescents with a mental health diagnosis who are experiencing a co-occurring substance abuse issue. These youth are at high risk for continued substance abuse and other problem behaviors, such as conduct disorder and delinquency. This is an evidence-based practice of weekly or twice weekly sessions conducted over a period of 4-6 months that target the youth's interpersonal functioning, the parents' parenting practices, parent-adolescent interactions, and family communications with key social systems.
4) Multi-systemic Therapy (MST) for Juvenile Offenders. Community Options for Families and Youth (COFY) contracts with the County to provide home-based multiple therapist family sessions over a 3-5 month period. These sessions are based on nationally recognized evidence-based practices designed to decrease

rates of anti-social behavior, improve school performance and interpersonal skills, and reduce out-of-home placements. The goal is to empower families to build a healthier environment through the mobilization of existing child, family and community resources.

5) Children's Clinic Staff. County clinical specialists and family partners serve all regions of the County and contribute a team effort to full service partnerships. Clinical specialists provide a comprehensive assessment on all youth deemed to be most seriously emotionally disturbed. The team presents treatment recommendations to the family, ensures the family receives the appropriate level of care, and family partners help families facilitate movement through the system.

The Children's Full Service Partnership Program is summarized below. Note that the total amount of these programs is funded by a combination of Medi-Cal reimbursed specialty mental health services and MHSA funds.

Amounts listed are the MHSA funded portion of the total cost:

Program/Plan Element	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 2020-21
Personal Service Coordinators	Seneca Family Agencies	Countywide	75	2,174,196
Multi-dimensional Family Therapy	Lincoln Child Center	Countywide	60	989,969
Multi-systemic Therapy	Community Options for Family and Youth	Countywide	65	1,107,602
Children's Clinic Staff	County Operated	Countywide	Support for full service partners	524,578
		Total	**200**	**$4,796,345**

Transition Age Youth. Eligible youth (ages 16-25) are individuals who are diagnosed with a serious emotional disturbance or serious mental illness, and experience one or more of the risk factors of homelessness, co-occurring substance abuse, exposure to trauma, repeated school failure, multiple foster care placements, and experience with the juvenile justice system.

Fred Finch Youth Center is located in West County and contracts with CCBHS to serve West and Central County. This program utilizes the assertive community treatment model as modified for young adults that includes a personal service coordinator working in concert with a multi-disciplinary team of staff, including peer and family mentors, a psychiatric nurse practitioner, staff with various clinical specialties, to include co-occurring substance disorder and bilingual capacity. In addition to mobile mental health and psychiatric services the program offers a variety of services designed to promote wellness and recovery, including assistance

finding housing, benefits advocacy, school and employment assistance, and support connecting with families.

Youth Homes is located in East County and contracts with CCBHS to serve Central and East County. This program emphasizes the evidence-based practice of integrated treatment for co-occurring disorders, where youth receive mental health and substance abuse treatment from a single treatment specialist, and multiple formats for services are available, to include individual, group, self-help and family. Youth Home's Short Term Residential Therapeutic Program (STRTP) also provides intensive individual mental health services to foster youth with a need for Specialty Mental Health Services (SMHS) who are residents in one of the STRTP programs, including limited follow up services for youth post residential discharge and their families, if appropriate. Services provided are Assessment, Individual Therapy, Collateral (including family therapy), Individual and Group Rehab, Crisis Intervention, Case Management Brokerage (including Linkage and Advocacy, and Placement), and Medication Evaluation and Medication Monitoring. All services are provided in a trauma informed, culturally sensitive, client-and-family centered, team-based manner and are individually determined based on need.

The Transition Age Youth Full Service Partnership Program is summarized below:

Program	**County/ Contract**	**Region Served**	**Number to be Served Yearly**	**MHSA Funds Allocated for FY 20-21**
Transition Age Youth Full Service Partnership	Fred Finch Youth Center	West and Central County	70	1,503,789
Transition Age Youth Full Service Partnership	Youth Homes	Central and East County	30	726,662
Transition Age Youth STRTPS and Outpatient	Youth Homes	Central County	24	2,096,385
County support costs				32,782
		Total	**150**	**$4,359,618**

Adult. Adult Full Service Partnerships provide a full spectrum of services and supports to adults over the age of 18 who are diagnosed with a serious mental illness, are at or below 200% of the federal poverty level and are uninsured or receive Medi-Cal benefits.

CCBHS contracts with Portia Bell Hume Behavioral Health and Training Center (Hume Center) to provide FSP services in the West and East regions of the County. Prior to COVID-19, the Hume contract was increased in order to provide enhanced services

including housing flex funds as well as serving 40 additional clients. Mental Health Systems takes the lead in providing full service partnership services to Central County, while Familias Unidas contracts with the County to provide the lead on full service partnerships that specialize in serving the County's LatinX population whose preferred language is other than English.

The Adult Full Service Partnership Program is summarized below:

Program/Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Full Service Partnership	Hume Center	West County East County	75 75	4,147,691
Full Service Partnership	Mental Health Systems	Central County	50	1,050,375
Full Service Partnership	Familias Unidas	West County	30	272,167
		Total	**275**	**$5,470,233**

Additional Services Supporting Full Service Partners. The following services are utilized by full service partners and enable the County to provide the required full spectrum of services and supports.

Adult Mental Health Clinic Support. CCBHS has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate.

Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management act as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care. Community Support Worker positions are stationed at all three adult clinics to support families of clients as they navigate and assist in the recovery of their loved ones.

The Adult Mental Health Clinic Support is summarized below:

Program/Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
FSP Support, Rapid Access	County Operated	West, Central, East County	Support for Full Service Partners	1,854,720
		Total		**$1,854,720**

Assisted Outpatient Treatment. In February 2015, the Contra Costa Board of Supervisors passed a resolution authorizing $2.25 million of MHSA funds to be utilized on an annual basis for providing mental health treatment as part of an assisted outpatient treatment (AOT) program. The County implements the standards of an assertive community treatment team as prescribed by Assembly Bill 1421, and thus meet the acuity level of a full service partnership. This program provides an experienced, multi-disciplinary team who provides around the clock mobile, out-of-office interventions to adults, a low participant to staff ratio, and provides the full spectrum of services, to include health, substance abuse, vocational and housing services. Persons deemed eligible for assisted outpatient treatment are served, whether they volunteer for services, or are ordered by the court to participate. CCBHS contracts with Mental Health Systems, Inc. to provide the Assertive Community Treatment (ACT), while CCBHS has dedicated clinicians and administrative support within the Forensic Mental Health Clinic to 1) receive referrals in the community, 2) conduct outreach and engagement to assist a referred individual, 3) conduct the investigation and determination of whether a client meets eligibility criteria for AOT, 4) prepare Court Petitions with supporting documentation and ongoing affidavits, 5) testify in court, 6) coordinate with County Counsel, Public Defender and law enforcement jurisdictions, 7) act as liaison with ACT contractor, and 8) participate in the development of the treatment plan.

The Assisted Outpatient Treatment Program is summarized in the following:

Program/ Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Assisted Outpatient Treatment	Mental Health Systems, Inc.	Countywide	75	2,136,653
Assisted Outpatient Treatment Clinic Support	County Operated	Countywide	Support for Assisted Outpatient Treatment	412,586
		Total	**75**	**$2,549,239**

Wellness and Recovery Centers. RI International contracts with the County to provide wellness and recovery centers situated in West, Central and East County to ensure the full spectrum of mental health services is available. These centers offer peer-led recovery-oriented, rehabilitation and self-help groups that teach self-management and coping skills. The centers offer Wellness Recovery Action Planning

(WRAP), physical health and nutrition education, advocacy services and training, arts and crafts, and support groups.

Program/Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Recovery and Wellness Centers	RI International	West, Central, East County	200	1,290,630
		Total	**200**	**$1,290,630**

Hope House - Crisis Residential Program. The County contracts with Telecare to operate a 16-bed crisis residential facility. This is a voluntary, highly structured treatment program that is intended to support seriously mentally ill adults during a period of crisis and to avoid in-patient psychiatric hospitalization. It also serves consumers being discharged from the hospital and long-term locked facilities that would benefit from a step-down from institutional care in order to successfully transition back into community living. Services are designed to be short term, are recovery focused with a peer provider component, and treat co-occurring disorders, such as drug and alcohol abuse.

Bay Area Community Services (BACS). The County contracts with BACS to operate two programs: 1) Nierika House, a short term crisis residential treatment program for adults living with a serious mental illness and dual diagnoses, located in Central County, and 2) Nevin House, a 16-bed facility in West County that provides transitional care in a therapeutic milieu for adults living with a co-occurring mental health and substance use disorders.

The Crisis Residential Program is summarized below:

Program	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Hope House - Crisis Residential Program	Telecare	Countywide	200	2,204,052
Bay Area Community Services	BACS	West and Central		1,762,140
		Total	**200**	**$3,966,192**

MHSA Funded Housing Supports. MHSA funds for housing supports supplements that which is provided by CCBHS and the County's Health, Housing and Homeless Services Division, and is designed to provide various types of affordable shelter and housing for low income adults with a serious mental illness or children with a severe emotional disorder and their families who are homeless or at imminent risk of chronic homelessness. Annual expenditures have been dynamic due to the variability of need, availability of beds and housing units, and escalating cost.

Housing supports are categorized as follows; 1) temporary shelter beds, 2) augmented board and care facilities or homes, 3) scattered site, or master leased housing, 4) permanent supportive housing, and 5) a centralized county operated coordination team.

1) Temporary Shelter Beds. The County's Health, Housing and Homeless Services Division operates a number of temporary bed facilities for adults and transitional age youth. CCBHS has a Memorandum of Understanding with the Health, Housing and Homeless Services Division that provides MHSA funding to enable individuals with a serious mental illness or a serious emotional disturbance to receive temporary emergency housing in these facilities. This agreement includes 400 bed nights per year for the Bissell Cottages and Appian House Transitional Living Programs, staff for the Calli House Youth Shelter, 23,360 bed nights for the Brookside and Concord temporary shelters, and 3,260 bed nights for the Respite Shelter in Concord.
2) Augmented Board and Care. The County contracts with a number of licensed board and care providers and facilities to provide additional funds to augment the rental amount received by the facility from the SSI rental allowance. These additional funds pay for facility staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community. An individualized services agreement for each person with a serious mental illness delineates needed supplemental care, such as assistance with personal hygiene, life skills, prescribed medication, transportation to health/mental health appointments, and connection with healthy social activities. Of these augmented board and care providers, there are currently seven that are MHSA funded, and augment their board and care with additional agreed upon care for persons with seriously mental illness. These include Divines, Modesto Residential, Oak Hill, Pleasant Hill Manor, United Family Care (Family Courtyard), Williams Board and Care Home, and Woodhaven. An eighth provider, Crestwood Healing Center, has 64 augmented board and care beds in Pleasant Hill, and has a 16-bed Pathways program that provides clinical mental health specialty services for up to a year (with a possible six month extension) for those residents considered to be most compromised by mental health issues. During this three year period CCBHS will seek to maintain and increase the number of augmented board and care beds available for adults with serious mental illness.
3) Scattered Site Housing. Shelter, Inc. contracts with the County to provide a master leasing program, in which adults or children and their families are provided tenancy in apartments and houses throughout the County. Through a combination of self-owned units and agreements with landlords Shelter, Inc. acts as the lessee to the owners and provides staff to support individuals and their families move in and maintain their homes independently.
   For this Three Year Plan the adult and transition age youth Full Service Partnership Programs will have funds added to enable flexible housing capacity as described above. The cost for this capacity is added to the respective budgets for the FSP Programs and is not reflected here.
4) Permanent Supportive Housing. Until 2016 the County participated in a specially legislated state- run MHSA Housing Program through the California Housing Finance Agency (CalHFA). In collaboration with many community partners the County embarked on a number of one-time capitalization projects to create 56 permanent housing units for individuals with serious mental illness. These

individuals receive their mental health support from CCBHS contract and county service providers. The sites include Villa Vasconcellos in Walnut Creek, Lillie Mae Jones Plaza in North Richmond, The Virginia Street Apartments in Richmond, Tabora Gardens in Antioch, Robin Lane apartments in Concord, Ohlone Garden apartments in El Cerrito, Third Avenue Apartments in Walnut Creek, Garden Park apartments in Concord, and scattered units throughout the County operated by Hope Solutions (formerly Contra Costa Interfaith Housing).

The aforementioned state-run program ended in 2016 and was replaced by the Special Needs Housing Program (SNHP). The County received and distributed $1.73 million in heretofore state level MHSA funds in order to preserve, acquire or rehabilitate housing units, and recently added 5 additional units of permanent supportive housing at the St. Paul Commons in Walnut Creek.

In July 2016 Assembly Bill 1618, or “No Place Like Home”, was enacted to dedicate in future years $2 billion in bond proceeds throughout the State to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness or are at risk of chronic homelessness. Local applications for construction and/or re-purposing of residential sites are being developed and submitted to the state. For the first round of NPLH state funding Contra Costa was awarded funding in partnership with Satellite Affordable Housing Association for construction of 10 dedicated NPLH units for persons with serious mental illness at their Veteran’s Square Project in the East region of the County. For the second round Contra Costa applied for funding to construct permanent supportive housing units in the Central and West regions of the County. An award was granted to Resources for Community Development in the amount of $6,000,103 for 13 NPLH Units at their Galindo Terrace development. CCBHS will continue to apply for State NPLH permanent supportive housing funds in future rounds in order to add this valuable resource as part of the full spectrum of care necessary for recovery from mental illness.

5) Coordination Team. Mental Health Housing Services Coordinator and staff work closely with the Health, Housing and Homeless Services Division staff to coordinate referrals and placements, facilitate linkages with other Contra Costa mental health programs and services, and provide contract monitoring and quality control.

The allocation for MHSA funded housing services is summarized below:

Plan Element	County/ Contract	Region Served	Number of MHSA beds, units budgeted	MHSA Funds Allocated for FY 20-21
Shelter Beds	County Operated	Countywide	75 beds (est.)	2,048,912
Augmented * Board and Care	Crestwood Healing Center	Countywide	80 beds	1,210,356
Augmented * Board and Care	Various	Countywide	330 beds	2,625,097
Scattered Site Housing	Shelter, Inc.	Countywide	119 units	2,420,426
Permanent Supportive Housing	Contractor Operated	Countywide	81 units	State MHSA funded
Coordination Team	County Operated	Countywide	Support to Homeless Program	532,200
		Total Beds/Units	**685 ****	**$8,836,991**

*Augmented Board and Care facility contracts vary in negotiated daily rate, and several contracts have both realignment as well as MHSA as funding sources. Thus, the budgeted amount for FY 20-21 may not match the total contract limit for the facility and beds available. The amount of MHSA funds budgeted are projections based upon the 1) history of actual utilization of beds paid by MHSA funding, 2) history of expenditures charged to MHSA, and 3) projected utilization for the upcoming year. CCBHS will continue to look for and secure additional augmented board and care beds. Annual Three Year Plan Updates will reflect adjustments in budgeted amounts.

****** It is estimated that over 1,000 individuals per year are receiving temporary or permanent supportive housing by means of MHSA funded housing services and supports. CCBHS is and will continue to actively participate in state and locally funded efforts to increase the above availability of supportive housing for persons with serious mental illness.

General System Development

General System Development is the service category in which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients who experience a serious mental illness or serious emotional disturbance, and to pay for mental health services for specific groups of clients, and, when appropriate, their families. Since the Community Services and Supports component was first approved in 2006, programs and plan elements included herein have been incrementally added each year by means of the community program planning process. These services are designed to support those individuals who need services the most.

Funds are now allocated in the General System Development category for the following

programs and services designed to improve the overall system of care:

Supporting Older Adults. There are two MHSA funded programs serving the older adult population over the age of 60, 1) Intensive Care Management, and 2) IMPACT (Improving Mood: Providing Access to Collaborative Treatment).

1) Intensive Care Management. Three multi-disciplinary teams, one for each region of the County, provide mental health services to older adults in their homes, in the community, and within a clinical setting. The primary goal is to support aging in place and to improve consumers' mental health, physical health and overall quality of life. Each multi-disciplinary team is comprised of a psychiatrist, a nurse, a clinical specialist, and a community support worker. The teams deliver a comprehensive array of care management services, linkage to primary care and community programs, advocacy, educational outreach, medication support and monitoring, and transportation assistance.
2) IMPACT. IMPACT is an evidence-based practice which provides depression treatment to older adults in a primary care setting who are experiencing co-occurring physical health impairments. The model involves short-term (8 to 12 visits) problem solving therapy and medication support, with up to one year follow-up as necessary. MHSA funded mental health clinicians are integrated into a primary treatment team.

The Older Adult Mental Health Program is summarized below:

Program	**County/ Contract**	**Region Served**	**Number to be Served Yearly**	**MHSA Funds Allocated for FY 20-21**
Intensive Care Management	County Operated	Countywide	237	3,036,899
IMPACT	County Operated	Countywide	138	381,744
		Total	**375**	**$3,418,643**

Supporting Children and Young Adults. There are two programs supplemented by MHSA funding that serve children and young adults: 1) Wraparound Program, and 2) expansion of the Early and Periodic Screening, Diagnosis and Treatment Program.

1) Wraparound Program. The County's Wraparound Program, in which children and their families receive intensive, multi-leveled treatment from the County's three children's mental health clinics, was augmented in 2008 by family partners and mental health specialists. Family partners are individuals with lived experience as parents of children and adults with serious emotional disturbance or serious mental illness who assist families with advocacy, transportation, navigation of the service system, and offer support in the home, community, and county service sites. Family partners participate as team members with the mental health clinicians who are providing treatment to children and their families. Mental Health Specialists are non-licensed care providers, often in successful recovery with lived experience as a

consumer or family member, who can address culture and language specific needs of families in their communities. These professionals arrange and facilitate team meetings between the family, treatment providers and allied system professionals.

2) EPSDT Expansion. EPSDT is a federally mandated specialty mental health program that provides comprehensive and preventative services to low income children and adolescents that are conjointly involved with Children and Family Services. State realignment funds have been utilized as the up-front match for the subsequent federal reimbursement that enables the County to provide the full scope of services. This includes assessment, plan development, therapy, rehabilitation, collateral services, case management, medication support, crisis services, intensive home-based services (IHBS), and Intensive Care Coordination (ICC). Recently the Department of Health Care Services has clarified that the continuum of EPSDT services are to be provided to any specialty mental health service beneficiary who needs it. In addition, Assembly Bill 403 mandates statewide reform for care provided to foster care children, to include the County's responsibility to provide Therapeutic Foster Care (TFC) services. This significant expansion of care responsibility, entitled Continuing Care Reform (CCR), will utilize MHSA funds as the up-front match for the subsequent federal reimbursement that enables the County to provide the full scope of services, and includes adding County mental health clinicians, family partners and administrative support.

The MHSA funded portion of the Children and Young Adult Programs are summarized in the following:

Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Wraparound Support	County Operated	Countywide	Supports Wraparound Program	1,419,138
EPSDT Expansion	County Operated	Countywide	Supports EPSDT Expansion	686,418
		Total		**$2,105,556**

Miller Wellness Center. The Miller Wellness Center, adjacent to the Contra Costa Regional Medical Center, co-locates primary care and mental health treatment for both children and adults, and is utilized to divert adults and families from the psychiatric emergency services (PES) located at the Regional Medical Center. Through a close relationship with Psychiatric Emergency Services children and adults who are evaluated at PES can quickly step down to the services at the Miller Wellness Center if they do not need hospital level of care. The Miller Wellness Center will also allow for urgent same day appointments for individuals who either are not open to the Contra Costa Behavioral Health Services System of Care or have disconnected from care after previously been seen. The Miller Wellness Center is certified as a federally qualified health center, and as such, receives federal financial participation for provision of specialty mental health services. MHSA funding is utilized to supplement this staffing

pattern with two community support workers to act as peer and family partner providers, and a program manager.

The MHSA allocation for the Miller Wellness Center is summarized below:

Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Supporting the Miller Wellness Center	County Operated	Countywide	Supports clients served by MWC	319,590
			Total	**$319,590**

Concord Health Center. The County's primary care system staffs the Concord Health Center, which integrates primary and behavioral health care. Two mental health clinicians are funded by MHSA to enable a multi-disciplinary team to provide an integrated response to adults visiting the clinic for medical services who have a co-occurring mental illness.

The allocation for this plan element is summarized below:

Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Supporting the Concord Health Center	County Operated	Central County	Supports clients served by Concord Health Center	254,496
			Total	**$254,496**

Liaison Staff. CCBHS partners with CCRMC to provide Community Support Worker positions to liaison with Psychiatric Emergency Services (PES) in order to assist individuals experiencing a psychiatric crisis connect with services that will support them in the community. These positions are on the CCBHS Transition Team, and schedule regular hours at PES.

The allocation for the Liaison Staff is as follows:

Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Supporting PES	County Operated	Countywide	Supports clients served by PES	145,907
			Total	**$145,907**

Clinic Support. County positions are funded through MHSA to supplement clinical staff implementing treatment plans at the adult clinics. These positions were created in direct response to identified needs surfaced in prior Community Program Planning Processes.

1) Case Management. For this three year period MHSA funds will be used to add Mental Health Specialist positions to increase the county operated adult clinics' case management capacity. These non-licensed staff will provide mental health and community support services to persons with serious mental illness, to include planning and monitoring of economic, vocational, educational, medical, socialization and housing services, linkage to requisite services, performing client advocacy and crisis intervention, and supporting clients in developing and maintaining the life skills required to achieve self-sufficiency. Adding these positions will increase the capacity of the clinics' mental health licensed staff to provide clinical treatment.
2) Resource Planning and Management. Dedicated staff at the three adult clinics assist consumers with money management and the complexities of eligibility for Medi-Cal, Medi-Care, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits. Money management staff are allocated for each clinic, and work with and are trained by financial specialists.
3) Transportation Support. The Community Program Planning Process identified transportation to and from clinics as a critical priority for accessing services. Toward this end one-time MHSA funds were purchased in prior years to purchase additional county vehicles to be located at the clinics. Community Support Workers have been added to adult clinics to be dedicated to the transporting of consumers to and from appointments.
4) Evidence Based Practices. Clinical Specialists, one for each Children's clinic, have been added to provide training and technical assistance in adherence to the fidelity of treatment practices that have an established body of evidence that support successful outcomes.

The allocations for Clinic Support Staff are as follows:

Plan Element	**County/ Contract**	**Region Served**	**Number to be Served Yearly**	**MHSA Funds Allocated for FY 20-21**
Case Management	County Operated	Countywide	Supplements Clinic Staff	1,000,000
Resource Planning and Management	County Operated	Countywide	Supplements Clinic Staff	780,546
Transportation Support	County Operated	Countywide	Supplements Clinic Staff	139,490
Evidence Based Practices	County Operated	Countywide	Supplements Clinic Staff	381,744
		Total		**$2,301,780**

Forensic Team. Clinical specialists are funded by MHSA to join a multi-disciplinary team that provides mental health services, alcohol and drug treatment, and housing supports to individuals with serious mental illness who are either referred by the courts for diversion from incarceration, or on probation and at risk of re-offending and incarceration. These individuals were determined to be high users of psychiatric emergency services and other public resources, but very low users of the level and type

of care needed. This team works very closely with the criminal justice system to assess referrals for serious mental illness, provide rapid access to a treatment plan, and work as a team to provide the appropriate mental health, substance abuse and housing services needed.

Mobile Crisis Response Team (MCRT). During the FY 2017-20 Three Year Plan the Forensic Team expanded its mobile crisis response capacity from fielding a mobile Mental Health Evaluation Team (MHET) with law enforcement to fielding a full Mobile Crisis Response Team to respond to adult consumers experiencing mental health crises in the community. Mental health clinicians and community support workers will work closely with the County's Psychiatric Emergency Services and law enforcement, if necessary, to respond to residents in crises who would be better served in their respective communities. MHSA funds will be utilized to supplement funding that enables this team to respond seven days a week with expanded hours of operation and the addition of two positions.

The allocation for mental health clinicians on the Forensic Team are as follows:

Plan Element	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Forensic Team	County Operated	Countywide	Support to the Forensic Team	381,744
MCRT	County Operated	Countywide	Supplements MCRT	1,276,560
			Total	**$1,658,304**

Quality Assurance and Administrative Support. MHSA funding supplements County resources to enable CCBHS to provide required administrative support, quality assurance and program evaluation functions for statutory, regulatory and contractual compliance, as well as management of quality of care protocols, such as fidelity to Assisted Outpatient Treatment and Assertive Community Treatment. County staff time and funding to support the mandated MHSA community program planning process are also included here. County positions have been incrementally justified, authorized and added each year as the total MHSA budget has increased.

The following functions and positions are summarized below:

1) Quality Assurance.

Function	MHSA Funds Allocated for FY 20-21
Medication Monitoring	241,158
Clinical Quality Management	726,568
Clerical Support	284,103
Total	**$1,251,829**

2) Administrative Support.

Function	MHSA Funds Allocated for FY 20-21
Program and Project Managers	803,419
Clinical Coordinator	120,643
Planner/Evaluators	508,877
Family Service Coordinator	108,333
Administrative and Financial Analysts	607,030
Clerical Support	310,325
Stakeholder Facilitation (contract)	15,000
ACT/AOT Fidelity Evaluation (contract)	100,000
Total	**$2,573,627**

Community Services and Supports (CSS) FY 20-21 Program Budget Summary

Full Service Partnerships		**Number to be Served: 700**	**$33,123,968**
	Children	4,796,345	
	Transition Age Youth	4,359,618	
	Adults	5,470,233	
	Adult Clinic Support	1,854,720	
	Assisted Outpatient Treatment	2,549,239	
	Wellness and Recovery Centers	1,290,630	
	Crisis Residential Center	3,966,192	
	MHSA Supportive Housing	8,836,991	
General System Development			$ **14,029,732**
	Older Adults	3,418,643	
	Children's Wraparound, EPSDT Support	2,105,556	
	Miller Wellness Center	319,590	
	Concord Health Center	254,496	
	Liaison Staff	145,907	
	Clinic Support	2,301,780	
	Forensic Team	1,658,304	
	Quality Assurance	1,251,829	
	Administrative Support	2,573,627	
	Total		**$47,153,700**

Prevention and Early Intervention

Prevention and Early Intervention (PEI) is the component of the Three-Year Plan that refers to services designed to prevent mental illnesses from becoming severe and disabling. This means providing outreach and engagement to increase recognition of early signs of mental illness and intervening early in the onset of a mental illness.

First approved in 2009, with an initial State appropriation of $5.5 million Contra Costa's Prevention and Early Intervention budget has grown incrementally to approximately $10.6 million annually in commitments to programs and services. The construction and direction of how and where to provide funding for this component began with an extensive and comprehensive community program planning process that was similar to that conducted in 2005-06 for the Community Services and Support component. Underserved and at risk populations were researched, stakeholders actively participated in identifying and prioritizing mental health needs, and strategies were developed to meet these needs. The programs and services described below are directly derived from this initial planning process, and expanded by subsequent yearly community program planning processes, to include current year.

New regulations for the PEI component went into effect on October 6, 2015. Programs in this component now focus their programming on one of the following seven PEI categories: 1) outreach for increasing recognition of early signs of mental illness; 2) prevention; 3) early intervention; 4) access and linkage to treatment; 5) improving timely access to mental health services for underserved populations; 6) stigma and discrimination reduction; and 7) suicide prevention. All of the programs contained in this component help create access and linkage to mental health treatment, with an emphasis on utilizing non-stigmatizing and non-discriminatory strategies, as well as outreach and engagement to those populations who have been identified as traditionally underserved.

Performance Indicators. PEI regulations also have new data reporting requirements that will enable CCBHS to report on the following performance indicators:

1) Outreach to Underserved Populations. Demographic data, such as age group, race/ethnicity and primary language enable an assessment of the impact of outreach and engagement efforts over time.

Demographic data was reported on 32,949 individuals served in Contra Costa Behavioral Health Services' Prevention and Early Intervention Programs for FY 2018-19. Within the seven PEI categories several programs focused their service delivery on traditionally underserved groups, such as recent immigrants, inner city youth, older adults, Native Americans, and persons who identify as LGBTQI+.

The following table illustrates *primary populations* served in Fiscal Year 18-19 by

Prevention and Early Intervention providers.

Prevention and Early Intervention Cultural and Linguistic Providers	
Provider	**Primary Population(s) Served**
Asian Family Resource Center	Asian / Pacific Islander (API)
Building Blocks for Kids (BBK)	African American / LatinX
Center for Human Development	African American / LGBTQI+
Child Abuse Prevention Council	LatinX
COPE / First Five	African American / LatinX
Hope Solutions (Interfaith Housing)	African American / LatinX
James Morehouse Project	African American / API / LatinX
Jewish Family Community Services of the East Bay	Afghan / Russian / Mid East (and other recent immigrants)
La Clinica	LatinX
Lao Family Development	API (and other recent immigrants)
Latina Center	LatinX
Lifelong (SNAP Program)	African American
Native American Health Center	Native American
People Who Care	African American / LatinX
Rainbow Community Center	LGBTQI+
RYSE	African American / LatinX
Stand!	African American / LatinX

It was noted that PEI programs served a larger percentage of African American / Black and LatinX / Hispanic community members than seen in the overall population. The below table summarizes how demographic groups are served by PEI programs. It should be noted that a significant number of participants declined to respond to surveys.

Demographic sub-group	**% PEI clients served in FY 18-19**
Asian	7%
African American / Black	14%
Caucasian / White	42%
LatinX / Hispanic	31%
Native American / Alaskan Native	<1%
Native Hawaiian / Other Pacific Islander	<1%
Multi-Racial	2%

In addition, 23% of persons served in PEI programs received services in their primary language of Spanish.

2) Linkage to Mental Health Care. Number of people connected to care, and average duration of reported untreated mental illness enable an assessment over time of impact of programs on connecting people to mental health care.

For FY 2018-19 PEI programs reported that, as a result of their referrals 1,872 persons engaged in mental health treatment and reported four weeks as the average length of time between referral and mental health service implementation. PEI programs

estimated an average duration of untreated mental illness of 17 weeks for persons who were referred for treatment. Of the 32,949 individuals who received PEI services in 18-19, 24% were Children & Transition Age Youth (TAY), 33% were Adults, 8% were Older Adults, and 36% declined to state. Further information about PEI Aggregate Data and Programs can be found in the Annual PEI Evaluation Report.

For the Three Year Plan for FY 2020-23 PEI programs are listed within the seven categories delineated in the PEI regulations.

Outreach for Increasing Recognition of Early Signs of Mental Illness
Programs in this category provide outreach to individuals with signs and symptoms of mental illness so they can recognize and respond to their own symptoms. Outreach is engaging, educating and learning from potential primary responders. Primary responders include, but are not limited to, families, employers, law enforcement, school, community service providers, primary health care, social services and faith based organizations.

Seven programs are included in this category:

1) Asian Family Resource Center provides culturally sensitive education and access to mental health services for immigrant Asian communities, especially the Southeast Asian and Chinese population of Contra Costa County. Staff provide outreach, medication compliance education, community integration skills, and mental health system navigation. Early intervention services are provided to those exhibiting symptoms of mental illness, and participants are assisted in actively managing their own recovery process.
2) The Counseling Options Parenting Education (COPE) Family Support Center utilizes the evidence-based practices of the Positive Parenting Program (Triple P) to help parents develop effective skills to address common child and youth behavioral issues that can lead to serious emotional disturbances. Targeting families residing in underserved communities this program delivers in English and Spanish a number of seminars, training classes and groups throughout the year.
3) First Five of Contra Costa, in partnership with the COPE Family Support Center, takes the lead in training families who have children up to the age of five. First Five also partners with the COPE Family Support Center to provide training in the Positive Parenting Program method to mental health practitioners who serve this at-risk population.
4) Hope Solutions (formerly Contra Costa Interfaith Housing) provides on-site services to formerly homeless families, all with special needs, at the Garden Park Apartments in Pleasant Hill, the Bella Monte Apartments in Bay Point, Los Medanos Village in Pittsburg, and supportive housing sites throughout the County. Services include coordination and assistance with accessing needed community resources, pre-school and afterschool programs, such as teen and family support groups, assistance with school preparation, and homework clubs. These services are

designed to prevent serious mental illness by addressing domestic violence, substance addiction and inadequate life and parenting skills.

5) Jewish Family Community Services of the East Bay provides culturally grounded, community-directed mental health education and navigation services to refugees and immigrants of all ages in the Latino, Afghan, Bosnian, Iranian and Russian communities of Central and East County. Outreach and engagement services are provided in the context of group settings and community cultural events that utilize a variety of non-office settings convenient to individuals and families.
6) The Native American Health Center provides a variety of culturally specific methods of outreach and engagement to educate Native Americans throughout the County regarding mental illness, identify those at risk for developing a serious mental illness, and help them access and navigate the human service systems in the County. Methods include an elder support group, a youth wellness group, a traditional arts group, talking circles, Positive Indian Parenting sessions, and Gatherings of Native Americans.
7) The Latina Center serves Latino parents and caregivers in West Contra Costa County by providing culturally and linguistically specific twelve-week parent education classes to high risk families utilizing the evidence based curriculum of Systematic Training for Effective Parenting (STEP). In addition, the Latina Center trains parents with lived experience to both conduct parenting education classes and to become Parent Partners who can offer mentoring, emotional support and assistance in navigating social service and mental health systems.

In addition, additional funding will be added for this Three Year Plan to provide prevention and early intervention services to families with young children who are experiencing serious emotional disturbances. The Needs Assessment and Community Program Planning Process has identified 0-5 age children with serious emotional disturbances as underserved. The FY 2017-20 MHSA Three Year Plan substantially increased funding for increasing treatment capacity in the Children's System of Care. The FY 2020-23 MHSA Three Year Plan will dedicate funding to provide outreach, engagement, training, education and linkage to mental health care for families with young children who are exposed to violence, physical and emotional abuse, parental loss, homelessness, the effects of substance abuse, and other forms of trauma.

The allocation for this category is summarized in the following:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Asian Family Resource Center	Countywide	50	146,317
COPE	Countywide	210	253,240
First Five	Countywide	(numbers included in COPE)	84,416
Hope Solutions	Central and East County	200	385,477
Jewish Family Community Services of the East Bay	Central and East County	350	179,720
Native American Health Center	Countywide	150	245,712
The Latina Center	West County	300	115,177
0-5 Children Outreach	Countywide	TBD	125,000
	Total	**1,260**	**$1,535,059**

Prevention

Programs in this category provide activities intended to reduce risk factors for developing a potentially serious mental illness, and to increase protective factors. Risk factors may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequality, substance abuse, domestic violence, previous mental illness, prolonged isolation, and may include relapse prevention for those in recovery from a serious mental illness.

a. Five programs are included in this category:
   1) The Building Blocks for Kids Collaborative, located in the Iron Triangle of Richmond, train family partners from the community with lived mental health experience to reach out and engage at-risk families in activities that address family mental health challenges. Individual and group wellness activities assist participants make and implement plans of action, access community services, and integrate them into higher levels of mental health treatment as needed.
   2) Vicente Alternative High School in the Martinez Unified School District provides career academies for at-risk youth that include individualized learning plans, learning projects, internships, and mental health education and counseling support. Students, school staff, parents and community partners work together on projects designed to develop leadership skills, a healthy lifestyle and pursuit of career goals.
   3) People Who Care is an afterschool program serving the communities of Pittsburg and Bay Point that is designed to accept referrals of at-risk youth from schools, juvenile justice systems and behavioral health treatment programs. Various vocational projects are conducted both on and off the program's premises, with selected participants receiving stipends to encourage leadership development. A

clinical specialist provides emotional, social and behavioral treatment through individual and group therapy.

4) Putnam Clubhouse provides peer-based programming for adults throughout Contra Costa County who are in recovery from a serious mental illness. Following the internationally recognized clubhouse model this structured, work focused programming helps individuals develop support networks, career development skills, and the self-confidence needed to sustain stable, productive and more independent lives. Features of the program provide respite support to family members, peer-to-peer outreach, and special programming for transition age youth and young adults.
5) The RYSE Center provides a constellation of age-appropriate activities that enable at-risk youth in Richmond to effectively cope with the continuous presence of violence and trauma in the community and at home. These trauma informed programs and services include drop-in, recreational and structured activities across areas of health and wellness, media, arts and culture, education and career, technology, and developing youth leadership and organizing capacity. The RYSE Center facilitates several city and system-wide training and technical assistance events to educate the community on mental health interventions that can prevent serious mental illness as a result of trauma and violence.

The allocation for this category is summarized below:

Program	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 20-21
Building Blocks for Kids	West County	400	223,404
Vicente	Central County	80	191,337
People Who Care	East County	200	229,795
Putnam Clubhouse	Countywide	300	600,345
RYSE	West County	2,000	518,110
	Total	**2,980**	**$1,762,991**

Early Intervention

Early intervention provides mental health treatment for persons with a serious emotional disturbance or mental illness early in its emergence.

a. The County operated First Hope Program serves youth who show early signs of psychosis or have recently experienced a first psychotic episode. Referrals are accepted from all parts of the County, and through a comprehensive assessment process young people, ages 12-25, and their families are helped to determine whether First Hope is the best treatment to address the psychotic illness and associated disability. A multi-disciplinary team provides intensive care to the individual and their family, and consists of psychiatrists, mental health clinicians, occupational therapists and employment/education specialists. These services are based on the Portland Identification and Early Referral (PIER) Model, and consists

of multi-family group therapy, psychiatric care, family psychoeducation, education and employment support, and occupational therapy.

The allocation for this program is summarized below:

Program	Region Served	Number to be Served Yearly	Funds Allocated for FY 20-21
First Hope	Countywide	200	2,587,108
	Total	**200**	**$2,587,108**

Access and Linkage to Treatment

Programs in this category have a primary focus on screening, assessment, and connecting children and adults as early as practicable to necessary mental health care and treatment.

a. Three programs are included in this category:
   1) The James Morehouse Project at El Cerrito High School, a student health center that partners with community-based organizations, government agencies and local universities, provides a range of youth development groups designed to increase access to mental health services for at-risk high school students. These on-campus groups address mindfulness (anger/stress management), violence and bereavement, environmental and societal factors leading to substance abuse, peer conflict mediation and immigration/acculturation.
   2) STAND! Against Domestic Violence utilizes established curricula to assist youth successfully address the debilitating effects of violence occurring both at home and in teen relationships. Fifteen-week support groups are held for teens throughout the County, and teachers and other school personnel are assisted with education and awareness with which to identify and address unhealthy relationships amongst teens that lead to serious mental health issues.
   3) Experiencing the Juvenile Justice System. Within the County operated Children's Services five mental health clinicians support families who are experiencing the juvenile justice system due to their adolescent children's involvement with the law. Three clinicians are out-stationed at juvenile probation offices. The clinicians provide direct short-term therapy and coordinate appropriate linkages to services and supports as youth transition back into their communities.

The allocation for this category is summarized in the following:

Program	Region Served	Number to be Served Yearly	Funds Allocated for FY 20-21
James Morehouse Project	West County	300	105,983
STAND! Against Domestic Violence	Countywide	750	138,136
Experiencing Juvenile Justice	Countywide	300	381,744
Total		**1,350**	**$625,863**

Improving Timely Access to Mental Health Services for Underserved Populations. Programs in this category provide mental health services as early as possible for individuals and their families from an underserved population. Underserved means not having access due to challenges in the identification of mental health needs, limited language access, or lack of culturally appropriate mental health services. Programs in this category feature cultural and language appropriate services in convenient, accessible settings.

a. Six programs are included in this category:

1) The Center for Human Development fields two programs under this category. The first is an African American wellness group that serves the Bay Point community in East Contra Costa County. Services consist of culturally appropriate education on mental health issues through support groups and workshops. Participants at risk for developing a serious mental illness receive assistance with referral and access to County mental health services. The second program provides mental health education and supports for LGBTQ youth and their supports in East County to work toward more inclusion and acceptance within schools and in the community.
2) The Child Abuse Prevention Council of Contra Costa provides a 23-week curriculum designed to build new parenting skills and alter old behavioral patterns and is intended to strengthen families and support the healthy development of their children. The program is designed to meet the needs of Spanish speaking families in East and Central Counties.
3) La Clinica de la Raza reaches out to at-risk Latina/os in Central and East County to provide behavioral health assessments and culturally appropriate early intervention services to address symptoms of mental illness brought about by trauma, domestic violence and substance abuse. Clinical staff also provide psycho-educational groups that address the stress factors that lead to serious mental illness.
4) Lao Family Community Development provides a comprehensive and culturally sensitive integrated system of care for Asian and Southeast Asian adults and families in West Contra Costa County. Staff provide comprehensive case management services, to include home visits, counseling, parenting classes, and assistance accessing employment, financial management, housing, and other service both within and outside the agency.
5) Lifelong Medical Care provides isolated older adults in West County opportunities for social engagement and access to mental health and social services. A variety of group and one-on-one approaches are employed in three housing developments to engage frail, older adults in social activities, provide screening for depression and other mental and medical health issues, and linking them to appropriate services.
6) Rainbow Community Center provides a community based social support program designed to decrease isolation, depression and suicidal ideation among

members who identify as lesbian, gay, bisexual, transgender, or who question their sexual identity. Key activities include reaching out to the community in order to engage those individuals who are at risk, providing mental health support groups that address isolation and stigma and promote wellness and resiliency, and providing clinical mental health treatment and intervention for those individuals who are identified as seriously mentally ill.

The allocation for this category is summarized below:

Program	Region Served	Number to be Served Yearly	Funds Allocated for FY 2020-21
Child Abuse Prevention Council	Central and East County	120	128,862
Center for Human Development	East County	230	161,644
La Clinica de la Raza	Central and East County	3,750	288,975
Lao Family Community Development	West County	120	196,128
Lifelong Medical Care	West County	115	134,710
Rainbow Community Center	Countywide	1,125	782,143
	Total	**5,460**	**$1,692,462**

Stigma and Discrimination Reduction
Activities in this category are designed to 1) reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to having a mental illness, 2) increase acceptance, dignity, inclusion and equity for individuals with mental illness and their families, and 3) advocate for services that are culturally congruent with the values of the population for whom changes, attitudes, knowledge and behavior are intended.

a. The County operated Office for Consumer Empowerment (OCE) provides leadership and staff support to a number of initiatives designed to reduce stigma and discrimination, develop leadership and advocacy skills among consumers of behavioral health services, support the role of peers as providers, and encourage consumers to actively participate in the planning and evaluation of MHSA funded services. Staff from the OCE support the following activities designed to educate the community in order to raise awareness of the stigma that can accompany mental illness.
   1) The PhotoVoice Empowerment Project enables consumers to produce artwork that speaks to the prejudice and discrimination that people with behavioral health challenges face. PhotoVoice's vision is to enable people to record and reflect their community's strengths and concerns, promote critical dialogue about personal and community issues, and to reach policymakers to effect change.
   2) The Wellness Recovery Education for Acceptance, Choice and Hope (WREACH) Speakers' Bureau forms connections between people in the community and people with lived mental health and co-occurring experiences, using face to face

contact by providing stories of recovery and resiliency and current information on health treatment and supports. Other related activities include producing videos, public service announcements and educational materials.

3) The OCE facilitates Wellness Recovery Action Plan (WRAP) groups by providing certified leaders and conducting classes throughout the County. Staff employ the evidence-based WRAP system in enhancing the efforts of consumers to promote and advocate for their own wellness. OCE also supports a writers' group in partnership with the Contra Costa affiliate of the National Alliance on Mental Illness (NAMI).
4) The Committee for Social Inclusion is an ongoing alliance of committee members that work together to promote social inclusion of persons who receive behavioral health services. The Committee is project based, and projects are designed to increase participation of consumers and family members in the planning, implementation and delivery of services. Current efforts are supporting the integration of mental health and alcohol and other drug services within the Behavioral Health Services Division. In addition, OCE staff assist and support consumers and family members in participating in the various planning committees and sub-committees, Mental Health Commission meetings, community forums, and other opportunities to participate in planning processes.
5) Through the Each Mind Matters initiative California Mental Health Services Authority (CalMHSA) provides technical assistance to encourage the County's integration of available statewide resources on stigma and discrimination reduction and suicide prevention. CCBHS partners via Memorandum of Understanding (MOU) with CalMHSA to link county level stigma and discrimination reduction efforts with statewide social marketing programs. This linkage will expand the County's capacity via language specific materials, social media, and subject matter consultation with regional and state experts to reach diverse underserved communities, such as Hispanic, African American, Asian Pacific Islander, LGBTQ, Native American and immigrant communities. Primary focus will be to reach Spanish speaking Latina/o communities via social media and materials adapted specifically for this population.

The allocation for stigma and discrimination efforts are summarized in the following:

Program	County/Contract	Region Served	Funds Allocated for FY 20-21
OCE	County Operated	Countywide	218,861
CalMHSA	MOU	Countywide	78,000
		Total	**$296,861**

Suicide Prevention

There are three plan elements that support the County's efforts to reduce the number of suicides in Contra Costa County: 1) augmenting the Contra Costa Crisis Center, and 2) supporting a suicide prevention committee. Additional funds are allocated to dedicate staff trained in suicide prevention to provide countywide trainings, education and consultation for a host of entities such as schools, social service providers, criminal

justice and first responder community based organizations to know the signs of persons at risk of suicide, assess lethality and respond appropriately.

1) The Contra Costa Crisis Center provides services to prevent suicides by operating a certified 24-hour suicide prevention hotline. The hotline connects with people when they are most vulnerable and at risk for suicide, enhances safety, and builds a bridge to community resources. Staff conduct a lethality assessment on each call, provide support and intervention for the person in crisis, and make follow-up calls (with the caller's consent) to persons who are at medium to high risk of suicide. MHSA funds enable additional paid and volunteer staff capacity, most particularly in the hotline's trained multi-lingual, multi-cultural response.
2) A multi-disciplinary, multi-agency Suicide Prevention Committee has been established, and has published a countywide Suicide Prevention Strategic Plan. This ongoing committee oversees the implementation of the Plan by addressing the strategies outlined in the Plan. These strategies include i) creating a countywide system of suicide prevention, ii) increasing interagency coordination and collaboration, iii) implementing education and training opportunities to prevent suicide, iv) implementing evidence based practices to prevent suicide, and v) evaluating the effectiveness of the County's suicide prevention efforts.

The allocation for this category is summarized in the following:

Plan Element	Region Served	Number to be Served Yearly	Funds Allocated for FY 20-21
Contra Costa Crisis Center	Countywide	25,000	320,006
Suicide Prevention Training	Countywide		50,000
County Supported	Countywide	N/A	Included in PEI administrative cost
	Total	**25,050**	**$370,006**

PEI Administrative Support

Staff time has been allocated by the County to provide administrative support and evaluation of programs and plan elements that are funded by MHSA. The allocation for this activity is summarized below:

Plan Element	Region Served	Yearly Funds Allocated
Administrative and Evaluation Support	Countywide	158,090
	Total	**$158,090**

Prevention and Early Intervention (PEI) Summary for FY 2020-21

Outreach for Increasing Recognition of Early Signs of Mental Illness	1,535,059
Prevention	1,762,991
Early Intervention	2,587,108
Access and Linkage to Treatment	625,863
Improving Timely Access to Mental Health Services for Underserved Populations	1,692,462
Stigma and Discrimination Reduction	296,861
Suicide Prevention	370,006
Administrative, Evaluation Support	158,090
Total	**$9,028,430**

Innovation

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

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

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2020-21:

1) Coaching to Wellness. Individuals who have experience as a consumer and/or family member of the mental health system have been trained to provide mental health and health wellness coaching to recipients of integrated health and mental health services within CCBHS. These peer providers are part of the County's Behavioral Health Services integration plans that are currently being implemented and are assigned to the adult mental health clinics. The Coaches have received training specific to the skill sets needed to improve health and wellness outcomes for consumers. The Coaching to Wellness Project began implementation in FY 2015-16 and will sunset in FY 20-21.
2) Partners in Aging. Older adults who are frail, homebound and suffer from mental health issues experience higher rates of isolation, psychiatric emergency interventions, and institutionalization that could be prevented. Field-based peer support workers engage older adults who have been identified by their IMPACT clinicians, primary care providers, or Psychiatric Emergency Services as individuals who need additional staff care in order to avoid repeated crises, engage in ongoing mental health treatment, increase their skills in the activities of daily living, and engage appropriate resources and social networks. The Partners in Aging Project began implementation in FY 2016-17.
3) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's community program planning process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include

training consumers to independently navigate public transportation, providing flexible resources to assist with transportation costs, educating consumers regarding schedules, costs and means of various modes of public transportation, and creating a centralized staff response to coordinate efforts and respond to emerging transportation needs. Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY 2016-17.

4) Center for Recovery and Empowerment (CORE). CCBHS recognizes substance abuse/dependence in adolescence as it negatively affects physical, social, emotional and cognitive development. Early onset of alcohol or other drug use is one of the strongest predictors of later alcohol dependence. This is a priority because CCBHS does not have a coordinated system of care to provide treatment services to youth with addictions and co-occurring emotional disturbances. The CORE Project is an intensive outpatient treatment program offering three levels of care: intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. Services will be provided by a multi-disciplinary team, and includes individual, group and family therapy, and linkage to community services.
5) Cognitive Behavioral Social Skills Training (CBSST). The project is designed to enhance the quality of life for the those residing in enhanced board & care homes by incorporating meaningful activity and skills into their daily routines and increasing overall functional improvement. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project applies this therapeutic practice to the population of individuals that have been placed in augmented board and care facilities. The CBSST Project has a clinical team, consisting of a licensed clinician and peer support worker, to lead cognitive behavioral social skills training groups at board and care facilities. Adults with serious mental illness learn and practice skills that enable them to achieve and consolidate recovery-based skills, while decreasing the need for costly interventions such as PES admissions. Funds have been added to expand services to reach additional board & care residents.

The allocation for these projects is summarized below:

Project	**County/ Contract**	**Region Served**	**Number to be Served Yearly**	**MHSA Funds Allocated for FY 20-21**
Coaching to Wellness	County Operated	Countywide	90	145,907
Partners in Aging	County Operated	Countywide	45	133,072
Overcoming Transportation Barriers	County Operated	Countywide	200	106,856
Center for Recovery and Empowerment	County Operated	West	80	1,152,936
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	400,403
Administrative Support	County	Countywide	Innovation Support	364,363
		Total	**520**	**$2,303,537**

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Workforce Education and Training

Workforce Education and Training (WET) is the component of the Three Year Plan that provides education and training, workforce activities, to include career pathway development, and financial incentive programs for current and prospective CCBHS employees, contractor agency staff, and consumer and family members who volunteer their time to support the public mental health effort. The purpose of this component is to develop and maintain a diverse mental health workforce capable of providing consumer and family-driven services that are compassionate, culturally and linguistically responsive, and promote wellness, recovery and resilience across healthcare systems and community-based settings.

CCBHS's WET Plan was developed and approved in May 2009, with subsequent yearly updates. The following represents funds and activities allocated in the categories of 1) Workforce Staffing Support, 2) Training and Technical Assistance, 3) Mental Health Career Pathway Programs, 4) Internship Programs, and 5) Financial Incentive Programs.

Workforce Staffing Support

1) Workforce Education and Training Coordination. County staff are designated to develop and coordinate all aspects of this component. This includes conducting a workforce needs assessment, coordinating education and training activities, acting as an educational and training resource by participating in the WET Greater Bay Area Regional Partnership and state level workforce activities, providing staff support to County sponsored ongoing and ad-hoc workforce workgroups, developing and managing the budget for this component, applying for and maintaining the County's mental health professional shortage designations, applying for workforce grants and requests for proposals, coordinating intern placements throughout the County, and managing the contracts with various training providers and community based organizations who implement the various workforce education and training activities.
2) Supporting Family Members. For the Three Year Plan a cadre of volunteers are recruited, trained and supervised for the purpose of supporting family members and significant others of persons experiencing mental illness. Critical to successful treatment is the need for service providers to partner with family members and significant others of loved ones experiencing mental illness. Family members of consumers should be provided with assistance to enable them to become powerful natural supports in the recovery of their loved ones. Stakeholders continue to underscore the need to provide families and significant others with education and training, emotional support, and assistance with navigating the behavioral health system. CCBHS contracts with National Alliance on Mental Illness Contra Costa (NAMI CC) to recruit, train and develop family members with lived experience to act as subject matter experts in a volunteer capacity to educate and support other family

members in understanding and best navigating and participating in the different systems of care.

3) Senior Peer Counseling Program. The Senior Peer Counseling Program within the CCBHS Older Adult Program recruits, trains and supports volunteer peer counselors to reach out to older adults at risk of developing mental illness by providing home visits and group support. Two clinical specialists support the efforts aimed at reaching Latina/o and Asian American seniors. The volunteers receive extensive training and consultation support.

The MHSA funding allocation for this category is summarized below:

Program/Plan Element	County/ Contract	Region Served	MHSA Funds Allocated for FY 20-21
WET Coordination	County Operated	Countywide	386,542
Supporting Families	NAMI CC	Countywide	618,000
Senior Peer Counseling	County Operated	Countywide	254,496
	Total		**$1,259,038**

Training and Technical Support

1) Staff Training. Various individual and group staff trainings will be funded that support the values of the MHSA. As a part of the MHSA community program planning process, staff development surveys, CCBHS's Training Advisory Workgroup and Reducing Health Disparities Workgroup, stakeholders identified six staff training and training-related themes; 1) Client Culture, 2) Knowledge and Skills, 3) Management, 4) Orientation, 5) Career Development, and 6) Interventions/Evidence Based Practices. Within these themes a number of training topics were listed and prioritized for MHSA funding in the Three-Year Plan.
2) NAMI Basics/Faith Net/Family to Family (De Familia a Familia). NAMI CC will offer these evidence-based NAMI educational training programs on a countywide basis to culturally diverse family members and care givers of individuals experiencing mental health challenges. These training programs are designed to support and increase family members' knowledge of mental health issues, navigation of systems, coping skills, and connectivity with community resources that are responsive and understanding of the challenges and impact of mental illness on the entire family.
3) Crisis Intervention Training. CCBHS partners with the County's Sherriff's Department to provide three-day Crisis Intervention Trainings twice a year for law enforcement officers so that they are better able to respond safely and compassionately to crisis situations involving persons with mental health issues. Officers learn from mental health professionals, experienced officers, consumers and family members who advise, problem-solve and support with verbal de-escalation skills, personal stories, and provide scenario-based training on responding to crises.
4) Mental Health First Aid Instructor Training. CCBHS works with the National Council to train staff to become certified instructors for Mental Health First Aid. These instructors will then provide Mental Health First Aid Training to community and faith-based organizations and agencies who are often first responders to community

trauma, violence or natural disaster. Mental Health First Aid is a proprietary evidence based in-person training for anyone who wants to learn about mental illness and addictions, including risk factors and warning signs. This eight-hour training provides participants with a five step action plan to help a person in crisis connect with professional, peer, social, and self-help care. Participants are given the opportunity to practice their new skills and gain confidence in helping others who may be developing a mental health or substance use challenge, or those in distress.

The MHSA funding allocation for this category is summarized below:

Plan Element	County/Contract	Region Served	MHSA Funds Allocated for FY 20-21
Staff Training	Various vendors	Countywide	238,203
NAMI Basics/ Faith Net/ De Familia a Familia	NAMI-Contra Costa	Countywide	70,596
Crisis Intervention Training	County Sherriff's Department	Countywide	15,000
Mental Health First Aid	The National Council	Countywide	20,000
	Total		**$343,799**

Mental Health Career Pathway Program

1) Service Provider Individualized Recovery Intensive Training (SPIRIT). SPIRIT is a college accredited recovery oriented, peer led classroom and experiential-based program for individuals with lived mental health experience as a consumer or a family member of a consumer. This classroom and internship experience leads to a certification for individuals who successfully complete the program and is accepted as the minimum qualifications necessary for employment within CCBHS in the classification of Community Support Worker. Participants learn peer provider skills, group facilitation, Wellness Recovery Action Plan (WRAP) development, wellness self-management strategies and other skills needed to gain employment in peer provider and family partner positions in both county operated and community-based organizations. The Office for Consumer Empowerment (OCE) offers this training annually and supplements the class with a monthly peer support group for those individuals who are employed by the County in various peer and family partner roles. The SPIRIT Program also provides support and assistance with placement and advancement for SPIRIT graduates consistent with their career aspirations.

The MHSA funding allocation for this category is summarized below:

Program	County/ Contract	Region Served	Number to be Trained Yearly	MHSA Funds Allocated for FY 20-21
SPIRIT	OCE County Staff	Countywide	50	346,258
	Contra Costa College			25,000
		Total	**50**	**$371,258**

Internship Programs

1) Internships. CCBHS supports internship programs which place graduate level students in various County operated and community-based organizations. Particular emphasis is put on the recruitment of individuals who are bi-lingual and/or bi-cultural, individuals with consumer and/or family member experience, and individuals who can reduce the disparity of race/ethnicity identification of staff with that of the population served. CCBHS provides funding to enable approximately 75 graduate level students to participate in paid internships in both county operated and contract agencies that lead to licensure as a Marriage and Family Therapist (MFT), Licensed Clinical Social Worker (LCSW), Clinical Psychologist and Mental Health Nurse Practitioner. These County financed internships are in addition to and separate from the state level workforce education and training stipend programs that are funded by the California Office of Statewide Health Planning and Development. This state funded stipend program requires that participants commit to working in community public mental health upon graduation. The County's assessment of workforce needs has determined that a combination of state and locally financed internships has enabled the County and its contractors to keep pace with the annual rate of turnover of licensed staff.

The MHSA funding allocation for this category is summarized below:

Program	County/ Contract	Region Served	Number to be Trained	MHSA Funds Allocated for FY 20-21
Graduate Level Internships	County Operated	Countywide		252,350
Graduate Level Internships	Contract Agencies	Countywide		100,000
		Total	**75**	**$352,350**

Financial Incentive Programs

1) Loan Repayment Program. For the Three Year Plan CCBHS is continuing its County funded and administered Loan Repayment Program that addresses critical staff shortages, such as language need, psychiatrists, hard to fill and retain positions, and provides potential career advancement opportunities for CCBHS Community Support Workers and contract providers performing in the roles of peer provider and family partner. CCBHS partners with the California Mental Health Services Authority (CalMHSA) to administer a loan repayment program patterned after state level loan repayment programs but differing in providing flexibility in the amount awarded to each individual, and the County selecting the awardees based upon workforce need.

The MHSA funding allocation for this category is summarized below:

Program	County/ Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 2020-21
Loan Repayment	CalMHSA	Countywide	Variable	300,000
			Total	**$300,000**

Workforce Education and Training (WET) Component Budget Authorization for FY 2020-21:

Workforce Staffing Support	1,259,038
Training and Technical Assistance	343,799
Mental Health Career Pathways	371,258
Internship Program	352,350
Loan Forgiveness Program	300,000
Total	**$2,626,445**

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Capital Facilities/Information Technology

The Capital Facilities/Information Technology component of the Mental Health Services Act enables counties to utilize MHSA funds on a one-time basis for major infrastructure costs necessary to i) implement MHSA services and supports, and ii) generally improve support to the County's community mental health service system.

For the Three-Year Plan Contra Costa has one Information Technology Project.

Information Technology

1) Electronic Mental Health Record System – Data Management. Contra Costa received approval from the State to utilize MHSA funds to develop and implement an electronic mental health record system. The project has transformed the current paper and location-based system with an electronic system where clinical documentation can be centralized and made accessible to all members of a consumer's treatment team, with shared decision-making functionality. It replaced the existing claims system, where network providers and contract agencies would be part of the system and be able to exchange their clinical and billing information with the County. The electronic health record system now allows doctors to submit their pharmacy orders electronically, permit sharing between psychiatrists and primary care physicians to allow knowledge of existing health conditions and drug inter-operability, and allows consumers to access part of their medical record, make appointments, and electronically communicate with their treatment providers.

   For the upcoming three-year period CCBHS will set aside MHSA Information Technology component funds to build into this electronic system CCBHS data management capability by means of ongoing and ad hoc reports. These reports will be electronically accessed via the Health Services' iSITE, and will depict a series of performance indicators, such as productivity, service impact, resource management, and quality assurance. This will enable more effective analysis, decision-making, communication and oversight of services by providing visibility of selected indicators that can influence the quality and quantity of behavioral health care that is provided.

Capital Facilities

1) Capital Facilities Project. Funds have been set aside to support upcoming Capital Facilities projects that may arise in the upcoming cycle.

Capital Facilities/ Information Technology (CFTN) Budget Authorization for FY 2020-21:

Electronic Mental Health Data Management System	250,000
Capital Facilities Projects	250,000
Total	**$500,000**

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The Budget

Previous chapters provide detailed projected budgets for individual MHSA plan elements, projects, programs, categories and components for FY 2020-21. The following table summarizes the total MHSA spending authority by component for each year of the Three-Year Plan.

	CSS	PEI	INN	WET	CF/TN	TOTAL
FY 20/21	47,153,700	9,028,430	2,303,537	2,626,445	500,000	61,612,112
FY 21/22	42,107,484	9,028,430	2,303,538	2,626,445	250,000	56,315,897
FY 22/23	41,357,484	9,028,430	2,303,538	2,626,445	250,000	55,565,897

Appendix E, entitled *Funding Summaries,* provides a FY 2020-21 through FY 2022-23 Three Year Mental Health Services Act Expenditure Plan. This funding summary matches budget authority with projected revenues and shows sufficient MHSA funds are available to fully fund all programs, projects and plan elements for the duration of the three year period. The following fund ledger depicts projected available funding versus total budget authority for each year of the Three-Year Plan:

Fiscal Year 2020/21

A. Estimated FY 2020/21 Available Funding	CSS	PEI	INN	WET	CF/TN	TOTAL
1.Estimated unspent funds from prior fiscal years	35,264,485	6,931,380	5,088,324	835,529	3,819,504	51,939,221
2. Estimated new FY 20/21 funding	42,035,398	9,525,844	2,713,750	0	0	54,274,992
3. Transfers in FY 20/21	(8,108,453)			8,108,453		
4.Estimated available funding for FY 20/21	69,191,430	16,457,224	7,802,074	8,943,982	3,819,504	106,214,214
B. Budget Authority for FY20/21	47,153,700	9,028,430	2,303,537	2,626,445	500,000	61,612,112
C. Estimated FY 20/21 Unspent Fund Balance	22,037,732	7,428,794	5,498,536	6,317,537	3,319,504	44,602,103

Fiscal Year 2021/22

A. Estimated FY 2021/22 Available Funding	CSS	PEI	INN	WET	CF/TN	TOTAL
1.Estimated unspent funds from prior fiscal years	20,037,732	7,428,794	5,498,536	6,317,537	3,319,504	44,602,103
2. Estimated new FY 21/22 funding	37,851,055	8,577,610	2,443,614	0	0	48,872,279
3. Transfers in FY 21/22						
4.Estimated available funding for FY 21/22	59,888,787	16,006,404	7,942,150	6,317,537	3,319,504	93,474,382
B. Budget Authority for FY 21/22	42,107,484	9,028,430	2,303,538	2,262,445	250,000	56,315,897
C. Estimated FY 21/22 Unspent Fund Balance	17,781,303	6,977,974	5,638,612	3,691,092	3,069,504	37,158,485

Fiscal Year 2022/23

A. Estimated FY 2022/23 Available Funding	CSS	PEI	INN	WET	CF/TN	TOTAL
1.Estimated unspent funds from prior fiscal years	17,781,303	6,977,974	5,638,612	3,691,092	3,069,504	37,158,485
2. Estimated new FY 22/23 funding	30,800,881	6,979,936	1,988,464	0	0	39,769,282
3. Transfers in FY 22/23						
4.Estimated available funding for FY 22/23	48,582,184	13,957,910	7,627,076	3,691,092	3,069,504	76,927,767
B. Budget Authority for FY22/23	41,357,484	9,028,430	2,303,538	2,262,445	250,000	55,565,897
D. Transfers in FY 22/23 to Prudent Reserve				0	0	
C. Estimated FY 22/23 Unspent Fund Balance	7,224,700	4,929,480	5,323,538	1,064,647	2,819,504	21,361,869

Estimated Prudent Reserve for FY 20/21	**7,579,248**

Notes.

1. The Mental Health Services Act requires that 20% of the total of new funds received by the County from the State MHSA Trust Fund go for the PEI component. The balance of new funding is for the CSS component. From the total of CSS and PEI components, five percent of the total new funding is to go for the Innovation (INN) component and is to be equally divided between the CSS and PEI allotment. The estimated new funding for each fiscal year includes this distribution.
2. Estimated new funding year includes the sum of the distribution from the State MHSA Trust Fund and interest earned from the County's MHSA fund.
3. The County may set aside up to 20% annually of the average amount of funds allocated to the County for the previous five years for the Workforce, Education and Training (WET) component, Capital Facilities, Information Technology (CF/TN) component, and a prudent reserve. For this three-year period the

County has allocated $8,108,453 for FY 2020/21, no transfers in FY 2021/22 and FY 2022/23.

4. The MHSA requires that counties set aside sufficient funds, entitled a Prudent Reserve, to ensure that services do not have to be significantly reduced in years in which revenues are below the average of previous years. The County's prudent reserve balance through June 30, 2020 is $7,579,248, and includes interest earned. This amount is less than the estimated maximum allowed of $13,188,000 as per formula stipulated in Department of Health Care Services Information Notice No. 19-037.
5. It is projected that the requested total budget authority for the Three Year Plan period enables the County to fully fund all proposed programs and plan elements while maintaining sufficient funding reserves (prudent reserve plus unspent funds from previous years) to offset any reduction in state MHSA Trust Fund distribution.

Evaluating the Plan

Contra Costa Behavioral Health Services is committed to evaluating the effective use of funds provided by the Mental Health Services Act. Toward this end a comprehensive program and fiscal review process has been implemented to a) improve the services and supports provided, b) more efficiently support the County's MHSA Three Year Program and Expenditure Plan, and c) ensure compliance with statute, regulations and policies.

During each three-year period, each of the MHSA funded contract and county operated programs undergoes a program and fiscal review. This entails interviews and surveys of individuals both delivering and receiving services, review of data, case files, program and financial records, and performance history. Key areas of inquiry include:

- Delivering services according to the values of the Mental Health Services Act.
- Serving those who need the service.
- Providing services for which funding was allocated.
- Meeting the needs of the community and/or population.
- Serving the number of individuals that have been agreed upon.
- Achieving the outcomes that have been agreed upon.
- Assuring quality of care.
- Protecting confidential information.
- Providing sufficient and appropriate staff for the program.
- Having sufficient resources to deliver the services.
- Following generally accepted accounting principles.
- Maintaining documentation that supports agreed upon expenditures.
- Charging reasonable administrative costs.
- Maintaining required insurance policies.
- Communicating effectively with community partners.

Each program receives a written report that addresses each of the above areas. Promising practices, opportunities for improvement, and/or areas of concern will be noted for sharing or follow-up activity, as appropriate. The emphasis will be to establish a culture of continuous improvement of service delivery, and quality feedback for future planning efforts.

In addition, a MHSA Financial Report is generated that depicts funds budgeted versus spent for each program and plan element included in this plan. This enables ongoing fiscal accountability, as well as provides information with which to engage in sound planning.

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Acknowledgements

We acknowledge that this document is not a description of how Contra Costa Behavioral Health Services has delivered on the promise provided by the Mental Health Services Act. It is, however, a plan for how the County can continually improve upon delivering on the promise. We have had the honor to meet many people who have overcome tremendous obstacles on their journey to recovery. They were quite open that the care they received literally saved their life. We also met people who were quite open and honest regarding where we need to improve. For these individuals, we thank you for sharing.

We would also like to acknowledge those Contra Costa stakeholders, both volunteer and professional, who have devoted their time and energy over the years to actively and positively improve the quality and quantity of care that has made such a difference in people's lives. They often have come from a place of frustration and anger with how they and their loved ones were not afforded the care that could have avoided unnecessary pain and suffering. They have instead chosen to model the kindness and care needed, while continually working as a team member to seek and implement better and more effective treatment programs and practices. For these individuals, we thank you, and feel privileged to be a part of your team.

The MHSA Staff

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Appendix A
Mental Health Service Maps

Mental Health Services Act funded programs and plan elements are only a portion of the total funding that supports public mental health services provided by Contra Costa County employees and staff employed by contractors. The backbone of the Contra Costa Behavioral Health Services system of care is its three county operated Children's and three county operated Adult clinics that serve the Western, Central and Eastern regions of the county.

The following six service maps provide a visual picture, or architecture, of the constellation of types of Contra Costa Mental Health's programs, and thus enable the viewer to see the inclusion of MHSA funded services as part of the entire system of care.

Central County Adult Mental Health Services

CA Dept. of State Hospitals
Napa State Hospital
Metropolitan State Hospital

Telecare

Idylwood Convalescent

Crestwood MHRCs

Canyon Manor

California Psychiatric Transitions

Countywide Long-term Care Providers (IMDs/MHRCs)

George & Cynthia Miller Wellness Center
Martinez

County Psychiatric Emergency Services

County Inpatient: CCRMC – 4C

Central County Adult Mental Health Clinic
1420 Willow Pass Rd., Concord
Population Served: Adults & Older Adults, TAY
Services:
Assessments
Case Management
Psychiatric Services
Crisis Intervention
Housing Services
Benefits Assistance
Rapid Access
Suicide Prevention Pilot
Perinatal/Post-partum Depression Pilot
Individual Therapy
Therapy Groups
Primary Care (Willow Pass Wellness Center)

Rainbow Community Center
Concord

Putnam Clubhouse
Concord

Jewish Family & Community Services of the East Bay
Walnut Creek

C.O.P.E. Family Support Center
Concord

Center for Human Development
Pleasant Hill

Contra Costa Interfaith Housing
Pleasant Hill

La Clinica de la Raza
Concord

Child Abuse Prevention Council
Concord

Prevention & Early Intervention Programs

John Muir Behavioral Health
Concord

Herrick Hospital
Berkeley

BHC Heritage Oaks
Sacramento

BHC Sierra Vista
Sacramento

St. Helena Hospital
St. Helena

St. Helena Hospital
Vallejo

Acute Care Psychiatric Hospitals

Countywide Services

Bay Area Community Services

Nierika House
Crisis Residential Facility
1959 Solano Way, Concord

Nevin House
Transitional Residential Facility
3215/3221 Nevin Ave., Richmond

Portia Bell Hume Behavioral Health and Training Center
Medication Management
1470 Civic Court, Suite 1111, Concord

Conservatorship/Guardianship

Consumer Self-Help Center
Patients' Rights Advocates

Contra Costa Crisis Center

First-Hope Program
PEI

Forensic Services
Assisted Outpatient Treatment

Hope House
Crisis Residential Facility
300 Ilene St., Martinez

Older Adult Services
Senior Peer Counseling Impact
ICM

Transition Services

Vocational Services

Augmented Board and Care Homes

Crestwood Super B&Cs
The Bridge
Our House
Pathways

Blessed Care Home
Pittsburg

CC's Adult Residential Care Home
Concord

Concord Hill
Concord

Ducre's Residential Care
Richmond

Family Courtyard
Richmond

God's Grace
Hayward

Happy Home
Concord

Johnson Care Home
Antioch

Margarita's Villa of Care
Concord

Menona Drive Care Home
Antioch

Modesto Residential
Modesto

Oak Hills Residential Facility
Pittsburg

Paraiso Home
Oakley

Pleasant Hill Manor
Pleasant Hill

Scenic View
Martinez

Springhill Home
Pittsburg

Williams Board and Care
Richmond

Williams Board and Care
Vallejo

Woodhaven Home
Concord

Yvonne's Home Care
Richmond

System of Care – Regional Community Based Organizations

Mental Health Systems Central FSP
Concord

Fred Finch
TAY FSP

Rainbow Community Center
Counseling Program
Concord

Youth Homes TAY FSP

Pathways to Wellness
(Service Countywide)

NAMI
(Service Countywide)

Provider Network

YWCA
Martinez

Individual Providers (90 Adult and Children)

Consumer-Driven Programs

RI International
Consumer-Run Community Center
2975 Treat Blvd., Walnut Creek

Central County Children's Mental Health Services

Central County Children's Mental Health Clinic
2425 Bisso, Ste. 200
Concord, CA 94520
Population Served: Children and TAY
Services:
Psychiatric Services
Outpatient Services
Parent Partners
Parent Project
PIP Program
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
Family Based Therapy for Eating Disorders

George & Cynthia Wellness Center
Martinez

County Psychiatric Emergency Services

Child-Parent Psychotherapy

Family-Based Treatment for Eating Disorder

Countywide Services

Children's Specialty Programs
2425 Bisso Ln. #200
Concord
Population Served: Children & TAY
- Child & Family Mental Health Services
- Social Services Child Assessment Unit
- Spirit of Caring
- Katie A.
- Local and National Case Management

COFY
Multi-Systemic Therapy and Functional Family Therapy

Consumer Self-Help Center
Patients' Rights Advocates

County-Wide Assessment Team
2425 Bisso Ln. #235
Concord
Population Served: Children & TAY

First-Hope Program
PEI

Hospital & Residential Unit
2425 Bisso Ln. #280
Concord
Population Served: Children & TAY
- Hospital Liaison
- Emergency Foster Care
- TBS Services Coordination

Mental Health and Probation Services
202 Glacier Dr.
Martinez
Population Served: Children & TAY
- Juvenile Hall, Juvenile Assessment and Consultation Services
- Orin Allen Youth Rehabilitation Facility
- Regional Probation Liaisons

Lincoln Child Center
In-Home Behavioral Services

Lincoln
Multi-Dimensional Family Therapy

We Care
0-5

Seneca
Mobile Response Team

Start FSP Seneca

TBS Providers
COFY
Seneca
Youth Homes
La Cheim
ASPIRAnet
Fred Finch Youth Center
Milhouse Children's Services
St. Vincent's School for Boys
Victor Community Support Services

Core

Fred Finch - Avalon
Dual-diagnoses residential treatment and nonpublic school

Contra Costa Crisis Center
Walnut Creek, Service Countywide

School-Based Program Unit

Head Start

Unbundled Day Treatment

- **Basis**
  Mount Diablo High School, Concord
- **La Cheim Nonpublic School**
  Antioch and El Sobrante, service Countywide
- **Seneca Olivera Nonpublic School**
  Concord
- **Seneca Collaborative**
  At: Pleasant Hill Middle School, Riverside MS (MDUSD)
- **La Cheim**
  Concord

Outpatient School-wide Mental Health Services

- **COFY**
  Marchus School – Elementary and Middle (CCCOE)
- **Fred Finch**
  Elementary: Bel Air, Shore Acres, Wren Ave, Meadow Homes, Ygnacio Valley
  Middle: El Dorado, Oak Grove, Valley View
  High: Mt. Diablo, Ygnacio Valley, Concord
- **Mt. Diablo Unified School District**
  Elementary Schools: Sunrise
  High Schools: Mt. Diablo, Olympic, Alliance

System of Care – Community Based Organizations

- **Youth Services Bureau**
  Concord
- **STAND!**
  Concord
- **Fred Finch CCTAY FSP**
  San Pablo, serves West and Central
- **MDUSD Fair Oaks Wrap Clinic**
  Concord
- **Vicente Martinez High School**
  Serves East and Central
- **Rainbow Community Center**
  Concord
- **NAMI**
  (Service Countywide)
- **YWCA**
  Martinez

Provider Network

90 Individual Providers (Adults and Children)

Prevention & Early Intervention Programs

- **Center for Human Development**
  Pleasant Hill
- **Child Abuse Prevention Council**
  Concord
- **Contra Costa Interfaith Housing**
  Pleasant Hill
- **C.O.P.E. Family Support Center**
  Concord
- **La Clinica de la Raza**
  Concord
- **Vicente Martinez High School**
  Martinez
- **Rainbow Community Center**
  Concord
- **STAND!**
  Concord
- **Jewish Family and Community Services of the East Bay**
  Walnut Creek

Residential Services

- **Short-Term Residential Therapeutic Program**
- **Treatment Foster Care**
  Seneca

Contracted Psychiatric Hospitals

- **John Muir Behavioral Health**
  Concord
- **Herrick Hospital**
  Berkeley
- **BHC Heritage Oaks**
  Sacramento
- **BHC Sierra Vista**
  Sacramento
- **St. Helena Hospital**
  St. Helena
- **St. Helena Hospital**
  Vallejo

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East County Adult Mental Health Services

CA Dept. of State Hospitals
Napa State Hospital
Metropolitan State Hospital

Telecare

Idylwood Convalescent

Crestwood
MHRCs

Canyon Manor

California Psychiatric Transitions

Countywide Long-term Care Providers (IMDs/MHRCs)

George & Cynthia Miller Wellness Center
Martinez

County Psychiatric Emergency Services

County Inpatient: CCRMC – 4C

East County Adult Mental Health Clinics
2311 Loveridge Rd.
Pittsburg, CA 94565
Population Served: Adults & Older Adults, TAY
Services:
Assessments
Case Management
Psychiatric Services
Crisis Intervention
Housing Services
Benefits Assistance/Financial Counseling
Rapid Access
Money Management
Vocational Services
Individual Therapy
Therapy Groups
Primary Care (Pittsburg Health Center)

Child Abuse Prevention Council
Concord, service Countywide

Rainbow Community Center
Concord, service Countywide

C.O.P.E. Family Support Center
Concord, service Countywide

Jewish Family & Children's Services
Walnut Creek, service Countywide

La Clinica de la Raza
Pittsburg

Contra Costa Interfaith Housing
Pittsburg

Center for Human Development
Bay Point

Prevention & Early Intervention Programs

John Muir Behavioral Health
Concord

Herrick Hospital
Berkeley

BHC Heritage Oaks
Sacramento

BHC Sierra Vista
Sacramento

St. Helena Hospital
St. Helena

St. Helena Hospital
Vallejo

Acute Care Psychiatric Hospitals

Countywide Services

Bay Area Community Services

Nierika House
Crisis Residential Facility
1959 Solano Way, Concord

Nevin House
Transitional Residential Facility
3215/3221 Nevin Ave., Richmond

Portia Bell Hume Behavioral Health and Training Center
Medication Management
1470 Civic Court, Suite 1111, Concord

Conservatorship/Guardianship

Consumer Self-Help Center
Patients' Rights Advocates

Contra Costa Crisis Center

First-Hope Program
PEI

Forensic Services
Assisted Outpatient Treatment

Hope House
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300 Ilene St., Martinez

Older Adult Services
Senior Peer Counseling Impact
ICM

Transition Services

Vocational Services

Augmented Board and Care Homes

Crestwood Super B&Cs
The Bridge
Our House
Pathways

Blessed Care Home
Pittsburg

CC's Adult Residential Care Home
Concord

Concord Hill
Concord

Ducre's Residential Care
Richmond

Family Courtyard
Richmond

God's Grace
Hayward

Happy Home
Concord

Johnson Care Home
Antioch

Margarita's Villa of Care
Concord

Menona Drive Care Home
Antioch

Modesto Residential
Modesto

Oak Hills Residential Facility
Pittsburg

Paraiso Home
Oakley

Pleasant Hill Manor
Pleasant Hill

Scenic View
Martinez

Springhill Home
Pittsburg

Williams Board and Care
Richmond

Williams Board and Care
Vallejo

Woodhaven Home
Concord

Yvonne's Home Care
Richmond

System of Care – Regional Community Based Organizations

Portia Bell Hume Behavioral Health and Training Center
Adult FSP
555 School St., Pittsburg

Youth Homes
TAY FSP
2213 Buchanan Rd., Antioch

Psychotherapy Institute
Antioch

Pathways to Wellness
(Service Countywide)

NAMI
(Service Countywide)

Provider Network

Amador Institute
Antioch

YWCA
Antioch

50 Individual Providers (Adults and Children)

Consumer-Driven Programs

Don Brown Shelter
West 4th St., Antioch

RI International
Consumer-Run Community Center
3701 Lone Tree Way, Antioch

Revised 02-10-20 MN

East County Children's Mental Health Services

Antioch Children's Behavioral Health
2335 Country Hills Drive
Antioch, CA 94509
Population Served: Children and TAY
Services:
Head Start Program
Psychiatric Services
Outpatient Services
Parent Partners
Parent Project
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
Family Based Therapy for Eating Disorders
NAMI/Basics

County Psychiatric Emergency Services

George & Cynthia Wellness Center
Martinez

Child-Parent Psychotherapy

Family-Based Treatment for Eating Disorder

Countywide Services

Children's Specialty Programs
2425 Bisso Ln. #200
Concord
Population Served: Children & TAY
- Child & Family Mental Health Services
- Social Services Child Assessment Unit
- Spirit of Caring
- Katie A.
- Local and National Case Management

COFY
(Multi-Systemic Therapy and Functional Family Therapy)

Consumer Self-Help Center
(Patients' Rights Advocates)

County-Wide Assessment Team
2425 Bisso Ln. #235
Concord
Population Served: Children & TAY

First-Hope Program
(PEI)

Hospital & Residential Unit
2425 Bisso Ln. #280
Concord
Population Served: Children & TAY
- Local and National Case Management
- Hospital Liaison
- TBS Services Coordination

Mental Health and Probation Services
202 Glacier Dr.
Martinez
Population Served: Children & TAY
- Juvenile Hall, Juvenile Assessment and Consultation Services
- Orin Allen Youth Rehabilitation Facility
- Regional Probation Liaisons

Lincoln Child Center
(In-Home Behavioral Services)

Lincoln
(Multi-Dimensional Family Therapy)

Lynn Center

Seneca
(Mobile Response Team)

Start FSP Seneca

TBS Providers
COFY
Seneca
Youth Homes
La Cheim
ASPIRAnet
Fred Finch Youth Center
Milhouse Children's Services
St. Vincent's School for Boys
Victor Community Support Services

CORE

Fred Finch - Avalon
Dual-diagnoses residential treatment and nonpublic school

Contra Costa Crisis Center
Walnut Creek, Service Countywide

Jewish Family and Community Services of the East Bay
Walnut Creek, service Countywide

Foster Youth Mental Health
A Better Way, Seneca

Wraparound Services

School-Based Program Unit

Head Start

Outpatient Services

Seneca Center
At:Riverview Middle School (Mount Diablo Unified School District)

Outpatient School-wide Mental Health Services

Lincoln
Pittsburg Unified School District Elementary, Middle, and High Schools

Mental Health Enhanced Classroom(s)

TBD
Elementary Schools: Foothill, Petite Academy
Middle Schools: Black Diamond, Learning Academy

System of Care – Regional Community Based Organizations

Community Health for Asian Americans
Antioch

La Clinica
Oakley

Amador Institute
Antioch

Child Therapy Institute
Antioch

Center for Psychotherapy
Antioch

Youth Homes TAY FSP
Antioch

NAMI
(Service Countywide)

YWCA
Antioch

Provider Network

50 Individual Providers (Adults and Children)

Prevention & Early Intervention Programs

Center for Human Development
Bay Point

Contra Costa Interfaith Housing
Pittsburg

La Clinica de la Raza
Pittsburg

People Who Care
Pittsburg

Rainbow Community Center
Concord, service Countywide

STAND!
Antioch

Child Abuse Prevention Council
Concord, service Countywide

Jewish Family and Community Services of the East Bay
Walnut Creek

Residential Services

Short-Term Residential Therapeutic Program

Treatment Foster Care
Seneca

Contracted Psychiatric Hospitals

John Muir Behavioral Health
Concord

Herrick Hospital
Berkeley

BHC Heritage Oaks
Sacramento

BHC Sierra Vista
Sacramento

St. Helena Hospital -
St. Helena

St. Helena Hospital -
Vallejo

Revised 02.10.2020 MN

West County Adult Mental Health Services

CA Dept. of State Hospitals
Napa State Hospital
Metropolitan State Hospital

Telecare

Idylwood Convalescent

Crestwood
MHRCs

Canyon Manor

California Psychiatric Transitions

Countywide Long-term Care Providers (IMDs/MHRCs)

George & Cynthia Miller Wellness Center
Martinez

County Psychiatric Emergency Services

County Inpatient: CCRMC – 4C

West County Adult Mental Health Clinics
13585 San Pablo, 2nd floor
San Pablo Ca 94601
Population Served: Adults & Older Adults, TAY

Services:
Assessments
Case Management
Psychiatric Services
Crisis Intervention
Housing Services
Benefits Assistance
Rapid Access
Individual Therapy
Therapy Groups

RYSE
TAY
Richmond

Lifelong Medical Care
Richmond

C.O.P.E. Family Support Center
Concord, service Countywide

Rainbow Community Center
Concord, service Countywide

Child Abuse Prevention Council
Concord, service Countywide

Native American Health Center
Richmond

The Latina Center
Richmond

Lao Family Community Development
San Pablo

Jewish Family and Community Services of the East Bay
Walnut Creek, service Countywide

Building Blocks for Kids
Richmond

Asian Family Resource Center
Richmond

Prevention & Early Intervention Programs

John Muir Behavioral Health
Concord

Herrick Hospital
Berkeley

BHC Heritage Oaks
Sacramento

BHC Sierra Vista
Sacramento

St. Helena Hospital
St. Helena

St. Helena Hospital
Vallejo

Acute Care Psychiatric Hospitals

Countywide Services

Operated by BACS

Nierika House
Crisis Residential Facility
1959 Solano Way, Concord

Nevin House
Transitional Residential Facility
3215/3221 Nevin Ave., Richmond

Operated by Portia Bell Hume

Phoenix Center
Medication Management
1470 Civic Court, Suite 1111 in Concord

Conservatorship/Guardianship

Consumer Self-Help Center
Patients' Rights Advocates

Contra Costa Crisis Center

First-Hope Program
FEP PEI

Forensic Services
AB109; AOT; Competency Restoration; MHET; MCRT; Diversion

Hope House
Crisis Residential Facility
300 Ilene St., Martinez

Older Adult Services
Senior Peer Counseling Impact ICM

Transition Services

Vocational Services

Crestwood
The Bridge Board & Care
Our House Board & Care

Crestwood Pathways
Transitional Residential

Augmented Board and Care Homes

Crestwood Super B&Cs
The Bridge
Our House
Pathways

Blessed Care Home
Pittsburg

CC's Adult Residential Care Home
Concord

Concord Hill
Concord

Ducre's Residential Care
Richmond

Family Courtyard
Richmond

God's Grace
Hayward

Happy Home
Concord

Johnson Care Home
Antioch

Margarita's Villa of Care
Concord

Menona Drive Care Home
Antioch

Modesto Residential
Modesto

Oak Hills Residential Facility
Pittsburg

Paraiso Home
Oakley

Pleasant Hill Manor
Pleasant Hill

Scenic View
Martinez

Springhill Home
Pittsburg

Williams Board and Care
Richmond

Williams Board and Care
Vallejo

Woodhaven Home
Concord

Yvonne's Home Care
Richmond

System of Care – Regional Community Based Organizations

Familias Unidas
Adult FSP
205 39th Street, Richmond

Fred Finch
TAY FSP
2523 El Portal Dr., San Pablo

Portia Bell Hume Center
West County Adult FSP and Outpatient
Richmond

Pathways to Wellness
(Service Countywide)

NAMI
(Service Countywide)

Provider Network

40 Individual Providers (Adults and Children)

Consumer-Driven Programs

RI International
Consumer-Run Community Center
2101 Vale Rd.
San Pablo

West County Children's Mental Health Services

West County Children's Mental Health Clinic
303 41st Street
Richmond, CA
Population Served: Children and TAY
Services:
Psychiatric Services
Outpatient Services
Parent Partners
Wrap Around Services
Cognitive Behavioral Therapy
Dialectical Behavior Therapy
Trauma Focused Cognitive Behavioral Therapy
NAMI Basics

County Psychiatric Emergency Services

George & Cynthia Wellness Center
Martinez

Child-Parent Psychotherapy

Family-Based Treatment for Eating Disorder

Countywide Services

Children's Specialty Programs
2425 Bisso Ln. #235
Concord
Population Served: Children & TAY
- Child & Family Mental Health Services
- Social Services Child Assessment Unit
- Spirit of Caring
- Katie A.
- Local and National Case Management

COFY
(Multi-Systemic Therapy and Functional Family Therapy)

Consumer Self-Help Center
(Patients' Rights Advocates)

County-Wide Assessment Team
2425 Bisso Ln. #235
Concord
Population Served: Children & TAY

First-Hope Program
(PEI)

Hospital & Residential Unit
2425 Bisso Ln. #280
Concord
Population Served: Children & TAY
- Local and National Case Management
- Hospital Liaison
- TBS Services Coordination

Mental Health and Probation Services
202 Glacier Dr.
Martinez
Population Served: Children & TAY
- Juvenile Hall, Juvenile Assessment and Consultation Services
- Orin Allen Youth Rehabilitation Facility
- Regional Probation Liaisons

Lincoln Child Center
(In-Home Behavioral Services)

Lincoln
(Multi-Dimensional Family Therapy)

Early Childhood Mental Health Program
Richmond

Seneca
(Mobile Response Team)

STAND!
(Respite & Mentoring)

Start FSP Seneca

TBS Providers
COFY
Seneca
Youth Homes
La Cheim
ASPIRAnet
Fred Finch Youth Center
Milhouse Children's Services
St. Vincent's School for Boys
Victor Community Support Services

Fred Finch - Avalon
Dual-diagnoses residential treatment and nonpublic school

Contra Costa Crisis Center
Walnut Creek, service Countywide

School-Based Program Unit

Head Start

Unbundled Day Treatment

La Cheim
At: La Ceim School
El Sobrante (NPS)

Seneca
At: Catalyst
(WCCUSD)

Outpatient School-wide Mental Health Services at WCCUSD Schools

Familias Unidas
Richmond

Bay Area Community Resources (BACR)

Elementary Schools: Grant, Harbor Way, Lincoln, Nystrom, Peres, Martin Luther King, Stege, Washington, Transitional Learning
Middle Schools: Crespi, Pinole, Portola, Hercules
High Schools: El Cerrito, Richmond, Pinole Valley, Hercules

Community Health for Asian American

Elementary Schools: Lincoln, Nystrom
Middle Schools: Helms, LoVonya DeJean
High Schools: El Cerrito, Kennedy, Richmond

Seneca

Elementary Schools: Highland, Sheldon, Tara Hills
Middle Schools: Pinole, Transitional Learning Center (WCCUSD)

Y Team

Elementary School: Nystrom
Middle School: Crespi, Helms, Portola, LoVonya DeJean
High Schools: De Anza, El Cerrito, Kennedy, Richmond

System of Care – Regional Community Based Organizations

Alternative Family Services
Richmond

BACR
Richmond

Community Health for Asian Americans
Richmond

WCCUSD Wraparound Clinic
WCCUSD

Early Childhood Mental Health
Richmond

Fred Finch (TAY FSP)
Richmond

La Cheim
Richmond

Youth Services Bureau
Richmond

Child Therapy Institute
El Cerrito

NAMI
(Service Countywide)

Asian Community Mental Health
Richmond

Carrie McCluer & Associates
Crocket

Berkeley Youth Alternatives
Berkeley

Provider Network

40 Individual Providers (Adults and Children)

Prevention & Early Intervention Programs

Building Blocks for Kids
Richmond

The James Morehouse Project
El Cerrito

The Latina Center
Richmond

Native American Health Center
Richmond

RYSE
Richmond

STAND!
Richmond

C.O.P.E. Family Support Center
Concord, service Countywide

Child Abuse Prevention Council
Concord, service Countywide

Rainbow Community Center
Concord, service Countywide

The Jewish Family and Community Services of the East Bay
Walnut Creek

Residential Services

Short-Term Residential Therapeutic Program

Treatment Foster Care
Seneca

Contracted Psychiatric Hospitals

John Muir Behavioral Health
Concord

Herrick Hospital
Berkeley

BHC Heritage Oaks
Sacramento

BHC Sierra Vista
Sacramento

St. Helena Hospital -
St. Helena

St. Helena Hospital -
Vallejo

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Program and Plan Element Profiles

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Asian Family Resource Center (AFRC)

Point of Contact: Sun Karnsouvong
Contact Information: Asian Family Resource Center (AFRC), 12240 San Pablo Ave, Richmond, CA
Skarnsouvong@arcofcc.org

1. **General Description of the Organization**
   AFRC provides multicultural and multilingual services, empowering the most vulnerable members of our community to lead healthy, productive and contributing lives.
2. **Program: Building Connections (Asian Family Resource Center) - PEI**

a. Scope of Services: Asian Family Resource Center (AFRC), under the fiscal sponsorship of Contra Costa ARC, will provide comprehensive and culturally-sensitive education and access to mental health services for Asian and Asian Pacific Islander (API) immigrant and refugee communities, especially the Southeast Asian and Chinese population of Contra Costa County. AFRC will employ multilingual and multidisciplinary staff from the communities which they serve. Staff will provide the following scope of services:

   i. Outreach and Engagement Services: Individual and/or community outreach and engagement to promote mental health awareness, educate community members on signs and symptoms of mental illness, provide mental health workshops, and promote mental health wellness through community events. Engage community members in various activities to screen and assess for mental illness and/or assist in navigating them into the service systems for appropriate interventions: community integration skills to reduce MH stressors, older adult care giving skills, basic financial management, survival English communication skills, basic life skills, health and safety education and computer education, structured group activities (on topics such as, coping with adolescents, housing issues, aid cut-off, domestic violence, criminal justice issues, health care and disability services), mental health education and awareness, and health/mental health system navigation. AFRC, in collaboration with community-based organizations, will participate in 3-5 mental health and wellness events to provide wellness and mental health outreach, engagement, and education to immigrants and refugees in the Contra Costa County.

   ii. Individual Mental Health Consultation: This service will also be provided to those who are exhibiting early signs of mental illness, to assess needs, identify signs/symptoms of mental health crisis/trauma, provide linkages/referrals or assist in navigation into the mental health system, provide wellness support groups, access essential community resources, and linkage/referral to mental health services. Peer Navigators will be utilized to support participants in accessing services in a culturally sensitive manner. These services will generally be provided for a period of less than one year.

ACMHS will serve a minimum of 75 high risk and underserved Southeast Asian community members within a 12 month period, 25 of which will reside in East County with the balance in West and Central County.

iii. Translation and Case Management: AFRC staff will provide translation and case management services to identified mono-lingual consumers in the West County Adult Behavioral Health Clinic in San Pablo, CA. Services will include attending medical appointments, assisting with applications and forms, advocacy and system navigation.

b. Target Population: Asian and Pacific Islander immigrant and refugee communities (especially Chinese and Southeast Asian population) in Contra Costa County
c. Payment Limit: FY 20-21: $150,706
d. Number served: FY 18-19: 455 high risk and underserved community members
e. Outcomes:
   - All program participants received system navigation support for mental health treatment, Medi-Cal benefits, and other essential benefits.
   - Services are offered in the language of the consumer.
   - Program hosted three community wellness events and psycho-education workshops for the community.

Bay Area Community Services (BACS)

https://www.bayareacs.org/
Point of Contact: Jamie Almanza
Contact Information: Bay Area Community Services, Inc. BACS)
629 Oakland Avenue, Oakland, CA 94611
(510) 415-4672, JAlmanza@bayareacs.org

1. **General Description of the Organization**
   Bay Area Community Services' (BACS) mission is to uplift under-served individuals and their families by doing whatever it takes. BACS supports recovery for people experiencing psychiatric distress, through practical and therapeutic support. Their crisis residential programs are serene and home-like environments with around-the-clock care, supervision, and wellness & recovery support for individuals in crisis.
2. **Program: Nierika & Nevin House: Crisis Residential Facility and Transitional Care - CSS**

a. Scope of Services: The County contracts with BACS to operate two programs: 1) Nierika House, a short term crisis residential treatment program for adults living with a serious mental illness and dual diagnoses, located in Central County, and 2) Nevin House, a 16-bed facility in West County that provides transitional care in a therapeutic milieu for adults living with a co-occurring mental health and substance use disorders.

   Nierika House is a 2-week crisis residential treatment program for adults with mental health and dual diagnoses. Clients are referred from the Contra Costa County liaison, either as a stepdown from an inpatient hospitalization or a step up from the community and a diversion from inpatient care. A combination of therapeutic and psychiatric services aims to reduce the level of crisis so that a client can return to a lower level of care. A 24-hour staffing ratio of 1 staff per 8 clients allows for clients receive intensive structure and support, without requiring a hospital stay.

   Nevin House is a 16-bed facility in Richmond, CA through a collaborative with Contra Costa County Behavioral Health Services and serves adults with co-occurring mental health and substance use challenges.

b. Target Population: Adults ages 18 to 59 who require crisis support to avoid psychiatric hospitalization or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living.
c. Payment Limit: FY 20-21 $305, 355
d. Number served: In FY 18-19: Not Applicable.
e. Outcomes: To be determined.

Building Blocks for Kids (BBK)

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

1. **General Description of the Organization**

   Building Blocks for Kids (BBK) amplifies the voices of parents/caregivers of color and partners with them to advance equitable access and opportunities for all youth to have a quality education and all families to achieve emotional and physical well-being. We realize our goals through healing centered care, leadership development, and parent-led advocacy. BBK serves parents and primary caregivers living in West Contra Costa County that primarily represent low-income African-American, Latinx and immigrant populations.

2. **Program: Not Me Without Me - PEI**

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

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

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

b. Target Population: Parents and caregivers and their families living in West Contra Costa County
c. Payment Limit: FY 20-21: $231,340
d. Number served: In FY 18-19: 438 Individuals (includes outreach and education events).

e. Outcomes

- In FY 18-19, BBK Health and Wellness Team met with 22 community organizations, government agencies and individuals around partnering and collaboration.
- 93 women participated in a total of 32 Black Women's and Latinx Peer Sanctuary groups where they received facilitated support for self-case, advocacy, personal goal setting and reclaiming positive cultural practices.
- Summer Program at Belding Garcia Park served approximately 95 children who were provided a healthy meal each day and introduced to wellness related activities and events; developmental playgroups held at Belding Garcia and Monterey Pines Apartments.
- BBK partnered with Child Abuse Prevention Council to offer weekly evidence-based parenting classes (Nurturing Parenting) in Spanish and English. A total of 58 parents/caregivers graduated from the 22-week program.

Center for Human Development (CHD)

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

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

a. Scope of Services: The African American Wellness Program (formerly African American Health Conductor Program) serves Bay Point, Pittsburg, and surrounding communities. The purpose is to increase emotional wellness; reduce stress and isolation; and link African American participants, who are underserved due to poor identification of needs and lack of outreach and engagement, to appropriate mental health services. Key activities include: outreach through community events; culturally appropriate education on mental health topics through Mind, Body, and Soul support groups; conduct community health education workshops in accessible and non-stigmatizing settings; and navigation assistance for culturally appropriate mental health referrals.
b. The Youth Empowerment Program provides LGBTQ youth and their allies in Antioch, Pittsburg, and surrounding East County communities with strength-based educational support services that build on youths' assets, raise awareness of mental health needs identification, and foster resiliency. Key activities include: a) Three weekly educational support groups that promote emotional health and well-being, increase positive identity and self-esteem, and reduce isolation through development of concrete life skills; b) one leadership group that meets a minimum of twice a month to foster community involvement; and c) linkage and referral to culturally appropriate mental health service providers in East County.
c. Target Population: Wellness Program: African American residents in East County at risk of developing serious mental illness. Youth Empowerment Program: LGBTQ youth in East County
d. Payment Limit: FY 20-21: $166,493
e. Number served: FY 18-19: 342 individuals were served in both programs combined
f. Outcomes:
   i. African American Wellness Program
   - Mind-Body-Soul support groups held in four different East County locations, reaching approximately 200 individuals
   - Provided 90 clients with health system navigation
   - Provided 17 clients with mental health referrals

- Hosted approximately 12 community health / mental health workshops throughout the year
- 100% of the participants in the Mind-Body-Soul peer health education support groups reported and increased wellness (wellbeing) within fiscal year.

ii. Youth Empowerment Program

- 137 youth participated in Empowerment programs in FY 18-19, including group and individual sessions
- LGBTQ youth empowerment support groups held in Pittsburg and Antioch throughout the year with topics such as: “Family and Peer Conflict,” “Challenges to Relationships,” “Community Violence and Loss,” “Queer History and Activism,” “Stress, Anxiety and Depression,” “Identity Development and Coming Out.”
- Facilitated four events or fieldtrips during the year, including the Youth Pride Prom, and a fieldtrip to the Castro District and the GLBT Museum in SF
- 100% of participants in Empowerment in need of counseling services were informed and referred to LGBTQ-sensitive resources available to youth.
- LGBTQ Youth Support Groups facilitated weekly (primarily during the school year) at the following locations: Pittsburg High, Deer Valley High, and Rivertown Resource Center in Antioch.

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

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

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The Central Adult Mental Health Clinic operates within Contra Costa Mental Health's Adult System of Care, and provides assessments, case management, therapy, groups, psychiatric services, crisis intervention, peer support, housing services, and benefits assistance. Within the Adult Mental Health Clinic are the following MHSA funded programs and plan elements:
2. **Plan Element: Adult Full Service Partnership Support - CSS**
   Contra Costa Mental Health has dedicated clinical staff at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management acts as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.
3. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to 1) assist consumers in obtaining benefits they are entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older, who live in Central County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Number Served: For FY 18-19: Approximately 2,102 Individuals.

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

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

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health and Alcohol & Other Drugs into a single system of care. The Central Children's Mental Health Clinic operates within Contra Costa Behavioral Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and Wraparound services. Within the Children's Mental Health Clinic are the following MHSA funded plan elements:
2. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas:
   - Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the children. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model.
   - A Clinical Specialist in each regional clinic who provides technical assistance and oversight of evidence-based practices in the clinic.
   - Support for full service partners.

a. Target Population: Children aged 17 years and younger, who live in Central County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits.
b. Number Served: For FY 18-19: Approximately 934 Individuals.

Child Abuse Prevention Council (CAPC)

www.capc-coco.org
Point of Contact: Carol Carrillo
Contact Information: 2120 Diamond Blvd #120, Concord, CA 94520
ccarrillo@capc-coco.org

1. **General Description of the Organization**

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

2. **Program: The Nurturing Parenting Program - PEI**

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

b. Target Population: Latino children and their families in Central and East County.

c. Payment Limit: FY 20-21: $132,728

d. Number served: In FY 18-19: 164 parents and children

e. Outcomes:

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

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

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

1. **General Description of the Organization**

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

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

Multisystemic Therapy (MST) is an Evidence Based Program ecological model designed to work in home with family and caregivers. MST addresses complex clinical, behavioral, social, and educational problems experienced by the youth. Clients are referred by the Juvenile Probation Mental Health Liaisons, Probation Officers, and Regional Clinic Program Managers. The MST clinician primarily works with parents and caregivers to identify family goals as well as to target behaviors that put the adolescent into contact with Juvenile Probation. This intensive intervention model includes multiple sessions per week over a period of up to six months.

a. Scope of Services: Services include but are not limited to outreach and engagement, case management, outpatient mental health services, crisis intervention, collateral services, flexible funds. COFY MST staff must be available to consumer on a 24/7 basis.
b. Target Population: Children who have a serious emotional disturbance or serious mental illness; and have been identified as a juvenile offender or are at risk of involvement with Probation due to delinquent behavior. Services are county-wide.
c. Payment Limit: FY 20-21 $1,107,602
d. Number served: In FY18-19 COFY FSP served 79 individuals.
e. Outcomes:
   - Reduction in incidence of psychiatric crisis
   - Increase in Juvenile Assessment and Consultation Services (JACS)

Table 1. Pre- and post-enrollment utilization rates for 79 Fred Finch FSP participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	16	3	0.024	0.008	-65.5%
Inpatient episodes	0	0	0.000	0.00	0
Inpatient days	0	0	0.000	0.000	0
JACS	68	49	0.103	0.136	+0.033

Contra Costa Crisis Center

www.crisis-center.org
Point of Contact: Tom Tamura
Contact Information: P.O. Box 3364 Walnut Creek, CA 94598
925 939-1916, x107, TomT@crisis-center.org

1. **General Description of the Organization**

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

2. **Program: Suicide Prevention Crisis Line**

a. Scope of Services:

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

- The Crisis Center will provide community outreach and education about how to access crisis services. Priority and vigorous outreach efforts are directed to underserved and hard to reach populations such as youth, elderly, isolated, persons with limited English, LGBQT, etc. and focus changes as community needs emerge and are identified.
- The Crisis Center will offer grief support groups and postvention services to the community
- The Crisis Center will liaison with the County Coroner to provide referrals for grieving survivors (and mitigating contagion).
- In Partnership with County Behavioral Health, the Contra Costa Crisis Center will co-chair the Countywide Suicide Prevention Committee.

b. Target Population: Contra Costa County residents in crisis.
c. Payment Limit: FY 20-21: $529,606
d. Number served: In FY18-19: 68,449 total calls were fielded.
e. Outcomes:
    - Spanish language coverage was provided 80 hours/week
    - Call abandonment rate was 1.2%
    - Lethality assessments and follow up calls were provided for 100% of callers rated mid to high level risk.
    - Responded to 18,128 calls from people in crisis, suicidal or experiencing mental health issues.
    - A pool of 36 volunteers was maintained, and 3 volunteer trainings were offered during the year

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

http://copefamilysupport.org/
Point of Contact: Cathy Botello, Executive Director
Contact Information: 3000 Citrus Circle, Ste. 220, Walnut Creek, CA 94598
(925) 689-5811, cathy.botello@copefamilysupport.org

1. **General Description of the Organization**

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

2. **Program: Positive Parenting Program (Triple P) Education and Support – PEI**

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

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

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

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

a. Target Population: Contra Costa County parents of children and youth with identified special needs. Our targeted population includes caregivers residing in underserved communities throughout Contra Costa County.

b. Payment Limit: FY 20-21: $260,836 (ages 6–17), through First Five: $86,949 (ages 0–5).
c. Number served: In FY 18-19: 226
d. Outcomes:
    - Offered Triple P evidenced based parenting classes at 18 site locations throughout East and Central County
    - Pre and Post Test Survey results indicate program participants showed a 46% decrease in depression, 35% decrease in anxiety, and 32% decrease in overall stress
    - Access and linkage to on-going treatment supported through warm hand off referrals for housing, vocational, legal and mental health services

Crestwood Behavioral Health, Inc.

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

1. **General Description of the Organization**
   The mission at Crestwood Healing Center is to partner with Contra Costa County clients, employees, families, business associates, and the broader community in serving individuals affected by mental health issues. Together, they enhance quality of life, social interaction, community involvement and empowerment of mental health clients toward the goal of creating a fulfilling life. Clients are assisted and encouraged to develop life skills, participate in community based activities, repair or enhance primary relationships, and enjoy leisure activities. A supportive, compassionate, and inclusive program increases motivation and commitment.
2. **Program: The Pathway Program (Mental Health Housing Services – CSS**
   The Pathway Program provides psychosocial rehabilitation for 16 clients who have had little, if any, previous mental health treatment. The program provides intensive skills training to promote independent living. Many clients complete their high school requirements, enroll in college or are participating in competitive employment by the end of treatment.

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

b. Target Population: Adults aged 18 years and older, who live in Central County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
c. Payment Limit: FY 20-21 $1,210,356
d. Number served: For FY 18–19: Capacity of 64 beds at The Bridge in Pleasant Hill. Capacity of 30 beds at Our House in Vallejo.
e. Outcomes: To be determined.

Divine's Home

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

1. **General Description of the Organization**
   The County contracts with Divine's Home, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Cares – MHSA Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
   - Medication management
   - Nutritional meal planning
   - Assistance with laundry
   - Transportation to psychiatric and medical appointments
   - Improving socialization
   - Assist with activities of daily living (i.e., grooming, hygiene, etc.)
   - Encouraging meaningful activity
   - Other services as needed for individual residents

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

c. Number served: For FY 18-19: Capacity of 6 beds.

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

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

1. **General Description of the Organization**
   East County Adult Mental Health Services operates within Contra Costa Mental Health's Adult System of Care. Services are provided within a Care Team model. Each Care Team is comprised of a core team of psychiatrists, therapists, and community support workers. Additional services may be provided by nurses, family support worker, and a substance abuse counselor. The initial assessment, Co-Visit, is provided jointly by a psychiatrist and a therapist where both mental health and medication needs are addressed at this initial visit. Other services include crisis intervention, individual/group therapy, case management, housing services, benefits assistance, vocational services, and linkage to community-based programs and agencies.
2. **Plan Element: Adult Full Service Partnership Support - CSS**
   Contra Costa Mental Health has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management act as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.
3. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in 1) obtaining benefits they are entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older, who live in East County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Number Served: For FY 18-19 Approximately 2,221 Individuals.

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

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Christine Madruga, Program Manager
Contact Information: 2335 Country Hills Drive, Antioch, CA 94509
(925) 608-8736, Christine.Madruga@CCHealth.org

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The East Children's Mental Health Clinic operates within Contra Costa Behavioral Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and wraparound services. Within the Children's Behavioral Health Clinic are the following MHSA funded plan elements:
2. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas:
   - Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the clinic. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model.
   - A Clinical Specialist/EBP Team Leader in each regional clinic who provides technical assistance, clinical consultation, and oversight of evidence-based practices in the clinic.
   - Support for full service partnership programs.

a. Target Population: Children and youth aged 5 through 22 years, who live in East County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits.
b. Number Served: For FY 18-19: Approximately 729 Individuals.

Familias Unidas (formerly Desarrollo Familiar, Inc.)

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

1. **General Description of the Organization**
   Familias Unidas exists to improve wellness and self-sufficiency in Latino and other communities. The agency accomplishes this by delivering quality mental health counseling, service advocacy, and information/referral services. Familias Unidas programs include: mental health, education and prevention, and information/referrals.
2. **Program: Familias Unidas – Full Service Partnership - CSS**
   Familias Unidas provides a comprehensive range of services and supports in Contra Costa County to adults with serious emotional disturbance/serious mental illness who are homeless or at serious risk of homelessness. Services are based in West Contra Costa County.

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

b. Target Population: Adults in West County, who are diagnosed with a serious mental illness, are homeless or at imminent risk of homelessness, are at or below 300% of the federally defined poverty level, and are uninsured or receive Medi-Cal benefits.
c. Payment Limit: FY 20-21 $233,088
d. Number served: For FY 18-19: 20 Individuals
e. Outcomes: For FY 18-19:
   - Program participants will experience a net reduction in their Psychiatric Emergency Services utilization rate of at least 40% when the annual utilization rate for the clients' most recent 12 months of service, or total number of months the client has been enrolled for less than 12 months, is compared to the pre-enrollment rate.*
   - Program participants will experience a net reduction in their inpatient utilization rate of at least 60% when the annual utilization rate for the clients' most recent 12 months of service, or total number of months if a client has been enrolled for less than 12 months, is compared to the pre-enrollment rate.*
   - 75% of FSP participants placed into housing will receive housing support to maintain housing stability or be progressively placed into more independent living environments, as appropriate.

- 75% of FSP participants will rank Familias Unidas FSP services with a score of 4 or higher in the Client Satisfaction Questionnaire (CSQ-8), twice annually, or upon client discharge from the program.
- Less than 25% of active Familias Unidas FSPs will be arrested or incarcerated post-enrollment measured at the end of the fiscal year.
- Collect baseline data utilizing an engagement in meaningful activity/quality of life assessment tool (tool to be determined).
- Decrease in incidence of psychiatric crisis
- Decrease of the incidence of restriction

Table 1. Pre-and post-enrollment utilization rates for 20 Familias Unidas (Desarrollo Familiar, Inc.) FSP Participants enrolled in the FSP program during FY 18-19

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	28	14	0.126	0.061	-51.7%
Inpatient episodes	8	5	0.036	0.022	-39.7%
Inpatient days	76	51	0.342	0.222	-81.4%

First Five Contra Costa

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

1. **General Description of the Organization**

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

2. **Programs: Triple P Positive Parenting Program - (PEI)**

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

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

c. Payment Limit: FY 20-21: $86,949

d. Number Served: In FY 18-19: 226 parents in East and Central County (via partnership with C.O.P.E.)

e. Outcomes:

- Completed 18 free Triple P parenting classes for East and Central County (through partnership with C.O.P.E.)
- Offered case management support to parents as appropriate

First Hope
(Contra Costa Behavioral Health Services)

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

1. **General Description of the Organization**
   Contra Costa Behavioral Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The First Hope program operates within Contra Costa Behavioral Health's Children's System of Care but is a hybrid program serving both children and young adults.
2. **Program: First Hope: Early Identification and Intervention in Psychosis - PEI**

a. Scope of Service: The mission of the First Hope program is to reduce the incidence of psychosis and the secondary disability of those developing a psychotic disorder in Contra Costa County through:
   - Early Identification of young people between ages 12 and 30 who are showing very early signs of psychosis and are determined to be at risk for developing a serious mental illness.
   - Engaging and providing immediate treatment to those identified as "at risk", while maintaining progress in school, work and social relationships.
   - Providing an integrated, multidisciplinary team approach including psychoeducation, multi-family groups, individual and family therapy, case management, occupational therapy, supported education and vocation, family partnering, and psychiatric services within a single service model.
   - Outreach and community education with the following goals: 1) identifying all young people in Contra Costa County who are at risk for developing a psychotic disorder and would benefit from early intervention services; and 2) reducing stigma and barriers that prevent or delay seeking treatment through educational presentations.
   - In FY 18-19, the program expanded to offer Coordinated Specialty Care (CSC) services to First Episode Psychosis (FEP) young people ages 16-30, and their families, who are within 18 months of their first episode

b. Target Population: 12-30 year old young people and their families
c. Total Budget: FY 20-21: $2,587,099
d. Staff: 27 FTE full time equivalent multi-disciplinary staff
e. Number served: FY 18-19: 661
f. Outcomes:
   - Help clients manage Clinical High Risk symptoms and maintain progress in school, work and relationships
   - Zero conversion from clinical high risk to psychosis in FY 18-19
   - Reduce the stigma associated with symptoms
   - Reduce necessity to access psychiatric emergency services/ inpatient care

   Long Term Public Health Outcomes:
   - Reduce conversion rate from Clinical High Risk symptoms to schizophrenia
   - Reduce incidence of psychotic illnesses in Contra Costa County

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

Forensic Mental Health
(Contra Costa Behavioral Health Services)

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

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The Forensic Services team operates within Contra Costa Mental Health's Adult System of Care, and works closely with Adult Probation, *the courts, and local police departments.*
2. **Program: Forensic Services - CSS**
   The Forensics Services team is a multidisciplinary team comprised of mental health clinical specialists, registered nurses and community support workers. The purpose of the team is to engage and offer voluntary services to participants who are seriously and persistently mentally ill and are involved in the criminal justice system. Forensic Services hosts office hours at the three regional probation offices to enhance the opportunity for screening and service participation. The co-located model allows for increased collaboration among the participants, service providers, and Deputy Probation Officers.

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

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

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

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

a. Scope of Services: Authorized in Fiscal Year 2011-12 four clinical specialists were funded by MHSA to join Forensics Services Team. This team works very closely with the criminal justice system to assess referrals for serious mental illness, provide rapid access to a treatment plan, and work as a team to provide the appropriate mental health, substance abuse and housing services needed.
b. Target Population: Individuals who are seriously and persistently mentally ill who are on probation and at risk of re-offending and incarceration.
c. Budget: $982,245
d. MHSA-Funded Staff: 4.0 Full-time equivalent
e. Number Served: For FY 18-19: 559

Fred Finch Youth Center

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

1. **General Description of the Organization**
   Fred Finch seeks to provide innovative, effective, caring mental health and social services to children, young adults, and their families that allow them to build on their strengths, overcome challenges, and live healthy and productive lives. Fred Finch serves children, adolescents, young adults, and families facing complex life challenges. Many have experienced trauma and abuse; live at or below the poverty line; have been institutionalized or incarcerated; have a family member that has been involved in the criminal justice system; have a history of substance abuse; or have experienced discrimination or stigma.
2. **Program: Contra Costa Transition Age Youth Full Service Partnership - CSS**
   Fred Finch is the lead agency that collaborates with the Contra Costa Youth Continuum of Services, The Latina Center and Contra Costa Mental Health to provide a Full Service Partnership program for Transition Age Youth in West and Central Contra Costa County.

a. Scope of Services: Services will be provided using an integrated team approach, based on a modified Assertive Community Treatment (ACT) model of care and the Individual Placement and Support (IPS) model designed to support our TAY with gaining and maintaining competitive employment. The team includes a Personal Service Coordinator working in concert with a multi-disciplinary team of staff, including a Peer Mentor and Family Partner, an Employment Specialist, a Psychiatric Nurse Practitioner, staff with various clinical specialties, including co-occurring substance disorder and bi-lingual capacity. Services include:
   - Outreach and engagement
   - Case management
   - Outpatient Mental Health Services, including services for individuals with co-occurring mental health & alcohol and other drug problems
   - Crisis Intervention
   - Collateral
   - Medication support (may be provided by County Physician)
   - Housing support
   - Flexible funds
   - Referrals to Money Management services as needed
   - Supported Employment Services
   - Available to consumer on 24/7 basis

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

c. Payment Limit: FY 20-21 $1,576,435

d. Number served: For FY 18-19: 53

e. Outcomes: For FY 18/19:

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

Table 1. Pre- and post-enrollment utilization rates for 53 Fred Finch FSP participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	61	33	0.118	0.055	-53. %
Inpatient episodes	37	10	0.072	0.017	-77.0%
Inpatient days	293	64	0.568	0.106	-81.4%

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

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

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The George and Cynthia Miller Wellness Center is a Federally Qualified Health Center under the Contra Costa Health Services Hospital and Clinics Division.
2. **Program: George and Cynthia Miller Wellness Center (Formerly the Assessment and Recovery Center) - CSS**

a. Scope of Services: The George and Cynthia Miller Wellness Center (Miller Wellness Center) provides a number of services to the Contra Costa Behavioral Health Services' system of care consumers that includes the diversion of children and adults from Psychiatric Emergency Services (PES). Children and adults who are evaluated at PES may step-down to the Miller Wellness Center if they do not need hospital level of care. The Miller Wellness Center offers urgent same-day appointments for individuals who are not open to the Contra Costa Mental Health System, or who have disconnected from care after previously being seen. Services include brief family therapy, medication refills, substance abuse counseling, and general non-acute assistance. In addition, the Center provides appointments for patients post psychiatric inpatient discharge. This provides the opportunity for a successful transition that ensures that medications are obtained, and appointments are scheduled in the home clinic. The behavioral health service site is located in a Federally Qualified Health Center with separate entrances from the physical health side.
b. Target Population: Children and adults who are being diverted from PES, transition from inpatient, and consumers not yet connected to the outpatient system of care.
c. Total Budget: $319,590
d. Staff funded through MHSA: 3 FTE – A Program Manager, and two Community Support Workers.
e. Number Served: To Be Determined
f. Outcomes: To Be Determined

Hope Solutions (formerly Contra Costa Interfaith Housing)

https://www.hopesolutions.org/
Point of Contact: Sara Marsh
Contact Information: 399 Taylor Blvd. Ste. 115, Pleasant Hill, CA 94530
(925) 944-2244, Sara@ccinterfaithhousing.org

1. **General Description of the Organization**

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

2. **Program: Strengthening Vulnerable Families**

a. Scope of Services:

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

these families due to lowered stress regarding their housing status (eviction prevention) and increased access to resources and benefits. Increased recognition of early signs of mental illness will be achieved as well, due to the on-site case management staff's ability to respond to possible family concerns about family members' mental health, as they arise.

- Hope Solutions staff is also able to help community providers be aware of early signs of mental illness in their clients and support sensitive care and timely treatment for these issues.
- Hope Solutions has taken over ownership and property management (and on-site case management) for three households including 12 residents in Central and East County.

b. Target Population: Formerly homeless/at-risk families and youth.
c. Payment Limit: FY 20-21: $385,477
d. Number served: In FY 18-19: 445 clients
e. Outcomes:
    - Improved school functioning and regular attendance of school-aged youth in afterschool programs.
    - Improved family functioning and confidence as measured by the self-sufficiency matrix (SSM) and individual family goals and eviction prevention. (SSM evaluates 20 life skill areas including mental health, physical health, child custody, employment, housing stability).
    - Served 215 different families through 4003 hours of case management across 4 housing sites

James Morehouse Project (JMP) at El Cerrito High (fiscal sponsor of Bay Area Community Resources)

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

1. **General Description of the Organization**

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

2. **Program: James Morehouse Project (JMP) - PEI**

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

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

b. Target Population: At-risk students at El Cerrito High School

c. Payment Limit: FY 20-21: $109,167

d. Numbers Served: FY 18-19: 416 young people

e. Outcomes:

- With the help of a team that included 10 clinical interns, JMP served over 400 students through individual counseling, crisis intervention, support, youth leadership/advocacy and 29 different groups.
- Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth. *(95% of participating youth reported feeling like they have a trusted adult they can turn to if they need help)*

- Increased well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth. *(98% of participating youth indicated they have better tools to deal with stress and anxiety)*
- Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth. *(84% of youth reported better school attendance after program participation)*
- Reduced likelihood of ECHS youth being excluded from school.
- Strengthened culture of safety, connectedness and inclusion schoolwide.

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

https://jfcs-eastbay.org/
Point of Contact: Lisa Mulligan
Contact Information: 1855 Olympic Blvd. #200, Walnut Creek, CA 94596
(925) 927-2000, lmulligan@jfcs-eastbay.org

1. **General Description of the Organization**

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

2. **Program: Community Bridges - PEI**

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

b. Target Population: Immigrant and refugee families of Contra Costa County at risk for developing a serious mental illness.

c. Payment Limit: FY 20-21: $185,111

d. Number served: FY 18-19: 224 clients

e. Outcomes:

- Provided culturally and linguistically appropriate care to all consumers served
- Completed assessment and short-term intervention to 104 non English -speaking clients
- Provided individual health and mental health navigation services to 133 clients (adults and children)

- Provided 4 trainings on cross-cultural mental health concepts for 81 frontline staff from JFCS East Bay and other community agencies.

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

Point of Contact: Daniel Batiuchok
Contact Information: 202 Glacier Drive, Martinez, CA 94553
(925) 957-2739, Daniel.Batiuchok@hsd.cccounty.us

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The staff working to support youth in the juvenile justice system operate within Contra Costa Behavioral Health's Children's System of Care.
2. **Program: Mental Health Probation Liaisons and Orin Allen Youth Ranch Clinicians - PEI**
   County behavioral health clinicians strive to help youth experiencing the juvenile justice system become emotionally mature and law-abiding members of their communities. Services include: screening and assessment, consultation, therapy, and case management for inmates of the Juvenile Detention Facility and juveniles on probation, who are at risk of developing or struggle with mental illness or severe emotional disturbance.

a. Scope of Services: *Orin Allen Youth Rehabilitation Facility (OAYRF)* provides 100 beds for seriously delinquent boys ages 13-21, who have been committed by the Juvenile Court. OAYRF provides year-round schooling, drug education and treatment, Aggression Replacement Training, and extracurricular activities (gardening, softball). Additionally, the following mental health services are provided at OAYRF: psychological screening and assessment, crisis assessment and intervention, risk assessment, individual therapy and consultation, family therapy, psychiatric, case management and transition planning.
b. *Mental Health Probation Liaison Services (MHPLS)* has a team of three mental health probation liaisons stationed at each of the three field probation offices (in East, Central, and West Contra Costa County). The mental health probation liaisons are responsible for assisting youth and families as they transition out of detention settings and return to their communities. Services include; providing mental health and social service referrals, short term case management, short term individual therapy, short term family therapy. Additionally, the mental health probation liaisons are responsible for conducting court-ordered mental health assessments for youth within the county detention system.
c. Target Population: Youth in the juvenile justice system in need of mental health support
d. Payment Limit: FY 20-21: $422,667
e. Staff: 5 Mental Health Clinical Specialists: 3 probation liaisons, 2 clinicians at the Ranch
f. Number Served: FY 18-19: 300+

g. Outcomes:

- Help youth address mental health and substance abuse issues that may underlie problems with delinquency
- Increased access to mental health services and other community resources for at risk youth
- Decrease of symptoms of mental health disturbance
- Increase of help seeking behavior; decrease stigma associated with mental illness.

La Clínica de la Raza

https://www.laclinica.org/
Point of Contact: Laura Zepeda Torres
Contact Information: PO Box 22210, Oakland, CA, 94623
(510) 535 2911, lztorres@laclinica.org

1. **General Description of the Organization**
   With 35 sites spread across Alameda, Contra Costa and Solano Counties, La Clínica delivers culturally and linguistically appropriate health care services to address the needs of the diverse populations it serves. La Clínica is one of the largest community health centers in California.
2. **Program: Vías de Salud and Familias Fuertes - PEI**

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

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

b. Target Population: Contra Costa County Latino residents at risk for developing a serious mental illness.

a. Payment Limit: FY 20-21: $297,644

b. Number served: FY 18-19: 6960 consumers

c. Outcomes:

   i. Vias de Salud:

- Participants of support groups reported reduction in isolation and depression

- Offered 5944 depression screenings, 528 assessments and early intervention services, 1185 follow-up services

ii. Familias Fuertes:

- 100% of parents reported increased knowledge about positive family communication
- 100% of parents reported improved skills, behavior, and family relationships
- Offered 955 screenings for youth, 185 assessments for youth, 262 follow-up visits with families

Lao Family Community Development

https://lfcd.org/
Point of Contact: Kathy Chao Rothberg, Brad Meyer
Contact Information: 1865 Rumrill Blvd. Suite #B, San Pablo, Ca 94806
(510) 215-1220 krothberg@lfcd.org ; bmeyer@lfcd.org

1. **General Description of the Organization**

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

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

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

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

c. Payment Limit: FY 20-21: $202,012

d. Number served: In FY 18-19: 125

e. Outcomes:

- 100% of program participants completed the Lubben Social Networking Scale (LSNS) assessments. Results indicate program participation leads to a decrease in social isolation.

- Held 18 Strengthening Families Program (SFP) workshops
- Facilitated 8 different community events during the FY
- Provided case management and system navigation for 125 community members

The Latina Center

https://thelatinacenter.org/
Point of Contact: Miriam Wong, 3701 Barrett Ave #12, Richmond, CA 94805
(510) 233-8595, miriamrwong@gmail.com

1. **General Description of the Organization**
   The Latina Center is an organization of and for Latinas that strive to develop emerging leaders in the San Francisco Bay Area through innovative training, support groups and leadership programs. The mission of The Latina Center is to improve the quality of life and health of the Latino Community by providing leadership and personal development opportunities for Latina women.
2. **Program: Our Children First/Primero Nuestros Niños - PEI**

a. Scope of Services: The Latina Center (TLC) provides culturally and linguistically specific parenting education and support to at least 300 Latino parents and caregivers in West Contra Costa County that 1) supports healthy emotional, social and educational development of children and youth ages 0-15, and 2) reduces verbal, physical and emotional abuse. The Latina Center enrolls primarily low-income, immigrant, monolingual/bilingual Latino parents and grandparent caregivers of high-risk families in a 12-week parenting class using the Systematic Training for Effective Parenting (STEP) curriculum or PECES in Spanish (Padres Eficaces con Entrenamiento Eficaz). Parent Advocates are trained to conduct parenting education classes, and Parent Partners are trained to offer mentoring, support and systems navigation. TLC provides family activity nights, creative learning circles, cultural celebrations, and community forums on parenting topics.
b. Target Population: Latino Families and their children in West County at risk for developing serious mental illness.
c. Payment Limit: FY 20-21 $125,753
d. Number served: For FY 18-19: 327
e. Outcomes:
   - 100% of the 327 parent participants surveyed responded that the program has helped them become a better parent, improve their relationships with their family, improved communication with their children and given them more strategies for relating to and raising their children.
   - Provided community based 12-week parenting classes and workshops, including NAMI Basics and Mental Health First Aid (in Spanish)
   - A total of 88 parents completed the 12-week parenting course and graduated from the program
   - Classes were offered at different Richmond area community-based locations including Lake Elementary School, Catholic Charities and the Latina Center.
   - Hired a mental health counselor to offer culturally and linguistically appropriate one-on-one support for clients in need

Lifelong Medical Care

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

1. **General Description of the Organization**
   Founded in 1976, LifeLong Medical Care (LifeLong) is a multi-site safety-net provider of comprehensive medical, dental, behavioral health and social services to low-income individuals and families in West Contra Costa and Northern Alameda counties. In 2017, LifeLong provided approximately 300,000 health care visits to 61,000 people of all ages and cultural backgrounds.
2. **Program: Senior Network and Activity Program (SNAP) - PEI**

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

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

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

b. Target Population: Seniors in low income housing projects at risk for developing serious mental illness.
c. Payment Limit: FY 20-21: $138,751
d. Number served: FY 18-19: 138

e. Outcomes:

- Highlights from the FY include; three-month nutrition series; live drumming and creative movement classes; grief and loss group, conversational Spanish group, Men's Club, Tai Chi
- More than 65% of participants demonstrated self-efficacy and purpose by successfully completing at least one long-term project.
- 95% of respondents self-reported improvement in mood as a result of participating in SNAP.
- 98% of respondents reported feeling more connected to others as result of SNAP.
- 98% of respondents reported satisfaction with the SNAP program.

Lincoln

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

1. **General Description of the Organization**
   Lincoln was founded in 1883 as the region's first volunteer-run, non-sectarian, and fully integrated orphanage. As times and community needs evolved, Lincoln's commitment to vulnerable children remained strong. In 1951, Lincoln began serving abused, neglected and emotionally challenged children. Today, as a highly respected provider of youth and family services, Lincoln has a continuum of programs to serve children and families impacted by poverty and trauma throughout Alameda and Contra Costa Counties. Their therapeutic school and community based services include early intervention to intensive programming and focus on family strengthening, educational achievement and youth positive outlook.
2. **Program: Multi-Dimensional Family Therapy (MDFT) – Full Service Partnership - CSS**
   Multidimensional Family Therapy (MDFT), an evidence-based practice, is a comprehensive and multi-systemic family-based outpatient program for adolescents with co-occurring substance use and mental health issues who may be at high risk for continued substance abuse and other challenging behaviors, such as emotional dysregulation, defiance and delinquency. Working with the youth and their families, MDFT helps youth develop more effective coping and problem solving skills for better decision making, and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems. Services are delivered over 5 to 7 months, with weekly or twice-weekly, face-to-face contact, either in the home, the community or in the clinic.

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

b. Target Population: Children in West, Central and East County experiencing co-occurring serious mental health and substance abuse challenges. Youth and their families can be served by this program.
c. Payment Limit: FY 20-21 $989,969
d. Number Served: The program served 56 clients in FY18-19.
e. Outcomes: For FY 18-19:
   - Reduction in substance use or maintained abstinence
   - Reduction in delinquency or maintained positive functioning in community involvement
   - Improvement in emotional functioning

Table 1. Pre- and post-enrollment utilization rates for 56 Lincoln Child Center participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-	%change
PES episodes	8	2	0.017	0.005	-69.4%
Inpatient episodes	2	0	0.004	0.000	-100.0%
Inpatient days	7	0	0.015	0.000	-100.0%
JACS	45	34	0.097	0.090	-7.7%

PH Senior Care, LLC (Pleasant Hill Manor)

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

1. **General Description of the Organization**
   The County contracts with Pleasant Hill Manor, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Cares – MHSA Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

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

c. Number served: For FY 18-19: Capacity of 26 beds.

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

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

1. **General Description of the Organization**
   The Behavioral Health Services Division partners with the Health, Housing and Homeless Division to provide permanent and temporary housing with supports for person experiencing a serious mental illness and who are homeless or at risk of being homeless.
2. **Program: Homeless Programs - Temporary Shelter Beds - CSS**
   The County's Health Housing and Homeless Services Division operate a number of temporary bed facilities in West and Central County for transitional age youth and adults. CCBHS, maintains a Memorandum of Understanding with the Health Housing and Homeless Services Division that provides additional funding to enable up to 64 individuals with a serious mental illness per year to receive temporary emergency housing for up to four months.

a. Target Population: Individuals who are severely and persistently mentally ill or seriously emotionally disturbed; and are homeless.
b. Total MHSA Portion of Budget: $2,110,379
c. Number Served: FY 18-19: 75 beds fully utilized for 365 days in the year.

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

a. Target Population: Individuals who are severely and persistently mentally ill or seriously emotionally disturbed and are homeless or at risk of homelessness.
b. Total MHSA Portion of Budget: One Time Funding Allocated.
c. Number Served: FY 18-19: 50 units.

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

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

b. Total FTE: 4.0 FTE
c. Total MHSA Portion of Budget: $644,560
d. Number Served: FY 18-19: Approximately 700 individuals per year receive permanent or temporary supportive housing by means of MHSA funded housing services.

Mental Health Systems, Inc.

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

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

a. Mental Health Systems, Inc. (MHS) will provide Assisted Outpatient Treatment (AOT) services and subsequent Assertive Community Treatment (ACT) Full Service Partnership (FSP) services for up to 75 eligible adults in Contra Costa County. Program services shall meet the requirements of AB 1421 (Laura's Law) while respecting the choice, autonomy and dignity of individuals struggling with the symptoms of serious mental illness (SMI) and/or co-occurring substance abuse disorders. The program will be identified as the Contra Costa ACTion Team and the Mental Health Services Act (MHSA) will fund services. The program will be inclusive of outreach, engagement and support in the investigatory process of AOT determination and the subsequent provision of ACT services. MHS' FSP program model will incorporate an ACT Team whose multidisciplinary members will provide intensive community- based services to adults with SMI and co-occurring substance abuse disorders, who a) establish an AOT court settlement agreement, b) are court-ordered to receive these services, or c) meet the criteria and agree to voluntarily accept services. Target Population: Adults diagnosed with serious mental illness and co-occurring substance abuse disorders, who a) establish an AOT court settlement agreement, b) are court-ordered to receive these services, or c) meet the criteria for FSP services and agree to voluntarily accept services.

b. Payment Limit: FY 20-21 $1,081,886

c. Number Served: The program served 47 clients during the16-17 fiscal year, 68 clients during the 17-18 fiscal year, 115 clients during the 18-19 fiscal year.

d. Outcomes: For Calendar Year 2018
   - ACT treatment adherence was 66% overall.
   - Consumers receiving ACT services had a decrease in crisis episodes from 94% to 48%.
   - Consumers had a decrease in psychiatric hospitalizations from 53% to 18%.
   - Consumers had a decrease in jail bookings from 54% to 26%.
   - 69% of consumers obtained or maintained housing while in ACT.
   - 14 consumers maintained employment during FY 18/19.

Table 1. Pre-and post-enrollment utilization rates for 18 Mental Health Systems FSP participants enrolled in the FSP program during FY 18-19

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	80	31	0.370	0.287	-22.5%
Inpatient episodes	8	3	0.037	0.028	-25.0%
Inpatient days	100	61	0.463	0.565	-22.0%

Modesto Residential Living Center, LLC.

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

1. **General Description of the Organization**
   The County contracts with Modesto Residential, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Cares – MHSA Housing Services - CSS**
   The County contracts with Modesto Residential Living Center, a licensed board and care provider, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.

a. Scope of Services: Augmented residential services, including but not limited to:
   - Medication management
   - Nutritional meal planning
   - Assistance with laundry
   - Transportation to psychiatric and medical appointments
   - Improving socialization
   - Assist with activities of daily living (i.e., grooming, hygiene, etc.)
   - Encouraging meaningful activity
   - Other services as needed for individual residents

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

c. Number served: For FY 17-18: Capacity of 6 beds.

National Alliance on Mental Illness Contra Costa (NAMI CC)

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

1. **General Description of the Organization**
   NAMI CC has been assisting people affected by mental illness for over 30 years now. Services provide support, outreach, education, and advocacy to those affected by mental illness. NAMI's office is located in central Contra Costa County and the program has partnerships with other community and faith based organizations throughout the county that allow them to utilize their space and meet with people in their communities.
2. **Program: Family Volunteer Support Network (FVSN) - WET**
   NAMI CC will recruit, train and manage a network of volunteers with lived experience to support families and loved ones of people experiencing mental health issues. These volunteers will be an extended support network of resources, while assisting families in navigating the behavioral health system. This group of subject matter experts will help families gain a basic understanding of various mental health and substance abuse issues, learn to advocate for themselves or their loves one's needs and become a network to other families experiencing similar situations.

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

b. Target Population: Family members and care givers of individuals with lived mental health issues.
c. Payment Limit: FY 20-21 $618,000
d. Number Served: FY 18-19: 700 individuals.
e. Outcomes:
   - Staff the FVSN Program.
   - Provide one office in central Contra Costa County, and maintain three satellite locations in east, west, and south Contra Costa County.
   - Partner with other CCBHS, faith and other community agencies to support families affected by mental health issues.

- Develop training curriculum for FVSN Program.
- Start recruitment of volunteers.

3. Program: Family Psycho Education Program (Family to Family: Spanish, Mandarin/Cantonese, FaithNet, NAMI Basics, and Conversations with Local Law Enforcement) - WET

a. Scope of Services: Family to Family is an evidence based NAMI educational training program offered throughout the county in Spanish, Mandarin and Cantonese languages to family members and caregivers of individuals experiencing mental health challenges. This training is designed to support and increase a family member's/care giver's knowledge of mental health, its impact on the family, navigation of systems, connections to community resources, and coping mechanisms. NAMI FaithNet is an interfaith resource network of NAMI members, friends, clergy and congregations of all faith traditions who wish to encourage faith communities to be welcoming and supportive of persons and families living with mental illness. NAMI Basics is aimed to give an overview about mental health, how best to support a loved one at home, at school and when in getting medical care. The course is taught by a trained team of individuals and loved ones with lived experience. Conversations with Local Law Enforcement will serve to support the dialogue between local law enforcement and consumers/families through CCBH's Crisis Intervention Training (CIT). NAMI CC will also host six other conversations in partnership with local law enforcement agencies throughout the County to enhance learning and dialogue between all groups in response to community concerns and mental health supports. The desired goal is to enhance information sharing and relationships between law enforcement and those affected by mental health.

- For Family to Family (Mandarin/Cantonese) and De Familia a Familia (Spanish); provide training program to help address the unique needs of the specified population, helping to serve Spanish, Mandarin and Cantonese speaking communities to help families develop coping skills to address challenges posed by mental health issues in the family, and develop skills to support the recovery of loved ones.
- For NAMI Basics, provide instruction related to the mental health concepts, wellness and recovery principles, symptoms of mental health issues; as well as education on how mental illness and medications affect loved ones.
- For the FaithNet program, implement a mental health spirituality curriculum targeting faith leaders and the faith-based communities in the County, who have congregants or loved ones with severe and persistent mental illness. The goals are to implement training to equip faith leaders to have a better understanding of mental health issues; and their roles as first responders at times and replace misinformation about mental health diagnoses, treatment, medication, etc. with accurate information.
- For Conversations with Local Law Enforcement, support dialogue between local law enforcement and consumers/families through CCBH's Crisis Intervention Training (CIT) throughout the County to enhance learning and dialogue between all groups in response to community concerns and mental health supports. The desired goal is to enhance information sharing and relationships between law enforcement and those affected by mental health.
- Create partnerships with CCBHS, local law enforcement agencies, community/faith-based organizations as well as ethnic and culturally specific

agencies in order to coordinate family support efforts, ensure CCBHS connectivity with families of consumers, and stay abreast and be adaptive to current and future needs.
    - All training will be augmented by utilizing sites, such as faith centers, community based organizations, and community locations throughout the county on an as needed basis in order to enable access to diverse communities with the goal of reaching the broadest audiences
b. Target Population: Family members, care givers and loved ones of individuals with mental health challenges, as well as faith communities, local law enforcement, and the overall community who would like to learn more about supporting those with mental health challenges.
c. Payment Limit: $70,596
d. Number served: For FY 18-19: 780 individuals participated in training, workshops, and events.
e. Outcomes:
    - Deliver six Family-to-Family (Spanish, at least one in Mandarin/Cantonese) (12) week trainings during fiscal year.
    - Deliver four NAMI Basics (6) session trainings during fiscal year, with at least one in Spanish.
    - Hold four FaithNet events during fiscal year.
    - Deliver six Conversations with Local Law Enforcement in partnership with local law enforcement agencies and individuals or families affected by mental health issues throughout the County to enhance learning and dialogue between all groups in response to community concerns and mental health supports.
    - All trainings will educate individuals on how to manage crises, solve problems, communicate effectively, learn the importance of self-care, and assist in developing confidence and stamina to provide support with compassion, and learn about the impact of mental illness on the family.
    - Feedback will inform decision making. Member participation surveys will be created, administered and collected on a regular basis. Information collected will be analyzed to adjust methods to better meet the needs of all involved. Surveys will gauge participant knowledge, and level of confidence and understanding of mental health, advocacy and the public mental health system.

Native American Health Center (NAHC)

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

1. **General Description of the Organization**

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

2. **Program: Native American Wellness Center – PEI**

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

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

b. Target Population: Native American residents of Contra Costa County (mainly west region), who are at risk for developing a serious mental illness.

c. Payment Limit: FY 20-21: $256,559

d. Number served: FY 18-19: 289 total community members through various outreach efforts, as well as groups and individual case management

e. Outcomes:

   - Held a total of 26 community based events in FY 18-19 and trainings, including Mental Health First Aid

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

Oak Hills Residential Facility

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

1. **General Description of the Organization:**
   The County contracts with Oak Hills, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Cares – MHSA Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

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

c. Number Served: For FY 18-19: Capacity of 6 beds.

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

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

1. **General Description of the Organization**
   The Office for Consumer Empowerment is a County operated program that supports the entire Behavioral Health System and offers a range of trainings and supports by and for individuals who have experience receiving behavioral health services. The goals are to increase access to wellness and empowerment knowledge for participants of the Behavioral Health System.
2. **Program: Reducing Stigma and Discrimination – PEI**

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

3. **Program: Mental Health Career Pathway Program - WET**

a. Scope of Services: The Service Provider Individualized Recovery Intensive Training (SPIRIT) Program is a recovery-oriented peer led classroom and experientially based college accredited program that prepares individuals to become providers of

service. Certification from this program is a requirement for many Community Support Worker positions in Contra Costa Behavioral Health. Staff provide instruction and administrative support, and provide ongoing support to graduates.

4. Program: Overcoming Transportation Barriers – INN

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

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

c. Total MHSA Funding for FY 20-21: $232,190

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

e. Outcomes:

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

Older Adult Mental Health
(Contra Costa Behavioral Health Services)

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

1. **General Description of the Organization**
   The Older Adult Mental Health Clinic is in the Adult System of Care and provides mental health services to Contra Costa's senior citizens, including preventive care, linkage and outreach to under-served at risk communities, problem solving short-term therapy, and intensive care management for severely mentally ill individuals.
2. **Program: Intensive Care Management - CSS**
   The Intensive Care Management Teams (ICMT) provide mental health services to older adults in their homes, in the community and within a clinical setting. Services are provided to Contra Costa County residents with serious psychiatric impairments who are 60 years of age or older. The program provides services to those who are insured through Medi-Cal, dually covered under Medi-Cal and MediCare, or uninsured. The primary goal of these teams is to support aging in place as well as to improve consumers' mental health, physical health, prevent psychiatric hospitalization and placement in a higher level of care, and provide linkage to primary care appointments, community resources and events, and public transportation in an effort to maintain independence in the community. Additionally, the teams provide services to those who are homeless, living in shelters, or in residential care facilities. There are three multi-disciplinary Intensive Care Management Teams, one for each region of the county that increases access to resources throughout the county.
3. **Program: Improving Mood Providing Access to Collaborative Treatment (IMPACT) - CSS**
   IMPACT is an evidence-based practice which provides depression treatment to individuals age 55 and over in a primary care setting. The IMPACT model prescribes short-term (8 to 12 visits) Problem Solving Therapy and medication consultation with up to one year of follow-up as necessary. Services are provided by a treatment team consisting of licensed clinicians, psychiatrists, and primary care physicians in a primary care setting. The target population for the IMPACT Program is adults age 55 years and older who are receiving health care services at a federally qualified health center. The program focuses on treating older adults with late-life depression and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. The primary goals of the Impact Program are to prevent more severe psychiatric symptoms, assist clients in accessing community resources as needed, reducing stigma related to accessing mental health treatment and providing access to therapy to this underserved population.
4. **Program: Senior Peer Counseling - WET**
   This program reaches out to isolated and mildly depressed older adults in their home environments and links them to appropriate community resources in a culturally competent manner. Services are provided by Senior Peer Volunteers, who are trained and supervised by the Senior Peer Counseling Coordinators. The Latino Senior Peer Counseling Program is recognized as a resource for this underserved

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

a. Target Population: Depending on program, Older Adults aged 55 or 60 years and older experiencing serious mental illness or at risk for developing a serious mental illness.
b. Total Budget: Intensive Care Management - $2,995,707; IMPACT - $392,362; Senior Peer Counseling - $254,496.
c. Staff: 28 Full time equivalent multi-disciplinary staff.
d. Number served: For FY 18-19: ICMT served 305 individuals; IMPACT served 440 individuals; Senior Peer Counseling Program trained and supported 34 volunteers and served 267 individuals.
e. Outcomes: For IMPACT and ICM: Changes in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, decreased Patient Health Questionnaire (PHQ-9) scores, and reduced isolation, which is assessed by the PEARLS (ICM only). The SPC Program has implemented the Depression Anxiety Stress Scales (DASS) that will be administered at intake, and at the end of counseling to assess levels of anxiety and depression.

5. Program: Partners in Aging - INN

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

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

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

c. Annual Payment Limit: $250,000
d. Number served: For FY 18-19: 38 individuals
e. Outcomes: Reductions in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, and decreased Patient Health Questionnaire (PHQ-9) scores would indicate the effectiveness of this program. We are also utilizing the PEARLS to measure outcomes related to Partners in Aging.

People Who Care (PWC) Children Association

http://www.peoplewhocarechildrenassociation.org/
Point of Contact: Constance Russell
Contact Information: 2231 Railroad Ave, Pittsburg, 94565
(925) 427-5037, pwc.cares@comcast.net

1. **General Description of the Organization**

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

2. **Program: PWC Afterschool Program - PEI**

a. Scope of Services: Through its After School Program, People Who Care (PWC) will provide Prevention services through providing work experience for 200+ multicultural at-risk youth residing in the Pittsburg/Bay Point and surrounding East Contra Costa County communities, as well as programs aimed at increasing educational success among those who are either at-risk of dropping out of school, or committing a repeat offense. Key activities include job training and job readiness training, mental health support and linkage to mental health counseling, as well as civic and community service activities.

b. Target Population: At risk youth with special needs in East Contra Costa County.

c. Payment Limit: FY 20-21: $236,689

d. Number served: FY 18-19: 207

e. Outcomes:

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

Portia Bell Hume Behavioral Health and Training Center (Hume Center)

https://www.humecenter.org/
Point of Contact: Reynold Fujikawa (Community Support Program East)
Contact Information: 555 School Street, Pittsburg, CA 94565
(925) 384-7727, rfujikawa@humecenter.org
Point of Contact: Margaret Schiltz, (Community Support Program West)
Contact Information: 3095 Richmond Pkwy #201, Richmond, CA 94806
(510) 944-3781, mschiltz@humecenter.org

1. **General Description of the Organization**
   The Hume Center is a Community Mental Health Center that provides high quality, culturally sensitive and comprehensive behavioral health care services and training. The agency strives to promote mental health, reduce disparities and psychological suffering, and strengthen communities and systems in collaboration with the people most involved in the lives of those served. They are committed to training behavioral health professionals to the highest standards of practice, while working within a culture of support and mutual respect. They provide a continuity of care in Contra Costa that includes prevention and early intervention, behavioral consultation services, outpatient psychotherapy and psychiatry, case management, Partial Hospitalization services, and Full Service Partnership (FSP) Programs. Their FSPs are located in East and West county.
2. **Program: Adult Full Service Partnership - CSS**
   The Adult Full Service Partnership is a collaborative program that joins the resources of Hume Center and Contra Costa County Behavioral Health Services.

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

b. Referral, Admission Criteria, and Authorization:
   i. Referral: To inquire about yourself or someone else receiving our Full Service Partnership Services in our Community Support Program (CSP) East program, please call our Pittsburg office at (925) 432-4118. For services in our CSP West program, please contact our Richmond office at (510) 778-2816.
   ii. Admission Criteria: This program serves adult aged 26 and older who are diagnosed with severe mental illness and are:
      - Frequent users of emergency services and/or psychiatric emergency services
      - Homeless or at risk of homelessness
      - Involved in the justice system or at risk of this
      - Have Medi-Cal insurance or are uninsured
   iii. Authorization: Referrals are approved by Contra Costa Behavioral Health Division.

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

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

d. Target Population: Adults diagnosed with severe mental illness in East, Central and West County who are diagnosed with a serious mental illness, are at or below 300% of the federally defined poverty level, and are uninsured or receive Medi-Cal benefits.
e. Payment Limit: For FY 20/21 (East and West CSP): $4,272,121
f. Number served: For FY 18/19: 65 individuals (East); and 68 individuals (West)
g. Outcomes: For FY 18/19 (East):
   - Reduction in incidence of psychiatric crisis
   - Reduction of the incidence of restriction
   - For FY (West): 1. Reduction in incidence of psychiatric crisis 2. Reduction of the incidence of restriction

Table 1. Pre- and post-enrollment utilization rates for 65 Hume East FSP participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	301	150	0.408	0.209	-48.8%
Inpatient episodes	42	22	0.057	0.031	-46.2%
Inpatient days	572	519	0.966	0.848	-12.2%

Table 2. Pre- and post-enrollment utilization rates for 68 Hume West FSP participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	142	107	0.188	0.143	-23.9%
Inpatient episodes	17	8	0.022	0.011	-52.5%
Inpatient days	156	191	0.206	0.255	-23.6%

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

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

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

a. Scope of Services: Perform brief mental health assessment and intervention with adults, children, and their families. Provide short term case management, mental health services, individual and family support, crisis intervention, triage, coordination of care between primary care and Behavioral Health Services. Tasks also include linkage to schools, probation, social services and community services and lead groups at County Primary Care Center.
b. Target Population: Adults in central county, who present at the clinic for medical reasons
c. Number Served: For FY 18/19: 200+.
d. Outcomes: Improve overall health for individuals through decrease medical visit and increase coping with life situations.

Putman Clubhouse

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

1. **General Description of the Organization**

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

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

a. Scope of Services:

   i. Project Area A: Putnam Clubhouse's peer-based programming helps adults recovering from psychiatric disorders access support networks, social opportunities, wellness tools, employment, housing, and health services. The work-ordered day program helps members gain prevocational, social, and healthy living skills as well as access vocational options within Contra Costa. The Clubhouse teaches skills needed for navigating/accessing the system of care, helps members set goals (including educational, vocational, and wellness), provides opportunities to become involved in stigma reduction and advocacy. Ongoing community outreach is provided throughout the County via presentations and by distributing materials, including a brochure in both English and Spanish. The Young Adult Initiative provides weekly activities and programming planned by younger adult members to attract and retain younger adult members in the under-30 age group. Putnam Clubhouse helps increase family wellness and reduces stress related to caregiving by providing respite through Clubhouse programming and by helping Clubhouse members improve their independence.

   ii. Project Area B: Putnam Clubhouse assists the Office for Consumer Empowerment (OCE) by providing career support through hosting Career Corner, an online career resource for mental health consumers in Contra Costa County, and holding countywide career workshops.

   iii. Project Area C: Putnam Clubhouses assists Contra Costa County Behavioral Health in a number of other projects, including organizing community events and by assisting with administering consumer perception surveys.

   iv. Project Area D: Putnam Clubhouse assists Contra Costa County Behavioral Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support.

b. Target Population: Contra Costa County residents with identified mental illness and their families.

c. Payment Limit: FY 20-21: $650,322
d. Number served: In FY 18-19: 322
e. Outcomes (FY18-19):
   - 86 new members enrolled and participated in at least one activity
   - Held 4 career workshops
   - Prepared 9,935 meals for members
   - Provided 54,386 hours of Clubhouse programming to members
   - Clubhouse membership made a positive impact by decreasing hospitalizations

Rainbow Community Center

https://www.rainbowcc.org/
Point of Contact: Kiku Johnson
Contact Information: 2118 Willow Pass Rd, Concord, CA 94520.
(925) 692-0090, kikujohnson@rainbowcc.org

1. **General Description of the Organization**
   The Rainbow Community Center of Contra Costa County builds community and promotes well-being among Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) people and our allies. Services are provided in our main office in Concord, our satellite location in West County, and in East County by arrangements with partner organizations.
2. **Programs: Outpatient Behavioral Health and Training, and Community-Based Prevention and Early Intervention - PEI**

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

b. Target Population: LGBTQ community of Contra Costa County who are at risk of developing serious mental illness.
c. Payment Limit: FY 20-21: $805,607
d. Number served: FY 18-19: 1174
e. Outcomes:
   - Rainbow held approximately 28 trainings during the year

- Rainbow’s Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified.
- Offered services to LGBTQ seniors, adults and youth through their various tiered services

RI International, Inc. (formerly Recovery Innovations)

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

1. **General Description of the Organization**
   RI International was founded as META Services, an Arizona non-profit corporation. It has developed and provided a range of traditional mental health and substance abuse services for adults with long term mental health and addiction challenges. RI International pioneered an innovative initiative: the creation of the new discipline of Peer Support Specialist. This experience has transformed the RI International workforce to one in which Peer Support Specialists and professionals work together on integrated teams to deliver recovery-based services. The RI International experience has had a global impact on the mental health field serving as a demonstration that recovery from mental illness and/or addiction is possible. Based on transformation experience, RI International operates recovery-based mental health services in over 20 communities in five states and one location in New Zealand. RI International has provided recovery training and transformation consultation in 27 states and five countries abroad.
2. **Program: RI International Wellness Cities – CSS**
   RI International provides Adult Wellness Cities that serve individuals or *citizens* experiencing mental and/or behavioral health challenges in west, central and east Contra Costa County. Wellness Cities provide a variety of wellness and recovery-related classes and groups, one-on-one coaching, vocational opportunities, links to community resources, and recreational opportunities in a peer supported environment. The classes, groups and coaching are recovery-oriented and facilitated by peer recovery coaches. Coaches work with citizens to establish individualized goals, a wellness recovery action plan (WRAP), self-help and coping skills, support networks and a commitment to overall wellness. All services provided are related to at least one of the nine dimensions of wellness; physical, emotional, intellectual, social, spiritual, occupational, home and community living, financial and recreation/leisure. Participants seeking services become citizens of the city. Citizens develop a 6 month partnership with RI International and are assigned a Peer Recovery Coach who has experienced their own success in recovery by obtaining education, coping skills, self-management and/or sobriety. They share what they have learned and walk alongside each citizen on their individualized and strength-based path to recovery.

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

a. Scope of Services:
   - Peer and family support

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

b. Target Population: Adult mental health participants in Contra Costa County. RI International services will be delivered within each region of the county through Wellness Cities located in Antioch, Concord and San Pablo.
c. Annual MHSA Payment Limit: $1,290,630
d. Number served: FY 18-19: 219, of those 183 were active, regular participants. It is estimated that all RI International Contra Costa sites were visited 1,224 times on average each month by RI Citizens.
e. Outcomes: For FY 18-19, RI International served a total of 219 citizens, of which 157 developed a Wellness Recovery Action Plan (WRAP). Attendance numbers for the four core classes during FY 18-19 are as follows:
    - 157 attended WRAP classes and 47 completed the program.
    - 132 attended WELL classes and 50 completed the program.
    - 125 attended Facing up to Health classes 24 completed the program.
    - 133 attended the 9 Dimensions of Wellness classes and 44 completed the program.
    - RI International was also able to offer Illness Management Recovery (IMR) classes to RI Citizens; funded through Substance Abuse and Mental Health Services Administration (SAMHSA). 9 attended the IMR classes and 3 completed the program.

RYSE Center

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

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

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

b. Target Population: West County Youth at risk for developing serious mental illness.
c. Payment Limit: FY 20-21: $533,439

d. Unique Number served: FY 18-19: 720 young people

e. A Sampling of Outcomes from FY 18-19:

- 242 new members enrolled
- 87 young people completed Education, Career, Let's Get Free or Case Management Plans
- Young people developed original poetry and spoken word, performed at over 15 public and/or youth-led events.
- 39 new members were referred to RYSE through Probation or hospital linkages
- Restorative Justice Diversion Pilot**:** In May 2019 RYSE launched a collaborative agreement with the District Attorney's Office to bring restorative justice diversion to Contra Costa County.
- RYSE Commons**:** RYSE has launched our capital campaign and begun construction to expand into RYSE Commons, including a new building to serve as a Health Home for young people of color

Seneca Family of Agencies

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

1. **General Description of the Organization**

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

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

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

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

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

c. Payment Limit: FY 20- 21 $ 2,174,196

d. Number served: Number served in FY 18-19: 73 individuals

e. Outcomes:

Table 1. Pre-and post-enrollment utilization rates for 73 Seneca Start FSP Participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	88	22	0.151	0.061	-59.7%
Inpatient episodes	25	11	0.043	0.030	-29.1%
Inpatient days	166	87	0.285	0.241	-15.5%

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

SHELTER, Inc.

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

1. **General Description of the Organization**
   The mission of SHELTER, Inc. is to prevent and end homelessness for low-income, homeless, and disadvantaged families and individuals by providing housing, services, support, and resources that lead to self-sufficiency. SHELTER, Inc. was founded in 1986 to alleviate Contra Costa County's homeless crisis, and its work encompasses three main elements: 1) prevent the onset of homelessness, including rental assistance, case management, and housing counseling services, 2) ending the cycle of homelessness by providing housing plus services including employment, education, counseling and household budgeting to help regain self-sufficiency and 3) providing permanent affordable housing for over 200 low-income households, including such special needs groups as transition-age youth, people with HIV/AIDS, and those with mental health disabilities.
2. **Program: Supportive Housing - CSS**
   SHELTER, Inc. provides a master leasing program, in which adults or children and their families are provided tenancy in apartments and houses throughout the County. Through a combination of self-owned units and agreements with landlords SHELTER, Inc. acts as the lessee to the owners and provides staff to support individuals and their families move in and maintain their homes independently. Housing and rental subsidy services are provided to residents of the County who are homeless and that have been certified by Contra Costa Behavioral Health as eligible. This project is committed to providing housing opportunities that provide low barriers to obtaining housing that is affordable, safe and promotes independence to MHSA consumers.

a. Scope of Services.

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

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

b. Target Population: Consumers eligible for MHSA services. The priority is given to those who are homeless or imminently homeless and otherwise eligible for the full service partnership programs.
c. Annual Payment Limit: $2,420, 426
d. Number served: For FY 18-19 Shelter, Inc. served 118 consumers.
   - Outcomes: Quality of life: housing stability.
     i. Goal: 70% of MHSA Consumers residing in master leased housing shall remain stably housed for 18 months or longer.
     ii. Goal: 70% of MHSA Consumers residing in SHELTER, Inc. owned property shall remain stably housed for 12 months or longer.
     iii. Capacity of 119 Units.

STAND! For Families Free of Violence

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

1. **General Description of the Organization**

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

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

a. Scope of Services: STAND! provides services to address the effects of teen dating violence/domestic violence and helps maintain healthy relationships for at-risk youth throughout Contra Costa County. STAND! uses two evidence-based, best-practice programs: "Expect Respect" and "You Never Win with Violence" to directly impact youth behavior by preventing future violence and enhancing positive mental health outcomes for students already experiencing teen dating violence. Primary prevention activities include educating middle and high school youth about teen dating through the 'You Never Win with Violence' curriculum, and providing school personnel, service providers and parents with knowledge and awareness of the scope and causes of dating violence. The program strives to increase knowledge and awareness around the tenets of a healthy adolescent dating relationship. Secondary prevention activities include supporting youth experiencing, or at-risk for teen dating violence by conducting 20 gender-based, 15-week support groups. Each school site has a system for referring youth to the support groups. As a result of these service activities, youth experiencing or at-risk for teen dating violence will demonstrate an increased knowledge of: 1) the difference between healthy and unhealthy teen dating relationships, 2) an increased sense of belonging to positive peer groups, 3) an enhanced understanding that violence does not have to be "normal", and 4) an increased knowledge of their rights and responsibilities in a dating relationship.
b. Target Population: Middle and high school students at risk of dating violence.
c. Payment Limit: FY 20-21: $142,280
d. Number served: FY 18-19: 1903 participants
e. Outcomes:
   - *You Never Win with Violence* presentations to 1730 middle and high school youth (during 70 presentations) in Contra Costa County
   - 18 *Expect Respect* groups reached 252 participants
   - Offered 10-week long gender-based support groups
   - Trained adult allies (teachers and other school personnel)

Telecare Corporation

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

1. **General Description of the Organization**
   Telecare Corporation was established in 1965 in the belief that persons with mental illness are best able to achieve recovery through individualized services provided in the least restrictive setting possible. Today, they operate over 130 programs staffed by more than 4,000 employees in California, Oregon, Washington, Arizona, Nebraska, North Carolina, Texas, New Mexico and Pennsylvania and provide a broad continuum of services and supports, including Inpatient Acute Care, Inpatient Non-Acute/Sub-Acute Care, Crisis Services, Residential Services, Assertive Community Treatment (ACT) services, Case Management and Prevention services.
2. **Program: Hope House Crisis Residential Facility - CSS**
   Telecare Corporation operates Hope House, a voluntary, highly structured 16-bed Short-Term Crisis Residential Facility (CRF) for adults between the ages of 18 and 59. Hope House is serves individuals who require crisis support to avoid hospitalization, or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living. The focus is client-centered and recovery-focused and underscores the concept of personal responsibility for the resident's illness and independence. The program supports a social rehabilitation model, which is designed to enhance an individual's social connection with family and community so that they can move back into the community and prevent a hospitalization. Services are recovery based and tailored to the unique strengths of each individual resident. The program offers an environment where residents have the power to make decisions and are supported as they look at their own life experiences, set their own paths toward recovery, and work towards the fulfillment of their hopes and dreams. Telecare's program is designed to enhance client motivation to actively participate in treatment, provide clients with intensive assistance in accessing community resources, and assist clients develop strategies to maintain independent living in the community and improve their overall quality of life. The program's service design draws on evidence-based practices such as Wellness Action and Recovery Planning (WRAP), motivational interviewing, and integrated treatment for co-occurring disorders.

a. Scope of Services:
   - Individualized assessments, including, but not limited to, psychosocial skills, reported medical needs/health status, social supports, and current functional limitations within 24 hours of admission.
   - Psychiatric assessment within 24 hours of admission.
   - Treatment plan development with 72 hours of admission.
   - Therapeutic individual and group counseling sessions on a daily basis to assist clients in developing skills that enable them to progress towards self-sufficiency and to reside in less intensive levels of care.

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

b. Target Population: Adults ages 18 to 59 who require crisis support to avoid psychiatric hospitalization or are discharging from the hospital or long-term locked facilities and need step-down care to transition back to community living.
c. Payment Limit: FY 19-20 $2,270,173.00
d. Number served: FY18-19 Unduplicated client count of 241.
e. Outcomes:
    - Reduction in severity of psychiatric symptoms: Discharge at least 90% of clients to a lower level of care.
    - Consumer Satisfaction: Maintain an overall client satisfaction score of at least 4.0 out of 5.0.

United Family Care, LLC (Family Courtyard)

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

1. **General Description of the Organization**
   The County contracts with United Family Care, LLC (Family Courtyard), a licensed board and care provider, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Care Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

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

c. Number served: For FY 18-19: Capacity of 50 beds.

Vicente Martinez High School - Martinez Unified School District

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

1. **General Description of the Organization**
   The PEI program at Vicente Martinez High School and Briones School (co-located on the same campus) offers an integrated mental health focused experience for 10th-12th grade at-risk students of all cultural backgrounds. Students are provided a variety of experiential and leadership opportunities that support social, emotional and behavioral health, career exposure and academic growth while also encouraging, linking and increasing student access to direct mental health services.
2. **Program: Vicente Martinez High School & Briones School - PEI**

a. Scope of Services: Vicente Martinez High School and Briones School provide students of all cultural backgrounds an integrated, mental health focused, learning experience. Key services include student activities that support:
   - individualized learning plans
   - mindfulness and stress management interventions
   - team and community building
   - character, leadership, and asset development
   - place-based learning, service projects that promote hands-on learning and intergenerational relationships
   - career-focused exploration, preparation and internships
   - direct mental health counseling
   - timely access and linkage to direct mental health counseling

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

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

b. Target Population: At-risk high school students in Central County
c. Payment Limit: FY 20-21: $197,076
d. Number served: FY 18-19: 121 Transition Aged Youth (TAY)
e. Outcomes:
   i. Goals: Students enrolled in Vicente and Briones will:

   - Develop an increased ability to overcome social, familial, emotional, psychiatric, and academic challenges and hence work toward academic, vocational, relational, and other life goals
   - Increase mental health resiliency

- Participate in four or more different PEI related activities throughout the school year
- Decrease incidents of negative behavior
- Increase attendance rates

ii. <u>During the 18-19 School Year:</u>

- 97% of Vicente students enrolled during the 18-19 school year participated in PEI related activities.
- All seniors participated in a minimum of 15 hours of service learning.
- Staff organized and hosted 70 different types of activities and events to enrich the curricula.
- All students were offered mental health counseling.
- Developmental Assets Profile (DAP) assessment was administered to all students.
- All students were given the opportunity to apply, interview and participate in career-focused internships.

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

https://cchealth.org/mentalhealth/#simpleContained4
Point of Contact: Robin O'Neill, Mental Health Program Manager
Contact Information: 13585 San Pablo Ave, CA 94806
(510) 215-3700, Robin.ONeill@CCHealth.org

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The East Adult Mental Health Clinic operates within Contra Costa Mental Health's Adult System of Care, and provides assessments, case management, psychiatric services, crisis intervention, housing services, and benefits assistance. Within the Adult Mental Health Clinic are the following MHSA funded programs and plan elements:
2. **Plan Element: Adult Full Service Partnership Support - CSS**
   Contra Costa Mental Health has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination and rapid access for full service partners to health and mental health clinic services as needed and appropriate. Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for Full Service Partnership services, the Rapid Access Clinician will seek approval to refer the client to Full Service Partnership services. Clinic management acts as the gatekeepers for the Full Service Partnership programs, authorizing referrals and discharges as well as providing clinical oversight to the regional Full Service Partnership programs. Full Service Partnership Liaisons provide support to the Full Service Partnership programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care.
3. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to 1) assist consumers in obtaining benefits they entitled to, educate consumers on how to maximize use of those benefits and manage resources, and 2) provide transportation support for consumers and families.

a. Clinic Target Population: Adults aged 18 years and older who live in West County, are diagnosed with a serious mental illness and are uninsured or receive Medi-Cal benefits.
b. Total Number Served: For FY 18-19: Approximately 2,387 Individuals.

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

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

1. **General Description of the Organization**
   The Behavioral Health Services Division of Contra Costa Health Services combines Mental Health, Alcohol & Other Drugs and Homeless Program into a single system of care. The West Children's Mental Health Clinic operates within Contra Costa Mental Health's Children's System of Care, and provides psychiatric and outpatient services, family partners, and wraparound services. Within the Children's Mental Health Clinic are the following MHSA funded plan elements:
2. **Plan Element: Clinic Support - CSS**
   General Systems Development strategies are programs or strategies that improve the larger mental health system of care. These programs and strategies expand and enhance the existing service structure to assist consumers in the following areas: Family Partners and Wraparound Facilitation. The family partners assist families with advocacy, transportation assistance, navigation of the service system, and offer support in the home, community, and county service sites. Family partners support families with children of all ages who are receiving services in the children. Family partners are located in each of the regional clinics for children and adult services, and often participate on wraparound teams following the evidence-based model. A Clinical Specialist in each regional clinic who provides technical assistance and oversight of evidence-based practices in the clinic. Support for full service partners.

a. Target Population: Children aged 17 years and younger, who live in West County, are diagnosed with a serious emotional disturbance or serious mental illness, and are uninsured or receive Medi-Cal benefits
b. Number Served: For FY 18-19: Approximately 474 Individuals.

Williams Board and Care

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

1. **General Description of the Organization**
   The County contracts with Williams Board and Care, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Care - Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
   - Medication management
   - Nutritional meal planning
   - Assistance with laundry
   - Transportation to psychiatric and medical appointments
   - Improving socialization
   - Assist with activities of daily living (i.e., grooming, hygiene, etc.)
   - Encouraging meaningful activity
   - Other services as needed for individual residents

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

c. Number served: For FY 18-19: Capacity of 6 beds.

Woodhaven

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

1. **General Description of the Organization**
   The County contracts with Woodhaven, a licensed board and care operator, to provide additional staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community.
2. **Program: Augmented Board and Care - Housing Services - CSS**

a. Scope of Services: Augmented residential services, including but not limited to:
- Medication management
- Nutritional meal planning
- Assistance with laundry
- Transportation to psychiatric and medical appointments
- Improving socialization
- Assist with activities of daily living (i.e., grooming, hygiene, etc.)
- Encouraging meaningful activity
- Other services as needed for individual residents

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

c. Number served: For FY 18-19: Capacity of 4 beds.

Youth Homes, Inc.

https://www.youthhomes.org/
Point of Contact: Cameron Safarloo, Chief Executive Officer or
Byron Lacuaniello, Clinical Director
Contact Information: 3480 Buskirk Ave #210, Pleasant Hill, CA 94523
(925) 933–2627, camerons@youthhomes.org or byroni@youthhomes.org

1. **General Description of the Organization**
   Youth Homes, Inc. is committed to serving the needs of abused and neglected children and adolescents in California's San Francisco Bay Area. Youth Homes provides intensive residential treatment programs and community-based counseling services that promote the healing process for seriously emotionally abused and traumatized children and adolescents.
2. **Program: Transition Age Youth Full Service Partnership – CSS**
   Youth Homes implements a full-service partnership program using a combination of aspects of the Integrated Treatment for Co-Occurring Disorders model (also known as Integrated Dual Disorders Treatment – IDDT) and aspects of the Assertive Community Treatment (ACT) model. These models are recognized evidence-based practices for which the Substance Abuse and Mental Health Services Administration (SAMHSA) has created a tool kit to support implementation. The Assertive Community Treatment (ACT) model continues to be the strongest model of services to keep those with serious mental illnesses out of institutional care (hospital or criminal justice system) through intensive, coordinated multidisciplinary treatment. Integrated Treatment for Co-Occurring Disorders is an evidence-based practice for treating clients diagnosed with both mental health and substance abuse disorders. Youth Homes is committed to advancing training and integration of the ACT and IDDT models into daily practice. Participants in the Youth Homes FSP program are assigned a team of providers, so consumers do not get lost in the health care system, excluded from treatment, or confused by going back and forth between separate mental health and substance abuse programs. Each client will have a primary clinician/case manager to facilitate treatment. The team may also include a life skills coach, substance abuse specialist, youth advocate, psychiatrist, nurse, or family clinician depending on the need of the client. Employment, education and life skills workshops and individual coaching occur weekly through Youth Homes' Stepping Stones program, which is an integral part of Youth Homes' TAY Services. It is not expected that all full service partners will be experiencing a substance use issue; however, for those who have co-occurring issues, both disorders can be addressed by one team of providers. Although the program has office space in Antioch and in Pleasant Hill, the bulk of all meetings and support services occur in the community, in homes, parks, and other community locations which are part of the young adult consumer's natural environments.
3. **Program: Youth Home's Short Term Residential Therapeutic Program (STRTP) – CSS**
   Youth Home's Short Term Residential Therapeutic Program (STRTP) also provides intensive individual mental health services to foster youth with a need for Specialty Mental Health Services (SMHS) who are residents in one of the STRTP programs, including limited follow up services for youth post residential discharge and their families, if appropriate. Services provided are Assessment, Individual Therapy,

Collateral (including family therapy), Individual and Group Rehab, Crisis Intervention, Case Management Brokerage (including Linkage and Advocacy, and Placement), and Medication Evaluation and Medication Monitoring. All services are provided in a trauma informed, culturally sensitive, client-and-family centered, team-based manner and are individually determined based on need.

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

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

c. Annual MHSA Payment Limit (FSP): $748,462

d. Annual MHSA Payment Limit (STRTP): $2,096,385

e. Number served FSP: For FY 18-19: 40 individuals

f. Outcomes FSP: For FY 18-19:
   - Reduction in incidence of psychiatric crisis
   - Reduction of the incidence of restriction

Table 1. Pre- and post-enrollment utilization rates for 40 Youth Homes FSP Participants enrolled in the FSP program during FY 18-19

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	123	90	0.315	0.218	-30.9%
Inpatient episodes	39	17	0.100	0.041	-58.8%
Inpatient days	307	141	0.787	0.341	-56.6%
DET Bookings	15	9	0.038	0.022	-43.9%

Appendix C
Glossary

AB 1421 or Laura's Law - Assembly Bill 1421. Enacted in 2002, to create an assisted outpatient treatment program for any person who is suffering from a mental disorder and meets certain criteria. The program operates in counties that choose to provide the services. Adoption of this law enables a court, upon a verified petition to the court, to order a person to obtain and participate in assisted outpatient treatment. The bill provides that if the person who is the subject of the petition fails to comply with outpatient treatment, despite efforts to solicit compliance, a licensed mental health treatment provider may request that the person be placed under a 72-hour hold, based on an involuntary commitment. The law would be operative in those counties in which the county board of supervisors, by resolution, authorized its application and made a finding that no voluntary mental health program serving adults, and no children's mental health program, would be reduced as a result of the implementation of the law.

ACT - Assertive Community Treatment. An intensive and highly integrated approach for community mental health service delivery. It is an outpatient treatment for individuals whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness. Its mission to promote the participants' independence, rehabilitation, and recovery, and in so doing to prevent homelessness, unnecessary hospitalization, and other negative outcomes. It emphasizes out of the office interventions, a low participant to staff ratio, a coordinated team approach, and typically involves a psychiatrist, mental health clinician, nurse, peer provider, and other rehabilitation professionals.

ADA - Americans with Disabilities Act. Prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications and access to state and local government' programs and services.

AOD – Alcohol and Other Drugs. Is an office like Mental Health that is part of the division of Behavioral Health Services. Behavioral Health Services is under the Health Services Department.

AOT - Assisted Outpatient Treatment. A civil court ordered mental health treatment for persons demonstrating resistance to participating in services. Treatment is modeled after assertive community treatment, which is the delivery of mobile, community-based care by multidisciplinary teams of highly trained mental health professionals with staff-to-client ratios of not more than one to ten, and additional services, as specified, for adults with the most persistent and severe mental illness. AOT involves a service and delivery process that has a clearly designated personal services coordinator who is responsible for providing or assuring needed services. These include complete assessment of the client's needs, development with the client of a personal services plan, outreach and consultation with the family and other significant persons, linkage with all appropriate community services, monitoring of the quality and follow through of

services, and necessary advocacy to ensure each client receives those services which are agreed to in the personal services plan. AOT is cited under AB 1421 or Laura's Law.

APA - American Psychological Association. The mission of the APA is to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives.

BHS - Behavioral Health Services. Is a grouping of Contra Costa Mental Health and Alcohol and Other Drug Services which make up the division of BHS. BHS is under the Health Services Department.

Board and Care - Augmented Board and Care. A facility licensed by the State also contract with Contra Costa Mental Health to receive additional funding to provide a therapeutic environment and assist residents gain their independence through recovery and wellness activities. Extra staff time is devoted to create a home-like atmosphere, often with shared housekeeping activities, and provide or coordinate a variety of therapeutic, educational, social and vocational activities. Persons who experience severe and persistent mental illness are eligible.

BOS - Board of Supervisors. Appointed body that is responsible for; 1) appointing most County department heads, except elected officials, and providing for the appointment of all other County employees, 2) providing for the compensation of all County officials and employees, 3) creating officers, boards and commissions as needed, appointing members and fixing the terms of office, 4) awarding all contracts except those that are within the authority delegated to the County Purchasing Agent, 5) adopting an annual budget, 6) sponsoring an annual audit made of all County accounts, books, and records, 7) supervising the operations of departments and exercising executive and administrative authority through the County government and County Administrator 8) serving as the appellate body for Planning and Zoning issues, 9) serving as the County Board of Equalization (the Board has created an Assessment Appeals Board to perform this function

Brown Act. Established in 1953; ensures the public's right to attend and participate in meetings of local legislative bodies. It declares that the California public commissions, boards and councils and the other public agencies in this state exist to aid in the conduct of the people's business. Actions should be taken openly and their deliberations be conducted openly. The people should remain informed so that they may retain control over the instruments they have created. The Brown Act has been interpreted to apply to email communication as well.

CalMHSA - California Mental Health Services Authority. The mission of CalMHSA is to provide member counties a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts in1) development and implementation of common strategies and programs, 2) fiscal integrity, protections, and management of collective risk, 3) accountability at state, regional, and local levels.

CAO - County Administrator's Officer. The County Administrator's Office is responsible for; 1) staffing the Board of Supervisors and Board committees, 2)

overseeing implementation of Board directives, 3) planning, monitoring, and overseeing County operations, 4) ensuring that Board policies are carried out in the most efficient, cost-effective, and service oriented manner, 5) supervising appointed Department Heads and performing general administrative duties, 6) preparing the annual budget, 7) administering the County's labor management relations program, including managing the collective bargaining process, grievance investigations, providing training and counseling to managers and employees, as well as problem resolution

Case Management. Refers to a service in which a mental health clinician develops and implements a treatment plan with a consumer. This treatment plan contains a diagnosis, level of severity, agreed upon goals, and actions by the consumer, the case manager, and other service providers to reach those goals. The mental health clinician provides therapy and additionally takes responsibility for the delivery and/or coordination of both mental and rehabilitation services that assist the consumer reach his/her goals.

CASRA - California Association of Social Rehabilitation Agencies. A statewide non-profit organization that service clients of the California public mental health system. Member agencies provide a variety of services to enhance the quality of life and community participation of youth, adults and older adults living with challenging mental health issues.

CBHDA – California Behavioral Health Director's Association. A non-profit advocacy association representing the behavioral health directors from each of California's 58 counties, as well as two cities (Berkeley and Tri-City). Through advocacy, lobbying and education efforts, CBHDA promotes the reduction of individual and community problems related to unaddressed behavioral health issues. CBHDA regularly brings together behavioral health professionals to discuss ways to inform public policy and improve the delivery of behavioral health services.

CBO - Community Based Organization. An agency or organization based in the community that is often a non-profit.

CCMH - Contra Costa Mental Health. One of 58 counties, the City of Berkeley, and the Tri-Cities area East of Los Angeles legislatively empowered to engage in a contract, or Mental Health Plan, with the state to perform public mental health services. This enables Contra Costa County to utilize federal, state, county and private funding for these mental health services. The Mental Health Services Act is one source of state funding. CCMH is divided into a Children's System of Care and an Adult and Older Adult System of Care.

CFO - Chief Financial Officer. Abbreviation used to describe term.

CF/TN - Capital Facilities/Information Technology. The title of one of five components of the MHSA. This component enables a county to utilize MHSA funds for one-time construction projects and/or installation or upgrading of electronic systems, such as mental health records systems.

CHHS – California Health and Human Services Agency. The agency which oversees twelve departments and five offices that provides a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians. More than 33,000 people work for departments in CHHS at state headquarters in Sacramento, regional offices throughout the state, state institutions and residential facilities serving the mentally ill and people with developmental disabilities.

CIBHS - **California Institute for Behavioral Health Solutions.** A non-profit agency that helps health professionals, agencies and funders improve the lives of people with mental health and substance use challenges through policy, training, evaluation, technical assistance, and research.

Clinical Specialist. In the context of this document, refers to a licensed or registered intern in the specialties of social work, marriage and family therapy, psychology, psychiatric nurse practitioner, licensed professional clinical counselor, or psychiatrist. A Clinical Specialist is capable of signing a mental health consumer's treatment plan that can enable the County to bill Medi-Cal for part of the cost to deliver the service.

Clubhouse Model. A comprehensive program of support and opportunities for people with severe and persistent mental illness. In contrast to traditional day-treatment and other day program models, Clubhouse participants are called "members" (as opposed to consumers, patients, or clients) and restorative activities focus on their strengths and abilities, not their illness. The Clubhouse is unique in that it is not a clinical program, meaning there are no therapists or psychiatrists on staff. All participation in a clubhouse is strictly on a voluntary basis. Members and staff work side-by-side as partners to manage all the operations of the Clubhouse, providing an opportunity for members to contribute in significant and meaningful ways. A Clubhouse is a place where people can belong as contributing adults, rather than passing their time as patients who need to be treated. The Clubhouse Model seeks to demonstrate that people with mental illness can successfully live productive lives and work in the community, regardless of the nature or severity of their mental illness.

COLA - Cost of Living Adjustment. Abbreviation used to describe term.

Community Forum. In this context a community forum is a planned group activity where consumers, family members, service providers, and representatives of community, cultural groups or other entities are invited to provide input on a topic or set of issues relevant to planning, implementing or evaluating public services.

Conservatorship - A probate conservatorship is a court proceeding where a judge appoints a responsible person (called a conservator) to care for another adult who cannot care for him/herself or his/her finances.

Consumer. In this context consumers refer to individuals and their families who receive behavioral health services from the County, contract partners, or private providers. Consumers are also referred to as clients, patients, participants or members.

Co-Occurring Disorders or Dual Diagnosis. Refers to more than one behavioral and/or medical health disorder that an individual can experience and present for care and treatment. Common examples are an individual with a substance abuse disorder coupled with a mental health diagnosis, or a developmental disability, such as autism, coupled with a thought disorder.

CPAW - Consolidated Planning Advisory Workgroup. An ongoing advisory body appointed by the Contra Costa Mental Health Director that provides advice and counsel in the planning and evaluation of services funded by MHSA. It is also comprised of several sub-committees that focus on specific areas, such as stigma reduction, homelessness, and services to the four age groups. It is comprised of individuals with consumer and family member experience, service providers from the County and community based organizations, and individuals representing allied public services, such as education and social services.

CPPP - Community Program Planning Process. This a term used in regulations pertaining to the Mental Health Services Act. It means the process to be used by the County to develop Three-Year Expenditure Plans, and updates in partnership with stakeholders to 1) identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act, 2) Analyze the mental health needs in the community, and 3) identify and re-evaluate priorities and strategies to meet those mental health needs.

CSS - Community Services and Supports. The title of one of five components funded by the MHSA. It refers to mental health service delivery systems for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those provided in the mental health system of care that is not funded by MHSA. Within community services and supports are the categories of full service partnerships, general system development, outreach and engagement, and project based housing programs.

CSW – Community Support Worker. Peer Provider in Contra Costa County public mental health system.

CTYA – Children's, Teens, and Young Adults. Abbreviation used to describe term.

Cultural Competence. In this context, refers to equal access to services of equal quality provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.

DHCS - Department of Health Care Services. The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long term care. Our vision is to preserve and improve the overall health and well-being of all Californians.

DSM IV - Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. The

handbook used by health care professionals to diagnosis mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders

Dual Diagnosis. See **Co-Occurring Disorders.**

Employment or Vocational Services. A continuum of services and supports designed to enable individuals to get and keep a job. It includes 1) pre-vocational services, such as removing barriers to employment, 2) employment preparation, to include career counseling and education, training and volunteer activity support, 3) job placement, to include job seeking, placement assistance and on-the-job training, and 4) job retention, to include supported employment.

EPIC System. A nationwide computer software company that offers an integrated suite of health care software centered on a database. Their applications support functions related to patient care, including registration and scheduling; clinical systems for doctors, nurses, emergency personnel, and other care providers; systems for lab technicians, pharmacists, and radiologists; and billing systems for insurers.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment. A federally mandated specialty mental health program that provides comprehensive and preventative services to low income children and adolescents that are also involved with Children and Family Services.

Evidence Based Practices. This term refers to treatment practices that follow a prescribed method that has been shown to be effective by the best available evidence. This evidence is comprised of research findings derived from the systematic collection of data through observation and experiment, and the formulation of questions and testing of hypotheses.

Family Partners. Also referred to as Parent Partners, this professional brings lived experience as a family member of an individual with a serious mental illness to their provision of services. They often participate as a member of a multi-disciplinary team providing mental health treatment, and assist families understand, acquire and navigate the various services and resources needed. In Contra Costa County, Family or Parent Partners have a job classification of Community Support Worker.

Family-to-Family Training. An educational course for family, caregivers and friends of individuals living with mental illness. Taught by trained volunteer instructors from NAMI CC it is a free of cost twelve week course that provides critical information and strategies related to caregiving, and assists in better collaboration with mental health treatment providers.

Federal Poverty Level. This is a total household income amount that the federal government provides an annual guideline that defines whether individuals are living above or below the poverty level. For example, a family of four is determined to live under the poverty level if their total income in 2014 is $23,850.

51/50 – Fifty One Fifty. Refers to the Welfare and Institutions Code of California for the temporary, involuntary psychiatric commitment of individuals who present a danger

to themselves or others due to signs of mental illness.

FY- Fiscal Year. A fiscal year is a specified 12-month period used for accounting and reporting purposes. In Contra Costa County, the fiscal year runs from July 1st of one year to June 30th of the next year.

Focus Groups. In this context, refers to a small group (usually 8-15) of individuals to provide input, advice and counsel on practices, policies or proposed rulemaking on matters that affect them. Often these individuals are grouped by similar demographics or characteristics in order to provide clarity on a particular perspective.

Forensics. In this context, refers to the term used for individuals involved in the legal court system with mental health issues.

4C. Term used to refer to Psychiatric Ward of Contra Costa County Regional Medical Center.

FSP - Full Service Partnership. A term created by the MHSA as a means to require funding from the Act to be used in a certain manner for individuals with serious mental illness. Required features of full service partnerships are that there be a written agreement, or individual services and supports plan, entered into with the client, and when appropriate, the client's family.

This plan may include the full spectrum of community services necessary to attain mutually agreed upon goals. The full spectrum of community services consists of, but is not limited to, mental health treatment, peer support, supportive services to assist the client, and when appropriate the client's family, in obtaining and maintaining employment, housing, and/or education, wellness centers, culturally specific treatment approaches, crisis intervention/stabilization services, and family education services.

Also included are non-mental health services and supports, to include food, clothing, housing, cost of health care and co-occurring disorder treatment, respite care, and wrap-around services to children. The County shall designate a personal service coordinator or case manager for each client to be the single point of responsibility for services and supports, and provide a qualified individual to be available to respond to the client/family 24 hours a day, seven days a week.

The Full Service Partnership category is part of the Community Services and Supports (CSS) component of the MHSA. At least 50% of the funding for CSS is to go toward supporting the County's full service partnership category.

General System Development. A term created by the MHSA, and refers to a category of services funded in the Community Services and Supports component, and are similar to those services provided by community public mental health programs authorized in the Welfare and Institutions Code. MHSA funded services contained in the general system development category are designed to improve and supplement the county mental health service delivery system for all clients and their families.

Greater Bay Area Regional Partnership. Regional partnership means a group of County approved individuals and/or organizations within geographic proximity that acts as an employment and education resource for the public mental health system. These individuals and/or organizations may be county staff, mental health service providers, clients, clients' family members, and any individuals and/or organizations that have an interest in developing and supporting the workforce of the public mental health system. The Greater Bay Area Regional Partnership refers to an ongoing effort of individuals and/or organizations from the twelve county greater California bay area regions.

HSD - Health Services Department. The largest department of County government. The mission of HSD is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems. Behavioral Health Services is one of the nine divisions under HSD.

HIPAA - Health Information Portability and Accountability Act. Enacted into law in 1996 and provides the following; 1) the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs, 2) reduce health care fraud and abuse, 3) mandates industry-wide standards for health care information on electronic billing and other processes, and 4) requires the protection and confidential handling of protected health information

HPSA - Health Professional Shortage Area. A geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services. The Health Resources and Services Administration (HRSA) and State Primary Care Offices (PCOs) work together using public, private, and state-provided data to determine when such a shortage qualifies for designation as a HPSA.

H3 – Health, Housing and Homeless Services Division. Division under Health Services that partners with Behavioral Health Services and focuses on the integration of housing and homeless services across this County's health system. It coordinates health and homeless services across county and in the community; and works with key partners to develop strategies to address the community's health and social needs.

IMD – Institution for Mental Disease. Any institution that, by its overall character is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility: 1) Is licensed or accredited as a psychiatric facility; 2) Is under the jurisdiction of the state's mental health authority; 3) Specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or 4) Has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases.

IMPACT - Improving Mood Providing Access to Collaborative Treatment. This refers to an evidence based mental health treatment for depression utilized specifically for older adults, and is provided in a primary care setting where older adults are

concurrently receiving medical care for physical health problems. Up to twelve sessions of problem solving therapy with a year follow up is provided by a licensed clinical therapist, with supervision and support from a psychiatrist who specializes in older adults. The psychiatrist assesses for and monitors medications as needed, and both the clinician and psychiatrist work in collaboration with the primary care physician.

INN - Innovation. A component of the MHSA that funds new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system. These innovative programs accomplish one or more of the following objectives; 1) increase access to underserved groups, 2) increase the quality of services, to include better outcomes, 3) promote interagency collaboration, and 4) increase access to services. All new Innovation programs shall be reviewed and approved by the Mental Health Services Oversight and Accountability Commission. The Act states that five per cent of a County's revenues shall go for Innovation.

Iron Triangle. Refers to the central area of the city of Richmond that is bordered on three sides by railroad tracks. The communities within this area have a high number of households living below the poverty level, and have a high need for social services, to include public mental health.

Laura's Law. See **AB 1421**.

LCSW - Licensed Clinical Social Worker. Abbreviation used to describe term. See **Clinical Specialist.**

LGBTQ - Lesbian, Gay, Bi-sexual, Transgender, Questioning. Persons in these groups express norms different than the heterosexism of mainstream society, and often experience stigmatism as a result. Lesbian refers to women whose primary emotional, romantic, sexual or affectional attractions are to other women. Gay refers to men whose primary emotional, romantic, sexual or affectional attractions are to other men. Bi-sexual refers to men or women whose primary emotional, romantic, sexual, or affectional attractions are to both women and men. Transgender is a term that includes persons who cross-dress, are transsexual, and people who live substantial portions of their lives as other than their birth gender. People who are transgender can be straight, gay, lesbian or bi-sexual. Questioning refers to someone who is questioning their sexual and/or gender orientation.

Licensed Clinical Specialist. In this context, refers to the term a County civil service classification that denotes a person meeting minimum mental health provider qualifications, to include possessing a license to practice mental health treatment by the California Board of Behavioral Sciences (BBS). An intern registered by BBS also qualifies. A licensed clinical specialist or registered intern can sign mental health treatment plans that qualify for federal financial participation through the Medi-Cal program.

LMFT - Licensed Marriage Family Therapist. Abbreviation used to describe term. See **Clinical Specialist.**

LPS – Lanterman Petris Short Act. The LPS Act refers to Sections 5150, 5151 and 5152 of the Welfare and Institutions Code (WIC). It is a California law governing the involuntary civil commitment of individuals who - due to mental illness - pose a danger to self or others, or who are gravely disabled and require inpatient psychiatric care. It was named for its co-authors — Assembly member Frank Lanterman and Senators Nicholas C. Petris and Alan Short. The intent of the LPS Act is to end inappropriate lifetime commitment of people with mental illness and firmly establish the right to due process in the commitment process while significantly reducing state institutional expense.

LRP - Loan Repayment Program. Abbreviation used to describe term.

MDFT - Multi-Dimensional Family Therapy. An evidence based comprehensive and multi-systemic 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. Treatment is delivered in a series of 12 to 16 weekly or twice weekly 60 to 90 minute sessions. Treatment focuses on the social interaction areas of parents and peers, the parents' parenting practices, parent-adolescent interactions in therapy, and communications between family members and key social systems, such as school and child welfare.

Medi-Cal. California's version of the federal Medi-Caid program, in which health and mental health care can be provided by public health and mental health entities to individuals who do not have the ability to pay the full cost of care, and who meet medical necessity requirements. The federal Medi-Caid program reimburses states approximately half of the cost, with the remainder of the cost provided by a variety of state and local funding streams, to include the MHSA.

Mental Health Career Pathway Program. Programs designed to educate, train, recruit prepare, and counsel individuals for entry into and advancement in jobs in the public mental health system. These programs are a category listed as part of the Workforce Education and Training (WET) component of the MHSA.

MHP - Mental Health Plan. An agreement each county has with the state detailing the services that are to be provided.

Mental Health Professional Shortage Designations. Term used by the federal Human Resource Services Administration (HRSA) to determine areas of the country where there is a verified shortage of mental health professionals. These geographical areas are then eligible to apply for a number of federal programs where financial incentives in recruiting and retention are applied to address the workforce shortage.

MH – Mental Health. Abbreviation used for term.

MHC - Mental Health Commission. A group of individuals, often with lived experience as a consumer and/or family member of a consumer, who are appointed as representatives of the County's Board of Supervisors to provide 1) oversight and monitoring of the County's mental health system, 2) advocacy for persons with serious

mental illness, and 3) advise the Board of Supervisors and the mental health director.

MHLAP - Mental Health Loan Assumption Program. A program that makes payments to an educational lending institution on behalf of an employee who has incurred debt while obtaining an education, provided the individual agrees to work in the public mental health system for a specified period of time and in a capacity that meets the employer's workforce needs. The MHLAP is funded by the MHSA in the Workforce Education and Training component.

MHSA - Mental Health Services Act or Proposition 63. Was voted into law by Californians in November 2004. This Act combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. The MHSA has five components; community services and supports, prevention and early intervention, innovation, workforce education and training, and capital facilities and technology. An additional one percent of state income tax is collected on incomes exceeding one million dollars and deposited into a Mental Health Services Fund. These funds are provided to the County based upon an agreed upon fair share formula.

MHSA Three Year Plan - Mental Health Services Act Three Year Program and Expenditure Plan. Each County prepares and submits a three year plan, which shall be updated at least annually; known as the **Plan or Annual Update** and approved by the County's Board of Supervisors. The plan will be developed with local stakeholders by means of a community program planning process, and will include programs and funding planned for each component, as well as providing for a prudent reserve. Each plan or update shall indicate the number of children, adults and seniors to be served, as well as reports on the achievement of performance outcomes for services provided.

MHSIP - Mental Health Statistics Improvement Program. Is a survey used in Contra Costa as required by DHCS. QI staff elicit feedback from survey sites regarding barriers to acceptable response rates, and based on this, implemented a variety of strategies including training a substantial volunteer workforce to assist with participant recruitment and survey completion.

MHSOAC - Mental Health Services Oversight and Accountability Commission. Established by the MHSA to provide state oversight of MHSA programs and expenditures, and is responsible for annually reviewing and approving each county mental health program for expenditures pursuant to the components of Innovation and Prevention and Early Intervention.

Money Management. Term that refers to services that can encompass all aspects of assisting an individual plan and manage financial benefits and resources. It can include counseling on the interplay of work and other sources of income on Medi-Cal, Medicare, Social Security Disability Income (SSDI), and Supplemental Security Income (SSI). It can include becoming a conservator of funds for an individual who has been deemed to be unable to manage their own funds.

MST - Multi-Systemic Therapy. An evidence based mental health service that is a community-based, family driven treatment for antisocial/delinquent behavior in youth. The focus is on empowering parents and caregivers to solve current and future problems, and actively involves the entire ecology of the youth; family, peers, school and the neighborhood.

NAMI - National Alliance on Mental Illness. The nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raise awareness and build a community for hope for all of those in need. NAMI is the foundation for hundreds of NAMI State Organizations, NAMI Affiliates and volunteer leaders who work in local communities across the country to raise awareness and provide essential and free education, advocacy and support group programs. In Contra Costa County, there is a NAMI Contra Costa Office or NAMI CC.

Needs Assessment. Refers to part of the community program planning process (CPPP) where the mental health services and supports needs of the community are identified and assessed. This includes identifying populations, age groups and communities that remain unserved, underserved or inappropriately served.

NOFA – Notice of Funding Availability. Abbreviation used to describe term.

NPLH – No Place Like Home or Proposition 2. Allows the state to approve the use of the MHSA Funds to build and rehabilitate housing for those with mental illness who are homeless or at-risk of becoming homeless.

OCE – Office for Consumer Empowerment. A Contra Costa County operated program under the Behavioral Health Services division that offers a range of trainings and supports by and for individuals who have experience receiving mental health services. The goal is to increase access to wellness and empowerment for consumers; and to engage in their own individual recovery and become active in the community. This office leads the SPIRIT, WREACH, and WRAP programs.

OSHPD - Office of Statewide Health Planning and Development. A state department that assists California improve the structure and function of its healthcare delivery systems and promote healthcare accessibility. OSHPD is the state entity responsible for the implementation of various MHSA state level funded workforce education and training programs, such as the mental health loan assumption program, psychiatric residency programs, and several graduate stipend and internship programs.

Outreach and Engagement. In this context, is a MHSA term that is a community services and support category, and a category in which prevention and early intervention services can be provided. Services are designed to reach out and engage individuals in mental health care which have a serious mental illness, or are at risk of developing a serious mental illness. These are individuals who have not sought services in a traditional manner due to cultural or linguistic barriers.

Peer Provider. Term that refers to a professional who brings lived experience as a mental health consumer to their provision of services. They often participate as a member of a multi-disciplinary team providing mental health treatment, and assist consumers and their families understand, acquire and navigate the various services and resources needed. In Contra Costa County, Peer Providers have a job classification of Community Support Worker.

PEI - Prevention and Early Intervention. A term created by the MHSA, and refers to a component of funding in which services are designed to prevent mental illnesses from becoming severe and disabling. This means providing outreach and engagement to increase recognition of early signs of mental illness, and intervening early in the onset of a mental illness. Twenty percent of funds received by the MHSA are to be spent for prevention and early intervention services.

PES - Psychiatric Emergency Services. A unit of the Contra Costa County Regional Medical Center located next door to the Emergency Room in the county hospital in Martinez. It operated 24 hours a day, seven days a week, and consists of psychiatrists, nurses and mental health clinicians who are on call and available to respond to individuals who are brought in due to a psychiatric emergency. Persons who are seen are either treated and released, or admitted to the in-patient psychiatric hospital ward.

PhotoVoice Empowerment Program. The County sponsors classes designed to enable individuals to create artwork consisting of a photograph and a personally written story that speak to or represent the challenges of prejudice, discrimination and ignorance that people with behavioral health challenges face. These artworks are then displayed in the community to educate, raise awareness and reduce stigma.

PIER Model - Portland Identification and Early Referral Model. This is an evidence based treatment developed by the PIERS Institute of Portland, Maine. It is an early intervention program for youth, ages 12-25 which are at risk for developing psychosis. It is a multi-disciplinary team approach consisting of a structured interview to assess risk for psychosis, multi-family group therapy, psychiatric care, family psycho-education, supported education and employment, and occupational therapy.

PSC - Personal Service Coordinators. Refers to a mental health clinician or case manager who develops and implements an individual services and support plan with an individual diagnosed with a serious mental illness, and who is part of a full service partner program under the MHSA. This plan contains a diagnosis, level of severity, agreed upon goals, and actions by the consumer, the personal services coordinator, and other service providers to reach those goals. The personal service coordinator provides therapy, and additionally takes responsibility for the delivery and/or coordination of both mental health and rehabilitation services that assist the consumer reach his/her goals.

PTSD - Post-Traumatic Stress Disorder. An emotional illness that that is classified as an anxiety disorder, and usually develops as a result of a terribly frightening, life-threatening, or otherwise highly unsafe experience. PTSD sufferers re-experience the traumatic event or events in some way, tend to avoid places, people, or other things that

remind them of the event (avoidance), and are exquisitely sensitive to normal life experiences (hyper arousal).

Public Health Services. A division under Health Services whose mission is to promote and protect the health and well-being of individuals, families and community in Contra Costa County.

Public Mental Health System. This term is used to describe the public system that is in place to provide mental health services. There are 64 counties and 2 cities that receive MHSA funds to support their public mental health system. Each county's system is uniquely structured where services are provided by county staff or through contractors; such as community based organizations and other agencies.

Pre-Vocational Employment Services. These are services that enable a person to actively engage in finding and keeping a job. Often the services remove barriers to employment services, such as counseling on how working affects benefits, stabilizing medications, obtaining a driver's license or general education diploma, and resolving immigration or other legal issues.

Prudent Reserve. Term created by the MHSA, and refers to a County setting aside sufficient MHSA revenues in order to ensure that services do not have to be significantly reduced in years in which revenues are below the average of previous years.

Psychiatric Residency. Physicians who specialize in psychiatry complete a four year residency program at one of several schools of psychiatry, such as that located at the University of California at San Francisco. This is essentially a paid work study arrangement, where they practice under close supervision and concurrently take coursework. At the final residency year the psychiatrist can elect to work in a medical setting, teach, do research, or work in a community mental health setting.

QA/ QI - Quality Assurance and Quality Improvement. Entities in Contra Costa County responsible for monitoring the Mental Health Plan's effectiveness by providing oversight and review of clinics, organizations, and clinicians providing services to consumers. The goals are to perform program development and coordination work to implement and maintain a quality management program that effectively measures, assesses, and continuously improves the access to and quality of care and services provided to the County's mental health consumers. The Quality Management Coordinator is responsible for Chairing and facilitating the Quality Improvement Committee (QIC) and ensuring members receive timely and relevant information.

RFA - Request for Application. Abbreviation used to describe term.

RFI - Request for Information. Abbreviation used to describe term.

RFP - Request for Proposal. Abbreviation used to describe term.

RFQ - Request for Qualifications. Abbreviation used to describe term.

RHD - Reducing Health Disparities. Abbreviation used to describe term.

SAMHSA - Substance Abuse and Mental Health Services Administration. The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

SB - Senate Bill. Abbreviation used to describe term.

SNHP – Special Needs Housing Program. Allows local governments to use MHSA and other local funds to provide financing for the development of permanent supportive rental housing that includes units dedicated for individuals with serious mental illness, and their families, who are homeless or at risk of homelessness.

SNF - Skilled Nursing Facility. A special facility or part of a hospital that provides medically necessary services from nurses, physical and occupational therapists, speech pathologists and audiologist. A SNF aims to prevent hospitalizations, optimize antipsychotic medication use, and serve as an intermediate step into the community.

STRTP – Short Term Residential Treatment Program. A residential treatment model that serves youth who have high-level mental health needs or are seriously emotionally disturbed. The goal of STRTPs is to focus on stabilizing high-needs youth to allow an expedient and successful transition to a home setting.

SED - Seriously Emotionally Disturbed. Children from birth up to age eighteen with serious emotional disturbance are persons who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual and results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

SMI - Serious Mental Illness. Adults with a serious mental illness are persons eighteen years and older who, at any time during a given year, have a diagnosable mental, behavioral, or emotional disorder that meet the criteria of the Diagnostic and Statistical Manual, and the disorder has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

SOC – System of Care. Term used to refer to this county’s public mental health system.

SPIRIT - Service Provider Individualized Recovery Intensive Training. A recovery oriented, peer led classroom and experiential-based, college accredited educational program for individuals with lived experience as a consumer of mental health services. It is sponsored by Contra Costa Mental Health and Contra Costa Community College, and successful completion satisfies the minimum qualifications to be considered for employment by the County as a Community Support Worker.

Stakeholders. Stakeholders is a term defined in the California Code of Regulations to

mean individuals or entities with an interest in mental health services, including but not limited to individuals with serious mental illness and/or serious emotional disturbance and/or their families, providers of mental health and/or related services such as physical health care and/or social services, educators and/or representatives of education, representatives of law enforcement, and any organization that represents the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

Stigma and Discrimination. In this context, refers to the negative thoughts and/or behaviors that form an inaccurate generalization or judgment, and adversely affects the recovery, wellness and resiliency of persons with mental health issues. These thoughts and behaviors can include any person who has an influence on a person's mental health well-being, to include the person experiencing the mental health issue.

SUD - Substance Use Disorder. A disorder in which the use of one or more substances leads to a clinically significant impairment or distress. Although the term substance can refer to any physical matter, substance abuse refers to the overuse of, or dependence on, a drug leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others. The disorder is characterized by a pattern of continued pathological use of a medication, non-medically indicated drug or toxin which results in repeated adverse social consequences related to drug use, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems.

STEP - Systematic Training for Effective Parenting. A parent education program published as a series of books developed and published by the psychologists Don Dinkmeyer Sr., Gary D. McKay and Don Dinkmeyer Jr. The publication was supplemented by an extensive concept for training and proliferation. STEP has reached more than four million parents and has been translated into several languages. It provides skills training for parents dealing with frequently encountered challenges with their children that often result from autocratic parenting styles. STEP is rooted in Adlerian psychology and promotes a more participatory family structure by fostering responsibility, independence, and competence in children; improving communication between parents and children; and helping children learn from the natural and logical consequences of their own choices.

Supported Employment. Supported employment is a federal vocational rehabilitation term that means competitive work for individuals with the most significant disabilities that occurs in integrated work settings, or settings in which individuals are working toward competitive work. Such work is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Supported employment usually means that a professional support person, or job coach, assists the individual in a competitive work setting until assistance is no longer needed.

Supportive Housing. A combination of housing and services intended as a cost-effective way to help people live more stable, productive lives. Supportive housing is widely believed to work well for those who face the most complex challenges—individuals and families confronted with homelessness and who also have very low

incomes and/or serious, persistent issues that may include substance abuse, addiction or alcoholism, mental illness, HIV/AIDS, or other serious challenges to a successful life. Supportive housing can be coupled with such social services as job training, life skills training, alcohol and drug abuse programs, community support services, such as child care and educational programs, and case management to populations in need of assistance. Supportive housing is intended to be a pragmatic solution that helps people have better lives while reducing, to the extent feasible, the overall cost of care.

TAY - Transition Age Youth. A term meaning individuals who are between the age of 16 years and 25 years of age. Specific mental health programs that address this age group are in the adult system of care, and were designed to assist in the transition of services from the children's system of care, where individuals stop receiving services at 18.

Triple P - Positive Parenting Program. An evidence based practice designed to increase parents' sense of competence in their parenting abilities. It is a multilevel system of family intervention that aims to prevent severe emotional and behavioral disturbances in children by promoting positive and nurturing relationships between parent and child. Improved family communication and reduced conflict reduces the risk that children will develop a variety of behavioral and emotional problems.

WET - Workforce Education and Training. A term created by the MHSA, and refers to the component of the MHSA that funds programs and service that assist in the recruitment and retention of a skilled and culturally competent mental health workforce.

WIC - Welfare and Institutions Code. Regulations set that address services relating to welfare, dependent children, mental health, handicapped, elderly, delinquency, foster care, Medi-Cal, food stamps, rehabilitation, and long-term care, to name a few.

WRAP - Wellness Recovery Action Plan. An evidence-based practice that is used by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience with mental health difficulties and who were searching for ways to resolve issues that had been troubling them for a long time. WRAP involves listing one's personal resources and wellness tools, and then using those resources to develop action plans to use in specific situations.

Wraparound Services. An intensive, individualized care management process for children with serious emotional disturbances. During the wraparound process, a team of individuals who are relevant to the well-being of the child or youth, such as family members, other natural supports, service providers, and agency representatives collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends and other people drawn from the family's social networks. The team convenes frequently to measure the plan's components against relevant indicators of success. Plan components and strategies are revised when outcomes are not being achieved.

WREACH - Wellness Recovery Education for Acceptance, Choice and Hope. The WREACH Speaker's Bureau is designed to reduce the stigma that consumers and family members often face in the workplace, behavioral and physical health care systems, and in their communities. The WREACH program forms connections between people in the community and people with lived mental health and co-occurring disorders experiences by providing opportunities for sharing stories of recovery and resiliency, and sharing current information on health treatment and supports. Workshops are held to teach people and their families how to write and present their recovery and resilience stories. These individuals are then connected with audiences that include behavioral health providers, high school and college staff and students, law enforcement, physical health providers and the general community.

Appendix E

FY 2020-21 Through FY 20-23 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Contra Costa Date: 10/23/2020

	MHSA Funding						
	A	B	C	D	E	F	
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. FY 2020/21 Funding							
1. Unspent Funds from Prior Fiscal Years	35,264,485	6,931,380	5,088,324	835,529	3,819,504	-	51,939,222
2. New FY2020/21 Funding	42,035,398	9,525,844	2,713,750				54,274,992
3. Transfer in FY2020/21	(8,108,453)			8,108,453			-
4. Available Funding for FY2017/18	69,191,430	16,457,224	7,802,074	8,943,982	3,819,504	-	106,214,214
B. Budgeted FY20/21 MHSA Expenditures	47,153,698	9,028,430	2,303,538	2,626,445	500,000	-	61,612,111
C. Estimated FY2021/22Funding							
1. Unspent Funds from Prior Fiscal Years	22,037,732	7,428,794	5,498,536	6,317,537	3,319,504	-	44,602,103
2. Estimated New FY2021/22 Funding	37,851,055	8,577,610	2,443,614				48,872,279
3. Transfer in FY2020/21							
4. Estimated Available Funding for FY2021/22	59,888,787	16,006,404	7,942,150	6,317,537	3,319,504	-	93,474,382
D. Budgeted FY2021/22 Expenditures	42,107,484	9,028,430	2,303,538	2,626,445	250,000	-	56,315,897
E. Estimated FY2022/23 Funding						,	
1. Estimated Unspent Funds from Prior Fiscal Years	17,781,303	6,977,974	5,638,612	3,691,092	3,069,504	-	37,158,485
2. Estimated New FY2022/23 Funding	30,800,881	6,979,936	1,988,464				39,769,281
3. Transfer in FY2020/21							
4. Estimated Available Funding for FY2019/20	48,582,184	13,957,910	7,627,076	3,691,092	3,069,504	-	76,927,766
F. Budgeted FY2022/23 Expenditures	41,357,484	9,028,430	2,303,538	2,626,445	250,000	-	55,565,897
G. Estimated FY2022/23 Unspent Fund Balance	7,224,700	4,929,480	5,323,538	1,064,647	2,819,504	-	21,361,869

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	7,579,248

I. Estimated Beginning Balance for FY 2019/20	
1. Estimated Unspent Funds from Fiscal Year 2019/20	51,939,221
2. Estimated Local Prudent Reserve Balance on June 30, 2018	7,579,248
3. Estimated Total Beginning Balance	**59,518,469**

FY 2020-21 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Children	4,796,345	4,796,345				
2. Transition Age Youth	4,359,618	4,359,618				
3. Adults	7,324,953	7,324,953				
4. Assisted Outpatient Treatment	2,549,239	2,549,239				
6. Recovery Center	1,290,630	1,290,630				
7. Crisis Residential Center	3,966,192	3,966,192				
8. Housing Services	8,836,991	8,836,991				
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
Non-FSP Programs						
1. Older Adult Mental Health Program	3,418,643	3,418,643				
2. Children's Wraparound Support/EPSDT Support	2,105,556	2,105,556				
3. Miller Wellness Center	319,590	319,590				
4. Clinic Support	2,301,780	2,301,780				
5. Forensic Team	1,658,304	1,658,304				
7. Concord Health Center	254,496	254,496				
8. Liaison Staffs	145,907	145,907				
9. Quality Assurance	1,251,829	1,251,829				
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
CSS Administration	2,573,627	2,573,627				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	47,153,700	47,153,700	0	0	0	0
FSP Programs as Percent of Total	70.2%					

FY 2021-22 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children	2,892,595	2,892,595				
2. Transition Age Youth	2,263,233	2,263,233				
3. Adults	7,324,953	7,324,953				
5. Assisted Outpatient Treatment	2,549,239	2,549,239				
6. Wellness and Recovery Centers	1,006,691	1,006,691				
7. Crisis Residential Center	2,204,052	2,204,052				
8. MHSA Housing Services	8,836,991	8,836,991				
9.						
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11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
Non-FSP Programs						
1. Older Adult Mental Health Program	3,418,643	3,418,643				
2. Children's Wraparound Support/EPSDT Support	2,105,556	2,105,556				
3. Miller Wellness Center	319,590	319,590				
4. Concord Health Center	504,496	504,496				
5. Liaison Staff	145,907	145,907				
6. Clinic Support	2,798,778	2,798,778				
7. Forensic Team	1,908,304	1,908,304				
8. Quality Assurance	1,254,829	1,254,829				
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
CSS Administration	2,573,627	2,573,627				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	42,107,484	42,107,484		0	0	0
FSP Programs as Percent of Total	64.3%					

FY 2022-23 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children	2,892,595	2,892,595				
2. Transition Age Youth	2,263,233	2,263,233				
3. Adult	7,324,953	7,324,953				
5. Assisted Outpatient Treatment	2,549,239	2,549,239				
6. Wellness and Recovery Centers	1,006,691	1,006,691				
7. Crisis Residential Center	2,204,052	2,204,052				
8. MHSA Housing Services	8,836,991	8,836,991				
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
Non-FSP Programs						
1. Older Adult Mental Health Program	3,418,643	3,418,643				
2. Children's Wraparound Support	2,105,556	2,105,556				
3. Miller Wellness Center	319,590	319,590				
4. Concord Health Center	316,996	316,996				
5. Liaison Staff	145,907	145,907				
6. Clinic Support	2,423,778	2,423,778				
7. Forensic Team	1,720,804	1,720,804				
8. Quality Assurance	1,254,829	1,254,829				
9. Administrative Support	2,573,627	2,573,627				
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
CSS Administration						
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	41,357,484	41,357,484	0	0	0	0
FSP Programs as Percent of Total	65.5%					

FY 2020-21 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Outreach for Increasing Recognition of Early Signs of Mental Illness	1,535,059	1,535,059				
2. Prevention	1,762,991	1,762,991				
3. Access and Linkage to Treatment	625,863	625,863				
4. Improving Timely Access to Mental Health Services for Underserved Population	1,692,461	1,692,461				
5. Stigma and Discrimination Reduction	296,861	296,861				
6. Suicide Prevention	370,006	370,006				
7.						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. First Hope	2,587,099	2,587,099				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
PEI Administration	158,090	158,090				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	9,028,430	9,028,430	0	0	0	0

FY 2021-22 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Outreach for Increasing Recognition of Early Signs of Mental Illness	1,535,059	1,535,059				
2. Prevention	1,762,991	1,762,991				
3. Access and Linkage to Treatment	625,863	625,863				
4. Improving Timely Access to Mental Health Services for Underserved Population	1,692,461	1,692,461				
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PEI Programs - Early Intervention						
11. First Hope	2,587,099	2,587,099				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
PEI Administration	158,090	158,090				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	9,028,430	9,028,430	0	0	0	0

FY 2022-23 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Outreach for Increasing Recognition of Early Signs of Mental Illness	1,535,059	1,535,059				
2. Prevention	1,762,991	1,762,991				
3. Access and Linkage to Treatment	625,863	625,863				
4. Improving Timely Access to Mental Health Services for Underserved Population	1,692,461	1,692,461				
5. Stigma and Discrimination Reduction	296,861	296,861				
6. Suicide Prevention	370,006	370,006				
7. 0						
8.						
9.						
10.						
PEI Programs - Early Intervention						
11. First Hope	2,587,099	2,587,099				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
PEI Administration	158,090	158,090				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	9,028,430	9,028,430	0	0	0	0

FY 2020-21 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Coaching to Wellness	145,907	145,907				
2. Partners in Aging	133,072	133,072				
3. Overcoming Transportation Barriers	106,856	106,856				
4. CORE	1,152,936	1,152,936				
5. CBSST	400,403	400,403				
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
INN Administration	364,363	364,363				
Total INN Program Estimated Expenditures	2,303,537	2,303,537	0	0	0	0

FY 2021-22 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. CBSST	400,403	400,403				
2. CORE	1,152,936	1,152,936				
3. Overcoming Transportation Barriers	106,856	106,856				
4. Coaching to Wellness	145,907	145,907				
5. Partners in Aging	133,072	133,072				
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7.						
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10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
INN Administration	364,363	364,363				
Total INN Program Estimated Expenditures	2,303,537	2,303,537	0	0	0	0

FY 2022-23 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. CORE	1,152,936	1,152,936				
2. CBSST	400,403	400,403				
3. 0	385,836	385,836				
4.						
5.						
6.						
7.						
8.						
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10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
INN Administration	364,363	364,363				
Total INN Program Estimated Expenditures	2,303,538	2,303,538	0	0	0	0

FY 2020-21 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce Education and Training (WET) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	1,259,038	1,259,038				
2. Training and Technical Support	343,799	343,799				
3. Mental Health Career Pathway Program	371,258	371,258				
4. Internship Programs	352,350	352,350				
5. Financial Incentive Programs	300,000	300,000				
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
WET Administration						
Total WET Program Estimated Expenditures	2,626,445	2,626,445	0	0	0	0

FY 2021-22 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce Education and Training (WET) Component Worksheet

County: Contra Costa Date: October 26, 2020

I. Estimated Beginning Balance for FY 2016/17	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	1,259,038	1,259,038				
2. Training and Technical Support	343,799	343,799				
3. Mental Health Career Pathway Program	371,258	371,258				
4. Internship Programs	352,350	352,350				
5. Financial Incentive Programs	300,000	300,000				
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9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
WET Administration						
Total WET Program Estimated Expenditures	2,626,445	2,626,445	0	0	0	0

FY 2022-23 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce Education and Training (WET) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	1,259,038	1,259,038				
2. Training and Technical Support	343,799	343,799				
3. Mental Health Career Pathway Program	371,258	371,258				
4. Internship Programs	352,350	352,350				
5. Financial Incentive Programs	300,000	300,000				
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
WET Administration						
Total WET Program Estimated Expenditures	2,626,445	2,626,445	0	0	0	0

FY 2020-21 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Contra Costa

Date: October 26, 2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Facilities Projects	250,000	250,000				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11. Electronic Health Records System - Adminis	250,000	250,000				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	500,000	500,000	0	0	0	0

FY 2021-22 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Facilities Projects	125,000	125,000				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11. Electronic Health Records System - Adminis	125,000	125,000				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	250,000	250,000	0	0	0	0

FY 2022-23 Through FY 2020-23 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Contra Costa Date: October 26, 2020

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Facilities Projects	125,000	125,000				
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
CFTN Programs - Technological Needs Projects						
11. Electronic Health Record	125,000	125,000				
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
CFTN Administration						
Total CFTN Program Estimated Expenditures	250,000	250,000	0	0	0	0

Appendix F

PUBLIC COMMENT AND PUBLIC HEARING

MHSA Three Year Program and Expenditure Plan

Fiscal Years 2020-2023

MHSA Three Year Program and Expenditure Plan
Fiscal Years 2020-2023 Online Posting

Mental Health Services
Crisis Services
Problem Resolution Process
Mental Health Services Act (MHSA)
Wellness & Education
Workforce Education & Training
Laura's Law
CoCo LEAD Plus
Presumptive Transfer
Links
Newsletter
Internship Program
Training Opportunities
Provider Services
Network Provider Resources
Clinical Documentation Forms
Suicide Prevention Committee
Mental Health Commission

Related Links
Quality Improvement & Quality Assurance (QI/QA)
Outcome Measures
Consolidated Planning Advisory Workgroup (CPAW)
Behavioral Health Services

HOME › BEHAVIORAL HEALTH › MENTAL HEALTH › MENTAL HEALTH SERVICES ACT (MHSA) IN CONTRA COSTA COUNTY

Mental Health Services Act (MHSA) in Contra Costa County

Contra Costa County Behavioral Health Services (CCBHS) Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan integrates the components of Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training, and Capital Facilities/Information Technology.

This Plan describes county operated and contract programs that are funded by MHSA, what they will do, and how much money will be set aside to fund these programs. Also, the plan will describe what will be done to evaluate their effectiveness and ensure they meet the intent and requirements of the Mental Health Services Act.

California approved Proposition 63 in November, 2004, and the Mental Health Services Act became law. The Act provides significant additional funding to the existing public mental health system, and combines prevention services with a full range of integrated services to treat the whole person. With the goal of wellness, recovery and selfsufficiency, the intent of the law is to reach out and include those most in need and those who have been traditionally underserved. Services are to be consumer driven, family focused, based in the community, culturally and linguistically competent, and integrated with other appropriate health and social services. Funding is to be provided at sufficient levels to ensure that counties can provide each child, transition age youth, adult and senior with the necessary mental health services.

LATEST INFORMATION

- PUBLIC NOTICE:
  - Three Year Program and Expenditure Plan 2020-2023 | Spanish
  - Public Comment Forms | Spanish

  The public comment period begins on Friday, February 28, 2020, and ends Wednesday, April 1, 2020. A public hearing will be held on Wednesday, April 1, 2020 at 5:15 pm at Pleasant Hill Senior Center (Classroom), 233 Gregory Lane, Pleasant Hill, CA 94523
- FULL VIDEO: ECMH Community Forum
  - Part 1: Welcome & Intro to MHSA
  - Part 2: Early Childhood Mental Health Info
  - Part 3: Community Input & How to Stay Involved
- VIDEO: Suicide Prevention Community Forum
- VIDEO: Supportive Housing Forum
- VIDEO: 2018 Antioch Forum
- VIDEO: 2019 MHSA Immigrant Community Forum
- "MHSA FY 18-19 Revenue and Expenditure Report
- MHSA FY 17-18 Revenue and Expenditure Report
- Innovation Annual Report FY 17-18
- PEI Evaluation Report FY 15-18

medications and support set forth in their treatment plan. Finally, the Act requires this Three Year Plan be developed with the active participation of local stakeholders in a community program planning process.

Attached is a form and instructions should an individual wish to request a review of any issues related to:

- The MHSA Community Program Planning Process.
- Consistency between approved MHSA plans and program implementation.
- The provision of MHSA funded mental health services.

- PEI Evaluation Report FY 15-18

LINKS & RESOURCES

- MHSA Plan Update FY 2019-2020
- Find Mental Health Services in West County, East County and Central County
- CCBHS Needs Assessment
- MHSA 3 Year Plan 2017-2020
- MHSA Plan Update FY 2018-2019 | Spanish
- Consolidated Planning Advisory Workgroup (CPAW)
- County Behavioral Health Director's Association of California Mental Health Services Act

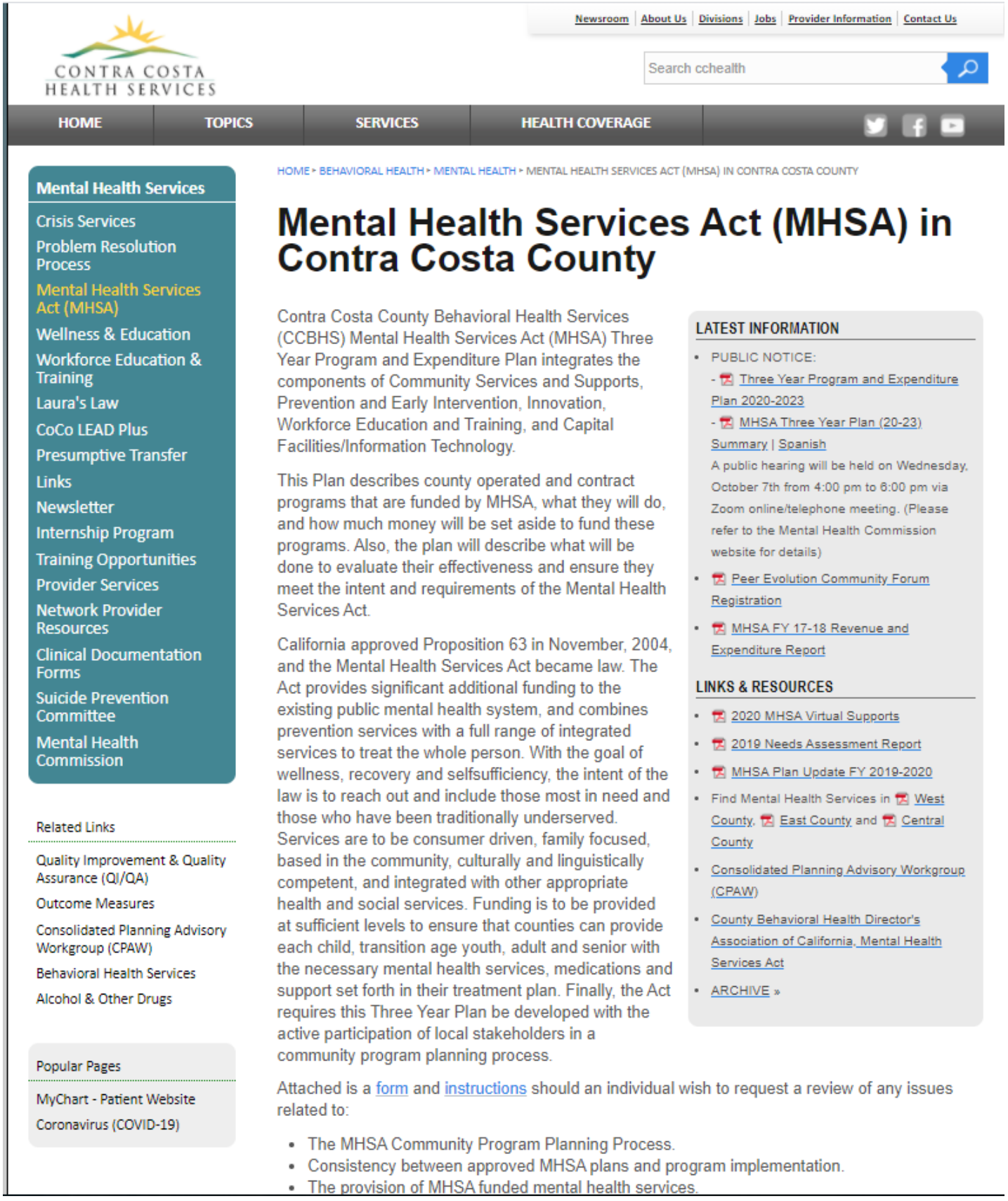
Community Services and Supports

Community Services and Supports is the component of the Three-Year Program and Expenditure Plan that refers to service delivery systems for mental health services and supports for children and youth, transition age youth (ages 16-25), adults, and older adults (over 60). Contra Costa County Mental Health utilizes MHSA funding for the categories of Full Service Partnerships and General System Development.

First approved in 2006 with an initial State appropriation of $7.1 million Contra Costa's budget has grown incrementally to $31.5 million annually in commitments to programs and services under this component. The construction and direction of how and where to provide funding began with an extensive and comprehensive community program planning process whereby stakeholders were provided training in the intent and requirements of the Mental Health Services Act, actively participated in various venues to identify and prioritize community mental health needs, and developed strategies by which service delivery could grow with increasing MHSA revenues.

For more information:

Mental Health Services Act
Contra Costa Mental Health Administration
1220 Morello Ave. Suite 100
Martinez, CA 94553 [Map & Directions]
MHSA@cchealth.org



CONTRA COSTA HEALTH SERVICES

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HOME | TOPICS | SERVICES | HEALTH COVERAGE

Mental Health Services
- Crisis Services
- Problem Resolution Process
- Mental Health Services Act (MHSA)
- Wellness & Education
- Workforce Education & Training
- Laura's Law
- CoCo LEAD Plus
- Presumptive Transfer
- Links
- Newsletter
- Internship Program
- Training Opportunities
- Provider Services
- Network Provider Resources
- Clinical Documentation Forms
- Suicide Prevention Committee
- Mental Health Commission

Related Links
- Quality Improvement & Quality Assurance (QI/QA)
- Outcome Measures
- Consolidated Planning Advisory Workgroup (CPAW)
- Behavioral Health Services
- Alcohol & Other Drugs

Popular Pages
- MyChart - Patient Website
- Coronavirus (COVID-19)

HOME > BEHAVIORAL HEALTH > MENTAL HEALTH > MENTAL HEALTH SERVICES ACT (MHSA) IN CONTRA COSTA COUNTY

Mental Health Services Act (MHSA) in Contra Costa County

Contra Costa County Behavioral Health Services (CCBHS) Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan integrates the components of Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training, and Capital Facilities/Information Technology.

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California approved Proposition 63 in November, 2004, and the Mental Health Services Act became law. The Act provides significant additional funding to the existing public mental health system, and combines prevention services with a full range of integrated services to treat the whole person. With the goal of wellness, recovery and selfsufficiency, the intent of the law is to reach out and include those most in need and those who have been traditionally underserved. Services are to be consumer driven, family focused, based in the community, culturally and linguistically competent, and integrated with other appropriate health and social services. Funding is to be provided at sufficient levels to ensure that counties can provide each child, transition age youth, adult and senior with the necessary mental health services, medications and support set forth in their treatment plan. Finally, the Act requires this Three Year Plan be developed with the active participation of local stakeholders in a community program planning process.

LATEST INFORMATION
- PUBLIC NOTICE:
  - Three Year Program and Expenditure Plan 2020-2023
  - MHSA Three Year Plan (20-23) Summary | Spanish
  A public hearing will be held on Wednesday, October 7th from 4:00 pm to 6:00 pm via Zoom online/telephone meeting. (Please refer to the Mental Health Commission website for details)
- Peer Evolution Community Forum Registration
- MHSA FY 17-18 Revenue and Expenditure Report

LINKS & RESOURCES
- 2020 MHSA Virtual Supports
- 2019 Needs Assessment Report
- MHSA Plan Update FY 2019-2020
- Find Mental Health Services in West County, East County and Central County
- Consolidated Planning Advisory Workgroup (CPAW)
- County Behavioral Health Director's Association of California, Mental Health Services Act
- ARCHIVE »

Attached is a form and instructions should an individual wish to request a review of any issues related to:

- The MHSA Community Program Planning Process.
- Consistency between approved MHSA plans and program implementation.
- The provision of MHSA funded mental health services.

medications and support set forth in their treatment plan. Finally, the Act requires this Three Year Plan be developed with the active participation of local stakeholders in a community program planning process.

Attached is a form and instructions should an individual wish to request a review of any issues related to:

- The MHSA Community Program Planning Process.
- Consistency between approved MHSA plans and program implementation.
- The provision of MHSA funded mental health services.

- PEI Evaluation Report FY 15-18

LINKS & RESOURCES

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- Find Mental Health Services in West County, East County and Central County
- CCBHS Needs Assessment
- MHSA 3 Year Plan 2017-2020
- MHSA Plan Update FY 2018-2019 | Spanish
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First approved in 2006 with an initial State appropriation of $7.1 million Contra Costa's budget has grown incrementally to $31.5 million annually in commitments to programs and services under this component. The construction and direction of how and where to provide funding began with an extensive and comprehensive community program planning process whereby stakeholders were provided training in the intent and requirements of the Mental Health Services Act, actively participated in various venues to identify and prioritize community mental health needs, and developed strategies by which service delivery could grow with increasing MHSA revenues.

For more information:

Mental Health Services Act
Contra Costa Mental Health Administration
1220 Morello Ave. Suite 100
Martinez, CA 94553 [Map & Directions]
MHSA@cchealth.org

CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1220 Morello Ave., Suite 100
Martinez, CA 94553
Ph (925) 957-2619
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

Mental Health Commission (MHC)
Hosts a Public Hearing for the Mental Health Services Act (MHSA) Three Year Plan FY 2020-2023
Wednesday, October 7, 2020 ◊ **4:00 pm - 6:00 pm**
VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

I. Call to order/Introductions

II. Public comments

III. Commissioner comments

IV. Chair comments

V. Approval of the September 2nd, 2020 minutes

VI. ANNOUNCE 2021 MHC officer and Executive Committee election and FORM Nominating Committee (10 min)

VII. DISCUSS re-opening of "4D" (former Contra Costa Regional Medical Center (CCRMC) acute psychiatric unit) for adult patients coming from Psychiatric Emergency Services – Dr. Samir Shah, CCRMC CEO and Dr. Suzanne Tavano, Director of Behavioral Health Services (20)

VIII. RECEIVE Behavioral Health Services Director's report -- Dr. Suzanne Tavano (10 min)

IX. Adjourn

-- The Public Hearing will follow the MHC meeting –

Call to Order the Public Hearing on the Mental Health Services Act Three Year Plan 2020 - 2023

I. Opening Comments by the Chair of the Mental Health Commission

II. Fiscal Years 2020 to 2023 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan – Jennifer Bruggeman, Program Manager, MHSA Programs, Dr. Suzanne Tavano, Director of Behavioral Health Services, and Windy Taylor, Program Manager, Behavioral Health Administration

III. Public Comment

In the interest of time and equal opportunity, speakers are requested to **please adhere to a 3 minute time limit, per person**. In accordance to the **Brown Act**, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item will occur, except for the purpose of clarification.

IV. Commissioner Comments

V. DEVELOP a list of Comments and Recommendations to the County Mental Health Administration and to the Board of Supervisors

VI. Adjourn Public Hearing

Authority for Public Hearing: California Welfare and Institutions Code (WIC) § 5848

(a) Each three-year program and expenditure 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, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. 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 three year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure 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.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

MENTAL HEALTH COMMISSION
(Hosts a Public Hearing for the Mental Health Services Act (MHSA) Three Year Plan FY 2020-2023)
MONTHLY MEETING AND PUBLIC HEARING MINUTES
October 7, 2020 – Draft

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. B. Serwin, MHC Chair, called the meeting to order @ 4:11 pm Members Present: Chair- Cmsr. Barbara Serwin, District II Cmsr. Diane Burgis, Supervisor, District III Cmsr, Douglas Dunn, District III Cmsr. Laura Griffin, District V Cmsr, John Kincaid, District II Cmsr. Kate Lewis, District I (arrived after start of meeting) Cmsr. Joe Metro, District V Cmsr. Kira Monterrey, District III Cmsr. Alana Russaw, District IV Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Cmsr. Graham Wiseman, District II Members Absent: Cmsr. Leslie May, Vice-Chair, District V Cmsr. Sam Yoshioka, District IV Other Attendees: Dr. Suzanne Tavano, (Director, Contra Costa Behavioral Health Services (CCBHS) Jaspreet Benepal (Interim Chief Executive Officer, Contra Costa Regional Medical Center and Health Centers) Jennifer Bruggeman (MHSA Program Manager) Y'Anad Burrell Kanwarpal Dhaliwal Lisa Finch Carolyn Goldstein-Hildago Mark Goodman, Chief of Staff, Supervisor Diane Burgis Office Lynda Kaufman Karen Lai Jeff Landau Anna Lubarov Audrey Montana (MHSA Administrative Support) Dawn Morrow Margaret Netherby Carolyn Obringer Teresa Pasquini Haji Razmi Stephanie Regular Kristine Suchan Windy Taylor Jennifer Tuipulotu Genoveva Zesati	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	

III. COMMISSIONER COMMENTS: • (Cmsr. J. Kincaid) Early voting has started. Since Monday, can use ballot drop boxes. Maps are in the voter information booklets. • (Cmsr. G. Wiseman) California released a report of an audit regarding Suicide Prevention in the state. Specifically, important is information regarding school districts. • (Cmsr. K. Monterrey) Where can we get data on suicide rates in the County as compared to admissions into Psychiatric Emergency Services (PES)? (Cmsr. B. Serwin) We will follow up afterwards with Dr. Suzanne Tavano (Director, Behavioral Health Services).	
IV. CHAIR COMMENTS/ANNOUNCEMENTS: None	
V. APROVE September 2, 2020 Meeting Minutes: • September 2, 2020 Minutes reviewed. **Motion:** J. Kincaid moved to approve the minutes as written. Seconded by D. Dunn. **Vote: 11-0-0** **Ayes:** B. Serwin (Chair), D. Burgis, D. Dunn, L. Griffin, J. Kincaid, J. Metro, K. Monterrey. A. Russaw, G. Stern, G. Swirsding, G. Wiseman **Abstain:** 0	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. ANNOUNCE 2021 MHC Officer and Executive Committee election and Form Nominating Committee (10 min): • The terms for the Mental Health Commission Executive Committee's Chair and Vice Chair and Executive Committee members end in December • Now beginning the 2021 election process. This Commission meeting will form a Nominating Committee. The role of the Committee is to bring a slate of candidates to the Commission. Identify candidates who either expressed interest in running or who are nominated by other Commissioners. Will ask each candidate if he or she wants to run. This Committee also conducts the election. Throughout October, the Committee develops the slate of candidates. • In November, the Committee will present the slate of candidates. • The election is held during the December Commission meeting. The elected candidates take office on January 1st. The Nominating Committee's work ends in December. • Volunteers for the Nominating Committee: o Cmsr. John Kincaid to Chair the Nominating Committee o Commissioners Kira Monterrey and Alana Russaw	
VII. DISCUSS re-opening of "4D" (former Contra Costa Regional Medical Center (CCRMC) acute psychiatric unit) for adult patients coming from Psychiatric Emergency Services – Dr. Samir Shah, CCRMC CEO and Dr. Suzanne Tavano, Director of Behavioral Health Services (20 min): Dr. Suzanne Tavano (Director, Behavioral Health Services) and Jaspreet Benepal (Interim Chief Executive Officer, Contra Costa Regional Medical Center and Health Centers) presented and responded to a list of questions: • Summary of 4D reopening announcement o Jaspreet Benepal ▪ Several factors formed the basis for expediting the opening 4D – For example, the global pandemic, issues with COVIC-19 related to congregated living situations and soon approaching the flu season soon approaching ▪ A major factor was the relaxation of regulations permitting opening of units that had either been suspended or had flex programing. With the waiving of	

State regulations, we could move quickly. Also, funding is now available but for a limited period of time.
    - There is a shortage of inpatient psychiatric unit beds in our county, the Bay Area and the State.
    - Also, PES volume is going up. Adults were waiting at PES to be placed elsewhere for treatment. 4D was placed in suspension in 2006 (14 years ago). Opening 4D will help to address the volume in PES. Can provide treatment locally and immediately.
  - Dr. Tavano
    - From data, clear the number of adults at PES require inpatient care but have to wait until an available bed is located. Needed more access to inpatient care.
    - Now the federal and state government have allowed flexibilities. Now have the opportunity to take 4D out of suspension. Never technically closed. The hospital license was suspended. New provisions allowed the unit to come out of suspension quickly.
    - For original purpose only – adult acute inpatient unit
    - In addition, funding related to COVID became available that supported the financing of some of the physical modifications of the unit. All these factors supported the reopening of 4D.

(Jaspreet Benepal)

- Questions for CCRMC CEO and Director of Behavioral Health Services
  Re: Re-opening of 4D from the Mental Health Commission
  - What is the difference between 4C and 4D?
    - There is no difference between 4C and 4D. Both are acute adult inpatient psychiatric units
    - In December will receive funding for COVID-19 and this will pay for physical modifications of the unit
    - Unit 4D had twenty beds that were suspended since 2006. Under the reopening conditions, can reopen only under same license that had in 2006.
    - PES has 23 beds. 4D will have 20. Will have a total of 43 inpatient beds.
  - Why 4D and not some other solution for creating more acute psychiatric beds?
    - Please refer to summary and answer to question one. 4D was the quickest opportunity to address all these issues and COVID-19. 4D previously also provided acute adult inpatient care which is urgently needed currently. This is the quickest method to get the unit out of suspension and to expand inpatient care. Also, funding expires in December.
    - To try to provide this expansion by other methods would take a very long time. No other method or route provided funds or a fast resolution to the issue
  - How long will opening 4D take?
    - Goal is to open by end of October. Now awaiting survey by the Fire Marshall, California Department of Public Health compliance survey and approval, etc. But, working fast to get these completed.
    - At the latest to open by the end of November. No exact date yet.
  - Is 4D viable in the long run?
    - The goal is to keep 4D open and active in the long term. But, must be ligature resistant and this will take a while. Currently have procedures and staffing to make sure the patients are safe.
  - What is the funding and business model for 4D?
    - The re-opening, start-up costs are financed by COVID-19 (to reduce congregate setting in PES). Most likely will also be covered by FEMA/CARES ACT. Funded through December 31st.

- Starting next year, need to make sure we manage the cost through revenue generated from this inpatient unit.

- The business plan (Dr. Tavano)
  - John Muir Medical Center has been an amazing partner. They will continue to serve children and adolescents. They expanded the capacity of these units. We are happy about that.
  - Bay Area Hospitals mostly are subject to the IMD exclusion rule. If we refer patients to these hospitals, many of the hospitals are not eligible for MediCal payments although the patients are MediCal eligible. So must use 100 percent realignment funds. If the hospital is not subject to the exclusion, we pay a little less than half with a match of local funding and use the federal dollars to make up the difference.
  - Realignment dollars that we have been using for placement of our patients at contracted hospitals was an expense
  - We can now use local funds as a match with federal dollars for 4D
  - Will refer new patients who come to PES and need acute care to 4D
  - Want to avoid sending patients to other Bay Area hospitals even as far as Sacramento for treatment. The goal is to provide treatment locally, in the community and near family members.
  - With the State, we can negotiate rates locally for acute days. Once someone leaves acute status and goes to administrative status, means their psychiatric condition has stabilized and no longer need hospital care. This is considered an Administrative Day for State reimbursement purposes. The State sets the reimbursement rates for Administrative Days extremely low. An Administrative Day is perhaps twenty five percent of the cost of an acute day in State reimbursement to the County. Will have to watch the Administrative Days.
  - Must build up alternative treatment centers like the Board and Cares. Patients are not waiting on Administrative Days for placement.
  - Also, once someone is placed under conservatorship and a recommendation is made for an MHRC long term facility, the accessibility of such programs is getting tighter. Always a struggle to find a bed even when willing to contract with a facility and pay. Harder now as with wildfires one facility had to be abandoned twice.
  - Will have to be creative and get all the treatment components in place.
- What would be the biggest impacts on PES with the freeing up of space?
  - Patients would be able to be placed as soon as treatment is required
  - Free up space at PES for other patients and provide beds and treatment
- Will PES be redesigned to better accommodate children? (Dr. Tavano)
  - We are continuing to look at the redesign of PES. We were to provide our final report to the Board of Supervisors in October. Moved to end of November or December.
  - Continuing to do the needs assessment due to COVID.
  - Looking at other options provided by community members. Later determined that was not feasible.
  - In this County, the ambulances must transport the person to an Emergency Department. On the State level, there is new legislation re alternative care sites. Looking at alternative sites – i.e. something on campus of the Contra Costa Regional Medical Center (free standing CSU). Looking at other alternatives.
  - This additional time gives us time to look at possibilities that we have not looked at before and to work with the state on licensing/certificate requirements
- What are the key regulatory challenges (physical plant, services)?

- Under these circumstances, can move quickly under regulation relaxation for now.
- Later most likely will have to comply with full regulations (not relaxation of regulations as currently have). Creating 4D for the long term. Taking full requirements into consideration. Moving forward as if we currently have to comply with full regulations and requirements.
- This is a soft opening and we will do as much as we can immediately for now but will work to ensure fulfill regulations later for the long term

o After COVID will regulatory requirements revert to pre-COVID requirements?
- Yes. Please refer to response to prior questions.

o How will the community be involved in the design and implementation of 4D? How specifically will the Mental Health Commission be involved?
- The email announcing the reopening of 4D was sent out. If you would like to be a part of the task force, please email me, Dr. Simir or Dr. Tavano. Also, welcome members of the Mental Health Commission to participate. Currently trying to create 4D as it was in 2006 but now in compliance with the newer regulations. Will have, for example, therapy, groups, treatment plans, etc. Happy to have you on our committees and task force.

Comments and Questions:

- (Anna Lubarov) An alternative could be to build a treatment facility that would be a Peer run respite. They would provide amazing recovery support and avoid higher level of care. Something to think about.
- (Teresa Pasquini) Thank you so much, Jaspreet and Dr. Tavano. I am fighting tears and am so proud and excited. I was around when the unit was closed. This County is opening an acute psychiatric unit that is so needed as many such units are closing. We recommended a Respite Center model in our paper, "Housing That Heals." We need options at different levels of care. It is best to have a loved one near home and in our community. It is very emotional. I welcome the opportunity to be able to support this. Thank you. (Jaspreet Benepal) I used to work on that unit. I remember that day very well. I join you in the excitement in opening 4D.
- (Cmsr. Graham Wiseman) Will temporary shelters be used during the construction of 4D? (Jaspreet Benepal) We have COVID funding until December. We will look at other options. We are looking at a separate free standing building for the children. We have not looked at using temporary structures at this point.
- (Cmsr. John Kincaid) Will the unit be ligature resistant? Is that, for example, replacing sprinkler heads, etc.? (Jaspreet Benepal) The work has already started. It is extensive and will take time. This is nationwide. Every hospital much comply. Any equipment (from doors, to beds, to mops, etc.) needs to be ligature resistant. There is a process for the hospitals. Already started the process for 4D in preparation to submit application for 4D. In the meantime, have a mitigating plan to make sure patients are safe.

VIII. RECEIVE Behavioral Health Services Director's Report - Dr. Suzanne Tavano (10 min):

- **Assembly Bill 1976** - Assisted Outpatient Treatment. Rather than counties opting in to participate, counties will have to opt out (and provide justification). Takes away the sunset rules.
- **Senate Bill 855** – Insurers should make mental health and substance abuse benefits available. Parody is coming to California.
- **Assembly Bill 2265** – Will allow Mental Health Services Act (MHSA) funding to support programs that address co-occurring mental health and substance use issues. We have been advocating for this a long time.
- **Senate Bill 803** – Provide for certified Peer Specialists and the creation of MediCal billing codes. County can opt in. Hopeful Contra Costa will move this forward when

details worked out. Congratulations to the SPIRIT program graduates of 2020. They had their graduation this week. They are amazing. • **Alternative care site for ambulances** - Will provide details later. Also, there is a new Director for Emergency Medical Services. • **Collaborative efforts** – Met with a number of Chiefs of Police and Mayors. Participated in some city Town Halls. Now working collaboratively with city managers and mayors throughout Contra Costa County. Will be doing a value stream mapping in the near future. Analyze the current situation and look for way to improve in the future. Look at crisis intervention (mobile crisis response) and also pre-crisis situations (i.e. CORE Team, Health Care Connect). Invite two commissioners to the Mental Health Commission to be a part of this process and be on the team. Will later come back and make the request of the Commission. • **External Quality Review Audit** - They were very complimentary. They were impressed we were able to sustain services thru COVID when some other counties were not able to do so. Want to acknowledge Fatima Mata Sol our AOD Administrator. She has a great team. Now going through the DHCS Triannual which is a review of our entire system and audit of our medical records. Tomorrow is their last day. When we receive the report, we will discuss the report with the Mental Health Commission. **Comments and Questions:** • (Anna Lubarov) It is amazing Contra County is working with the mayors. Wonder if this group is working with the Justice for Miles Hall foundation? If not, how ca we get the public involved? (Dr. Tavano) The value stream mapping is inclusive of community members. We assume there would be representation from the Foundation. It is intended to be very inclusive.	
IX: Adjourned Mental Health Commission Meeting at 5:15 pm	

Agenda Item / Discussion	Action /Follow-Up
(Public Hearing Commenced at 5:16 pm) I. **Opening Comments by the Chair of the Mental Health Commission:** • Chair of the Mental Health Commission, Commissioner Barbara Serwin, made Opening Comments. • This hearing is mandated by California Welfare and Institutions Code to conduct a Public hearing on the draft of the MHSA Three Year Plan or annual updates. The goal of this hearing is to encourage the Mental Health Commissioners and the public to review and make comment on any aspect of the MHSA Plan. • The Public Hearing usually occurs in May. However due to COVID-19 and the impact on the MHSA budget, the public hearing was delayed until adequate financial data and budget projections were in place. • Want to congratulate Jennifer Bruggeman and the rest of the MHSA Team, Dr. Tavano and Patrick Godley (Health Services Chief Financial Officer) for their dedication, perseverance and creativity in adjusting the MHSA Plan during and in response to COVID-19. • Obtaining projected revenues during a time of economic chaos is a huge challenge. Finding ways to keep community projects intact amidst a major decline in revenues is another huge challenge. Collaboration is hard work. But it has paid off and the Mental Health Commission is grateful.	Meeting was held via Zoom platform
II. Fiscal Years 2020 to 2023 mental Health Services Act (MHSA) Three Year Program and Expenditure Plan – Jennifer Bruggeman, Program Manager, MHSA Programs, Dr. Suzanne Tavano, Director of Behavioral Health Services, and Wendy Taylor, Program Manager, Behavioral Health Administration **Windy Taylor (Program Manager, Behavioral Health Administration)** (Document Presentation – "MHSA – Finance Committee – Wednesday, September 16, 2020, pages 16 – 18 – authored by Patrick Godley, Chief Operating Officer and Chief Financial Officer, Contra Cosa Health Services) • Background Information o Recently the Health Services Chief Financial Officer (Patrick Godley) presented three options for the MHSA budget moving forward based on the effects of COVID. He talked about how realignment also affected the MHSA funded programs. • Option One o Original posted budget in February 2020 with an operating budget of 68 million dollars. o Each of the Fiscal Years are detailed. Each includes the Fund Balance, Projected Funds to be received from the State, Trust Drawdown and resulting balance for each Fiscal Year. o Fiscal Year 2019/2020 ending balance was 52.7 Million dollars o Reviewed Chart for Option One o Fiscal Year 2022/2023 ▪ If operating under the 68 million dollar budget, the ending balance for this the 2022/2023 Fiscal Year would result in a negative balance ▪ A deficit of almost 24 million dollars	

- Option Two
  - The budget is kept at the actual dollar amount spent for the Fiscal Year 2019/2020. No anticipated change depicted
  - Budgeted amount for each Fiscal Year at 50.6 million dollars
  - Reviewed Chart for Option Two and ending balance
- Option Three
  - This option includes MHSA realignment and growth. Realignment was heavily affected by COVID. Many of the MHSA programs are funded by realignment dollars.
  - For Option Three, included the MHSA Rollover Growth dollars and the lost Realignment dollars that were made up for using MHSA funding
  - This would keep programs whole
  - The ending balance is ten million dollars
- Jennifer Bruggeman Comment
  - These three options were presented at the MHSA Finance Committee meeting in September.
  - Option Three was the option the Committee was in favor of
  - Option Three is the option we plan to move forward with

Jennifer Bruggeman (MHSA Program Manager)

(PowerPoint Presentation – "MHSA Three Year Program and Expenditure Plan – Revised Proposed Programming and Budget Summary for FY 2020-2023)

- COVID-19 Timeline
  - Provided summary of events from March 1, 2020 (from the posting of the Three Year Plan Draft for 30 days for Public Comment), through the onset of COVID-19, Shelter in Place to the present (October 2020)
  - The planned April 2020 Public Hearing on the 3 Year Plan was postponed in order to reassess the financial impact of COVID and revise the MHSA budget. The State provided Counties the flexibility to postpone the Public Hearings due to the unprecedented public health emergency of COVID, as a result, this Public Hearing is being held today. We will finalize the Plan and send the final MHSA Three Year Plan to the Board of Supervisors for approval.
- March 2020 Proposed Changes (Pre-COVID)
  - $14 million dollar increase in proposed increased fund and listed purposes for increased funding
- Fiscal Impact of COVID-19 on Contra Costa Behavioral Health Services
  - Tax based revenues down (MHSA dollars), Realignment dollars down
  - Option Three - Allow limited expansion in specific areas, maintain all programs and not have to make any cuts. Also maintains the MHSA Prudent Reserve at the current level.
- September 2020 Revised Proposal - Highlights
  - New increased funding for Mobile Crisis Response Team and community crisis response programming
  - Maintain some increased funding for housing supports, early childhood mental health and suicide prevention (priorities identified by stakeholders at MHSA Community Forums)
  - MHSA funds will be used to replace five - seven million dollars of lost realignment funds to preserve programs

- Program contracts remain at 2019-2020 funding levels - renew all contracts without having to cut programs
- Supportive Housing (Expansion)
  - Support Full Service Partnership programs to expand capacity & housing
  - No Place Like Home – increase permanent support housing units
  - Increase permanent support housing and supports
  - Increase Board and Care inventory
- Suicide Prevention & Education (Expansion)
  - Last September had a full day MHSA Community Forum event focused on Suicide Prevention. The community wanted more access to training and outreach efforts, to decrease stigma and spread awareness about mental health. Some are groups more high risk especially now during these challenging times.
  - Field staff to provide countywide suicide prevention education & Training
- Early Childhood Mental Health (Expansion)
  - Provide outreach, education and linkage to treatment for families with very young children (0-5 years) experiencing serious emotional disorders
  - Needs Assessment indicated this to be an underserved population
  - Response from feedback received during an MHSA Early Childhood Mental Health Community Forum held last November
- Workforce, Education and Training (WET) Financial Incentive Programs (Expansion)
  - Expand Loan Repayment Program to address critical staff shortages
  - Extend the Loan Repayment Program to additional positions as peers and clinicians. Have no significant impact on the budget.
- Proposed Fiscal Year 2020-2023 Budget
  - The 2020-2021 proposed budget has an increase from $54 million to $61.6 million dollars.
  - Budget increase to address priority services, Community Crisis Response and address realignment shortfalls. Prevents program cuts.
  - Will retain the MHSA Prudent Reserve at the current level of $7.5 million
  - Welcomed additional comments, questions, input and guidance and provided contact information

Dr. Suzanne Tavano (Director, Behavioral Health Services)

- Would like to thank the Mental Health Commission for focusing on this so quickly. The County has so far has not had to cut any positions or staff. We are working to sustain our programs and services.
- This MHSA Three Year Plan is a living document. Funding will go up if more funds become available and down if funding is reduced.

III. PUBLIC COMMENT:

- (Y'Anad Burrell) How was this meeting promoted to the public? What effort was done to inform the community? (Cmsr. Barbara Serwin and Jennifer Bruggeman) We follow up with you after this meeting on that question. Would be happy to discuss that with you in detail.
- (Y'Anad Burrell) Regarding the PowerPoint slides, were they or will they be made available to the community? (Jennifer Bruggeman) The MHSA Three Year Plan and the PowerPoint presentation is posted on the MHSA website.
- (Y'Anad Burrell) A lot of organizations listed for funding during a CPAW meeting previously are the same organizations funded each year. What African American owned and operated organizations have been given the opportunity to get funding

thru MHSA? Previously I was told they have to go through a process. What effort has this body made to reach out to African American owned and operated organizations to deliver services? Thank you. • (Dr. Tavano) Would like to thank all of the Mental Health Commissioners and particularly the MHSA Finance Committee for getting us very focused very quickly. Do appreciate that. We are so fortunate in our County to not have to cut programs and staff. This will sustain us. This is truly a living document. Every year we will be looking at what the revenues are. If they go up, great. We could do more. If they go down, we will adjust. We don't believe the projections will go down below what the projections are. It is a living document that can always be amended and updated in the future. • (Jennifer Bruggeman) Would like to thank the Mental Health Commissioners for their support. Thank everyone for being here. We appreciate your input. Please feel free to reach out to us directly at any time with questions. Thank you.	
IV. COMMISSIONER COMMENTS: • (Cmsr. B. Serwin) You all did an outstanding job. There were a lot of challenging forces. Congratulations.	
V. Develop a list of Comments and Recommendations to the County Mental Health Administration and to the Board of Supervisors: • During this Public Hearing, the MHSA Program Manager, Jennifer Bruggeman, indicated Option Three has been incorporated into this MHSA Three Year Plan budget, the Plan will be finalized and then presented before the Board of Supervisor for approval. Public comments received. Additional comments, questions, input and guidance were welcomed.	
VI. Adjourned Public Meeting at 5:45pm.	

Contra Costa Behavioral Health Services Administration Response to Public Comments, Public Hearing and Mental Health Commission Comments and Recommendations

As per Section 5848 of the California Welfare and Institutions Code the County shall summarize and analyze any substantive written recommendations for revisions by the public and/or the Mental Health Commission to the MHSA Three Year Program and Expenditure Plan.

I. 30 Day Public Comment Period

No written public comments were received.

II. Public Hearing

The following comments were provided by participants in the public hearing:

- How was this meeting promoted to the public? What effort was done to inform the community?

Response. Can follow up with you after this meeting on that question. Would be happy to discuss that with you in detail.

- Regarding the PowerPoint slides, were they or will they be made available to the community?

Response. The MHSA Three Year Plan and the PowerPoint presentation is posted on the MHSA website.

- A lot of organizations listed for funding during a CPAW meeting previously are the same organizations funded each year. What African American owned and operated organizations have been given the opportunity to get funding through MHSA? Previously I was told they have to go through a process. What effort has this body made to reach out to African American owned and operated organizations to deliver services? Thank you.
- Would like to thank all of the Mental Health Commissioners and particularly the MHSA Finance Committee for getting us very focused very quickly. Do appreciate that. We are so fortunate in our County to not have to cut programs and staff. This will sustain us. This is truly a living document. Every year we will be looking at what the revenues are. If they go up, great. We could do more. If they go down, we will adjust. We don't believe the projections will go down below what the projections are. It is a living document that can always be amended and updated in the future.
- Would like to thank the Mental Health Commissioners for their support. Thank everyone for being here. We appreciate your input. Please feel free to reach out to us directly at any time with questions. Thank you.

III. Mental Health Commission Comments

Upon completion of the Public Comment period Mental Health Commission (MHC) members provided individual comments. A summary of commissioner comments and Behavioral Health Services Administration (CCBHS) responses are as follows:

- You all did an outstanding job. There were a lot of challenging forces. Congratulations.
  - Mental Health Commission Chair provided follow up information via email in response to community member's question about how Three Year Plan was made

available to the public. Information about the MHSA Three Year Plan and Public Hearing was shared/discussed at the following:

- Key Stakeholder Meetings:
  - Mental Health Commission Finance Meeting on 9/16/20
  - Consolidated Planning Advisory Workgroup (CPAW) Steering Committee on 9/17/20
  - Suicide Prevention Coalition on 9/25/20
  - CPAW main meeting on 10/1/20 – The entire Three Year Plan was also presented including Q&A and public comment.
  - Reducing Health Disparities (RHD) on 10/5/20
- Websites:
  - The updated Three Year Plan and its summary (in English and Spanish) as well as notification of the Public Hearing are all posted on the MHSA website.
  - Notification of the public hearing was posted on the Mental Health Commission website
- Email notifications:
  - MHC email distribution list including CPAW Members, Board of Supervisors, County Staff, Community-Based Organizations, and Members of the Public (around 250 contacts)
  - MHSA email distribution list (around 350 contacts that do NOT overlap with the MHC list)
  - A total of around 600 unique contacts
  - Comparing the MHC and MHSA lists, the non-overlapping contacts include Members of the Public -- MHSA's list includes people who have attended any CPAW Meeting or Mental Health Services Act (MHSA) Community Forum; which reach into different regions of the County.

- Regarding extent to which MHSA programs reach African-Americans in Contra Costa County, there is data in the Prevention and Early Intervention (PEI) section of the Three Year Plan which speaks to programming and individuals served, and lists demographic sub-groups served by PEI programs (14% African Americans/Black; 31% LatinX/Hispanic; 42% Caucasian/White, etc.). The Reducing Health Disparities (RHD) group also reviews these efforts and needs. This is part of the Needs Assessment Report and annual Cultural Competence Plan (now Cultural Humility Plan).

IV. Mental Health Commission Recommendations

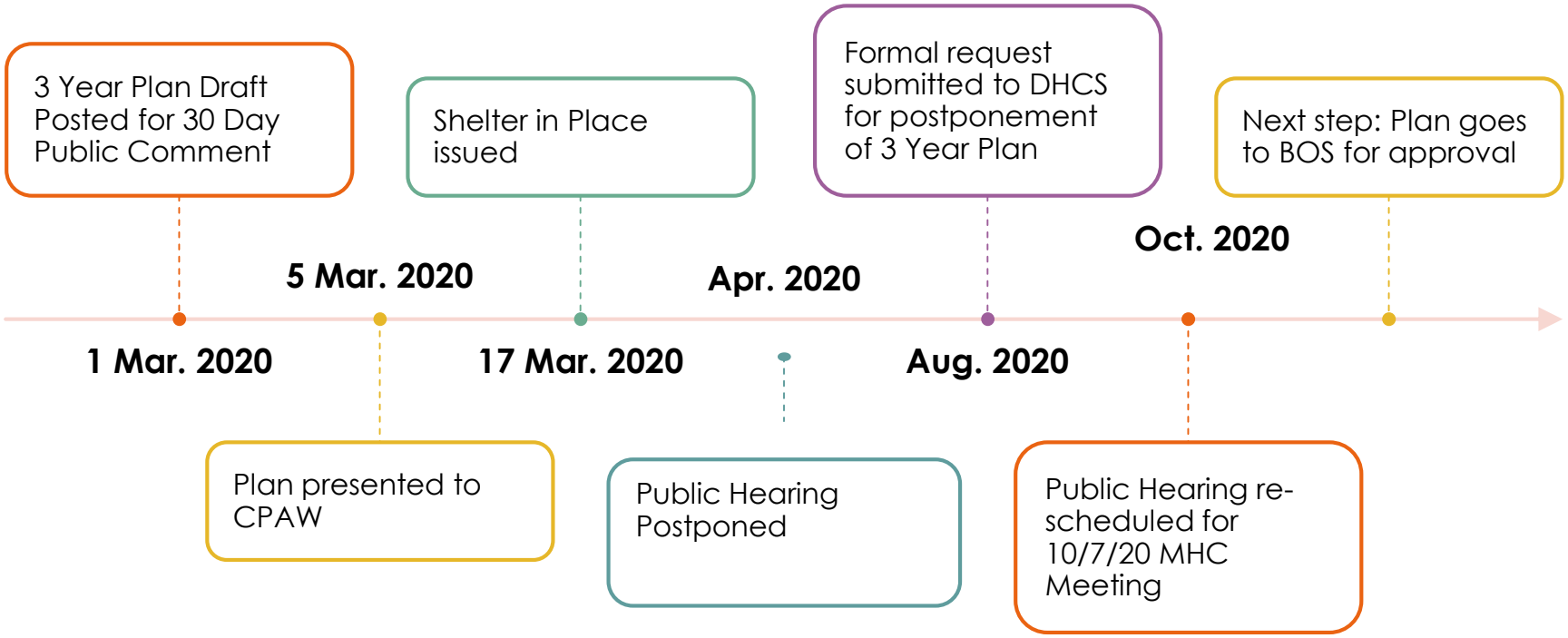
The Mental Health Commission thanked all those present today for their participation in the Public Hearing of the MHSA Three Year Program and Expenditure Plan for fiscal years 2020-2023. This hearing fulfills the Commission's duties under the Mental Health Services Act requirements. The Commission had no recommendations for consideration.

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

MHSA Three Year Program and Expenditure Plan

REVISED PROPOSED
PROGRAMMING AND BUDGET
SUMMARY FOR FY 2020-23

COVID-19 Timeline



March 2020 Proposed Changes (Pre-COVID)

$14 M budget increase proposed

Increased Funding for:

- Supportive Housing
- Early Childhood Mental Health Supports
- Suicide Prevention Training
- ACT to Fidelity
- Mental Health Career Pathways
- Intern Program
- STRTP
- CF/TN

Fiscal Impact of COVID-19 on CCBHS

- Tax-based revenue shortfalls
- FY 19-20 Realignment down ($9.5M)
- FY 20-21 Realignment down ($6.4M)
- Unspent MHSA funds to be utilized to preserve vital services
- Maintain Prudent Reserve

September 2020 Revised Proposal - Highlights

New increased funding for MCRT and community crisis response programming

Maintain some increased funding for housing supports, early childhood MH and suicide prevention (per CPPP)

MHSA funds to replace $5-7M in lost Realignment revenue to maintain specialty mental health services

Contracts remain at 19-20 funding levels

Supportive Housing

- Support to Full Service Partnership programs to increase capacity and add housing flex fund
- Maximize No Place Like Home participation to increase inventory of permanent supportive housing units
- Increase on site permanent supportive housing services and supports
- Retain and recruit additional augmented board and care beds

Early Childhood Mental Health

Provide outreach, education and linkage to treatment for families with very young children experiencing serious emotional disorders.

Suicide Prevention Training & Education

Field staff to provide countywide suicide prevention education and training.

WET Financial Incentive Programs

- Expand County funded and administered Loan Repayment Program to address critical staff shortages, such as language need, psychiatrists, hard to fill and retain positions
- Plan to extend Loan Repayment Program to additional positions including peers and clinicians
- No significant impact on Budget

Proposed FY 20-23 Budget

Increase FY 19-20 budget from $54m to $61.6m for FY 20-21

Budget increase to be used for additional services related to CPPP, Community Crisis Response and addressing Realignment shortfalls (primarily in Specialty Mental Health contracts).

Retain $7.5M in Prudent Reserve

- All comments, questions, input and guidance are most welcome!

- Suzanne.Tavano@cchealth.org
- MHSA@cchealth.org
- Jennifer.Bruggeman@cchealth.org

Innovation Annual Report FY 18-19

Contra Costa Behavioral Health Services

Mental Health Services Act

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Innovation Introduction

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

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

Approved Programs

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2018-19:

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

2) Coaching to Wellness. Individuals who have experience as a consumer and/or family member of the mental health system have been trained to provide mental health and health wellness coaching to recipients of integrated health and mental health services within CCBHS. These peer providers are part of the County's Behavioral Health Services integration plans that are currently being implemented. Three Wellness Coaches are paired with two Wellness Nurses, and are assigned to the adult mental health clinics. The Coaches have received training specific to the skill sets needed to improve health and wellness outcomes for consumers. The Coaching to Wellness Project began implementation in FY 2015-16.

3) Cognitive Behavioral Social Skills Training (CBSST). Many consumers spend years residing at County augmented board and care facilities with little or no mental health treatment provided, and little or no functional improvement taking place. Often this lack of progress results in multiple admissions to the County's Psychiatric Emergency Services and other, more costly, interventions. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project proposes to apply this therapeutic practice to the population of individuals that have been placed in augmented board and care facilities. The CBSST Project will create a clinical team, consisting of a licensed clinician and peer support worker, to lead cognitive behavioral social skills training groups at board and care facilities. Adults with serious mental illness will learn and practice skills that will enable them to achieve and consolidate recovery-based skills. The Cognitive Behavioral Social Skills Training project began implementation in FY 2018-19.

4) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's community program planning process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include training consumers to independently navigate public transportation, providing flexible resources to assist with transportation costs, educating consumers regarding schedules, costs and means of various modes of public transportation, and creating a centralized staff response to coordinate efforts and respond to emerging transportation needs. Three Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY 2016-17.

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

The allocations for these projects are summarized below:

Project	County/Contract	Region Served	Number to be Served Yearly	MHSA Funds Allocated for FY 18-19
Coaching to Wellness	County Operated	Countywide	90	474,089
Partners in Aging	County Operated	Countywide	45	181,067
Overcoming Transportation Barriers	County Operated	Countywide	200	241,450
Center for Recovery and Empowerment	County Operated	West	80	600,000
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	200,000
Administrative Support	County	Countywide	Innovation Support	463,227
			Total 655	***$2,159,833***

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

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

Innovation (INN) Component Yearly Program Budget Summary for FY 18-19

Projects Implemented			2,159,833
		Total	***$2,159,83***

Appendices

Aggregate Innovation Demographics

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

Total Served FY 18/19 = 193

Table 1. Age Group

	# Served	
Child (0-15)	0	
Transition Age Youth (16-25)	0	
Adult (26-59)	3	
Older Adult (60+)	8	
Decline to State	0	

Table 2. Primary Language

	# Served	
English	8	
Spanish	0	
Other	0	
Decline to State	0	

Table 3. Race

	# Served	
More than one Race	1	
American Indian/Alaska Native	0	

Asian	0	
Black or African American	0	
White or Caucasian	6	
Hispanic or Latino/A	3	
Native Hawaiian or Other Pacific Islander	0	
Other	1	
Decline to State	0	

Table 4. Ethnicity (If Non-Hispanic or Latino/A)

	# Served	
African	0	
Asian Indian/South Asian	0	
Cambodian	0	
Chinese	0	
Eastern European	0	
European	5	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
More than one Ethnicity	0	
Decline to State	1	
Other	0	

Table 5. Ethnicity (If Hispanic or Latino/A)

	# Served	
Caribbean	0	
Central American	0	
Mexican/Mexican American /Chicano	5	
Puerto Rican	0	
South American	0	
Other	0	

Table 6. Sexual Orientation		
	# Served	
Heterosexual or Strait	11	
Gay or Lesbian	0	
Bisexual	0	
Queer	0	
Questioning or Unsure of Sexual Orientation	0	
Another Sexual Orientation	0	
Decline to State	0	

Table 7. Gender Assigned Sex at Birth		
	# Served	
Male	4	
Female	8	
Decline to State	0	

Table 8. Current Gender Identity		
	# Served	
Man	4	
Woman	8	
Transgender	0	
Genderqueer	0	
Questioning or Unsure of Gender Identity	0	
Another Gender Identity	0	
Decline to State	0	

Table 9. Active Military Status

	# Served
Yes	0
No	9
Decline to State	0

Table 10. Veteran Status

	# Served
Yes	0
No	9
Decline to State	0

Table 11. Disability Status

	# Served
Yes	8
No	3
Decline to State	0

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	0
Difficulty Hearing or Having Speech Understood	0
Physical/Mobility	8
Chronic Health Condition	0
Other	0

Table 13. Cognitive Disability

	# Served
Yes	0
No	0

Program Profiles

Center for Recovery and Empowerment……B2
Coaching to Wellness ……B3
Cognitive Behavioral Social Skills Training in Augmented Board and Cares……B4
Overcoming Transportation Barriers……B5
Partners in Aging……B6

Program: Center for Recovery and Empowerment (CORE)

The Center for Recovery and Empowerment (CORE) program is an intensive outpatient treatment program that contains three levels of care: intensive, transitional, and continuing care. Because recovery is not linear, teens will be able to move between these levels of care depending on their need. These levels of care involve the following criteria: Intensive Care (6 weeks): During the Intensive Care phase of treatment, teens attend the program four days a week and family members attend twice weekly. An individual treatment plan and attendance contract with the teen is developed, teens are drug tested weekly to encourage honesty and accountability, and through involvement in the 12-step principles of recovery and educational presentations, teens are introduced to the recovery process. Teens also attend weekly individual and group sessions facilitated by therapists and counselors. Teens are linked with Young People's 12-step in the community to begin building connections with a sober peer group that will continue to be a support for ongoing recovery. Phone contact is maintained between CORE staff and client on offsite days.

a. **Target Population:** Adolescents between the ages of 13-19 with substance abuse disorders and co-occurring emotional disturbance will be the targeted group.
b. **Total MHSA Funding for FY 2018/19:** $600,000
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 18/19: 28 individuals
e. **Outcomes**: Evaluation of the program included pre- and post-enrollment of T-ASI indicators. Other proposed indicators include utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions. Child and Adolescent Level of Care Utilization System (CALOCUS).

Program: Coaching to Wellness/Performance Improvement Project

The Coaching to Wellness program provided an additional level of support for adult mental health consumers with certain chronic health conditions through intensive peer and nurse support. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness program provided a holistic team approach to providing care to our consumers. The goals of the program were to: 1) Improve consumer perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

f. **Target Population:** Adults aged 18 years and older who were currently receiving psychiatric-only services at a County-operated Adult clinic; Diagnosed with a serious mental illness (but at a stage to be engaged in recovery); Diagnosed with a chronic health risk condition of cardiac, metabolic, respiratory, and/or have weight issues; Expressed an interest in the program; and indicated a moderate to high composite score on mental health and medical levels of support needed.
g. **Total MHSA Funding for FY 2018/19:** $474,089
h. **MHSA-funded Staff:** 5.0 Full-time equivalents
i. **Total Number served**: For FY 18/19: 46 individuals
j. **Outcomes**: Evaluation of the program included pre- and post-surveys that measured key indicators in areas such as: perceived recovery, functioning, and quality of life. Self-rated health and mental health data is collected by the Wellness Coaches and Nurses at most individual contacts and vitals collected and levels of support assessed by the Wellness Nurses as needed. Satisfaction and achievement on self-identified wellness goals recorded at post-program. Other proposed indicators include primary care and mental health appointment attendance, and utilization rate of involuntary psychiatric emergency admissions and/or acute psychiatric admissions.

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

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

a. **Target Population:** Adults aged 18 years and older who are currently living in Board and Care Homes and are receiving services at a County-operated Adult clinic; Diagnosed with a serious mental illness.
b. **Total MHSA Funding for FY 2018/19:** $200,000
c. **MHSA-funded Staff:** 2.0 Full-time equivalents
d. **Total Number served**: For FY 18/19: 27
e. **Outcomes**: Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7) will be given to all group participants. Additional measuring tools would include the Recovery Assessment Scale (RAS) and the Independent Living Skills Survey (ILSS). Clinic and agency case managers will be asked to fill out the Level of Care Utilization System (LOCUS). 5150s will be tracked for pre/post data and length of hospital stay pre/post data

Program: Overcoming Transportation Barriers

a. **Scope of Services:**

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

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

c. **Total MHSA Funding for FY 2018/19:** $241,450

d. **MHSA Funded Staff:** 2 full-time equivalent staff positions

e. **Number Served:** For FY 18/19: 46 encounters

f. **Outcomes:**

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

Program: Partners in Aging

Partners in Aging is an Innovation Project that was implemented on September 1st, 2016. Partners in Aging adds up to two Community Support Workers, up to 3 Student Interns and 8 hours/week of Psychiatric Services to the IMPACT program. The project is designed to increase the ability of the IMPACT program to reach out to underserved older adult populations through outreach at the Miller Wellness Center and Psychiatric Emergency Services. Through Partners in Aging, IMPACT has provided more comprehensive services, including providing linkage to Behavioral Health, Ambulatory Care, and Alcohol and Other Drugs services. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community. Partners in Aging also to provided SBIRT (Screening, Brief Intervention and Referral to Treatment) services and referrals to IMPACT consumers who screen positive for alcohol or drug misuse.

a. **Scope of Services:** Community Support Workers and Student Interns provided linkage, in-home and in-community peer support, and health/mental health coaching to consumers open to or referred to the IMPACT program. In addition, the CSW and Student Intern provided outreach to staff at Psychiatric Emergency Services and Miller Wellness Center. They were available to meet with consumers at PES and MWC that meet the criteria for IMPACT to provide outreach, and linkage to services. The Student Intern also provide brief AOD screening and referrals, as well as conducting intakes, assessments, and providing individual psychotherapy. Additionally, a Geropsychiatrist will be available 8 hours/week to provide consultation, and in-person evaluations of IMPACT clients.
b. **Target Population:** The target population for the IMPACT Program is adults age 55 years and older who are insured by Medi-Cal, Medi-Cal and MediCare, or are uninsured. The program focused on treating older adults with moderate to severe late-life depression or anxiety and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. Partners in Aging also focused on providing outreach and services to older adults who are experiencing both mental health symptoms and alcohol or drug misuse.
c. **Total MHSA Funding for FY 2018/19:** $181,067
d. **MHSA Funded Staff:** 2 full-time equivalent staff positions
e. **Number served:** For FY 18/19: 32
f. **Outcomes:** Reductions in Level of Care Utilization System (LOCUS) scores, reductions in Psychiatric Emergency Service visits, reductions in hospitalizations, and decreased Patient Health Questionnaire (PHQ-9) scores would indicate the effectiveness of this program.

Innovation Project Annual and Final Reports

Center for Recovery and Empowerment……C2
Coaching for Wellness……..……C8
Cognitive Behavioral Social Skills Training in Augmented Board & Cares……C16
Overcoming Transportation Barriers……C24
Partners in Aging…… ……C32

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

Agency/Project Name: **Center for Recovery and Empowerment**

INNOVATIVE PROJECT TYPE:

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

SERVICES PROVIDED:

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

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

CORE's admission process consists of first receiving a referral. Referrals come from psychiatrists, social workers, schools or school nurses, probation, Kaiser, John Muir Behavioral Health Center, community-based organizations or they are self-referrals. When a referral is received the Program Supervisor or other dedicated staff member will discuss client's background over the phone. Client and/or family member will be asked to come in for an assessment to meet with all staff located at the project. To be accepted into the project staff is looking for the client to meet an appropriate mental health diagnosis, SUD level of need and willingness/ability of either client OR family to participate in program.

If client meets admission guidelines they will be enrolled into the program and begin onsite treatment. Day program schedule is as follows:

1) Transportation provided by van pick-up
2) Check-in with teacher for Golden Gate School Program
3) Complete Daily Goals Worksheet

4) School
5) Lunch and social skills integration
6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy - 1xweek, recovery assignments are done in group 5xweek
8) Tox screen and individual consultation with nurse to discuss results 1xweek
9) Adventure Therapy- ecotherapy, mindfulness and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1xweek per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from YPAA meetings 2xweek. They attend with Recovery Coach and process meeting afterwards with Recovery Coach and individual sponsors in YPAA
12) Sober social events – Clients attend social sober events, weekly, in order to develop and establish a sober peer group. These events are sponsored by YPAA and linkage is provided by Recovery Coach. They include events such as sober dances, parties, bowling, dinners, camping, etc.

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

During the development phase of the project a few challenges were discovered. Innovation projects by design are new and different patterns of service. During the implementation process the project encountered barriers. One of these barriers included finding a location for the project outside of inner-city communities and in an area where youth could be removed from settings where they could be easily triggered to use. This made it difficult because the location needed to be close to the client's home and allow for easy access to transportation to and from the program and provides "Safe and Sober" environment critical to an intensive recovery program. The location was eventually identified and secured for a building that had access to trails and parks nearby to allow for Adventure Therapy.

Another obstacle that the project faced was during the hiring process. Many positions didn't meet current County classifications and it was decided to contract out. This ultimately delayed hiring and the opening of the Center. This also influenced decisions on future positions and how to move forward on the process of hiring. The project decided to change some of the staffing pattern to avoid further delay in hiring and promote quicker implementation of opening of the Center.

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

Upon implementation the staffing pattern changed to meet County policy and requirements. The first change consisted of the Psychiatrist and a Registered Nursing position. These positions proved to be very hard to hire and fill. Neither position required enough hours to justify a part time position and with so few hours required recruitment proved to be difficult. After this evaluation it was proposed to replace this with a Psychiatric Nurse Practitioner (PNP). The PNP was eventually hired and supervised by a Psychiatrist over at the West County Children's Clinic. This position is responsible for providing oversite to clients who need vitals taken, meds reviewed or drug tests. An additional position that was converted was the Recovery Coach. This position was changed to a Community Support Worker because of similar job duties specified under the County classification.

Another staffing change during the onset of the project was a position that was contracted out. This position was for a Substance Abuse Counselor. The position was CADAC certified and held a License of a Professional Clinical Counselor. Eventually, the staff member vacated the position and it was converted to a Mental Health Clinical Specialist. The new person who was hired was working towards her CADAC certification and would meet the guidelines specified in the workplan within the coming year. Finally, it was determined that the project needed additional support with administrative functions. This pushed for the project to hire an experienced-level clerk to support this role which included billing set up and chart organization.

Originally, the project outline consisted of three levels in which the clients would be in each level for 12-week periods. As the project enrolled youth, it was determined that this duration was to be six weeks instead. This would allow for movement into the next phase to be quicker. It would also push for the mentorship portion of the project to be rolled out to increase flow between levels.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

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

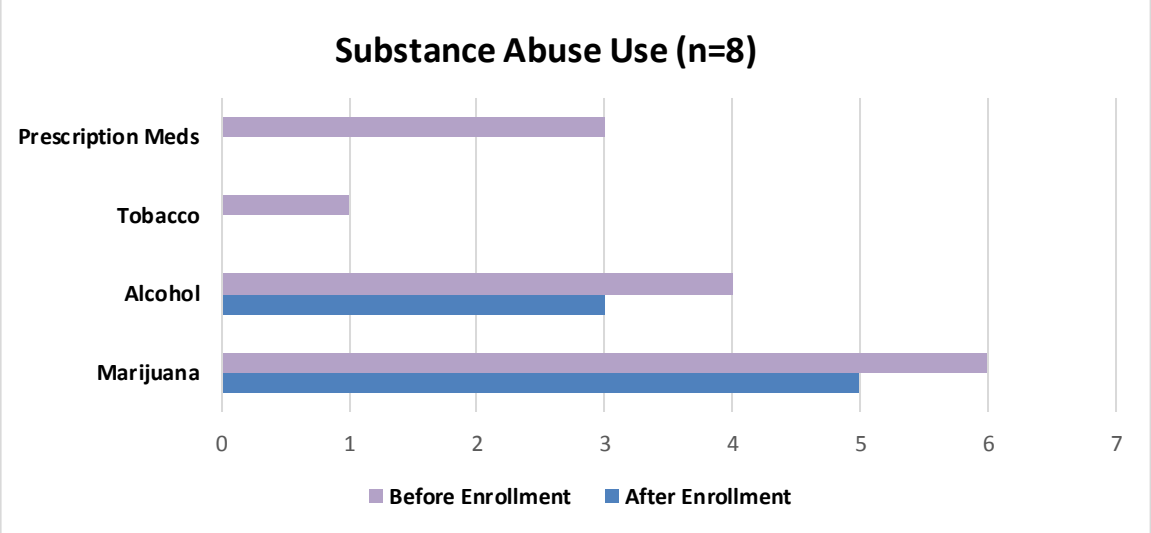
This project used the Teen Addiction Severity Index (T-ASI) to measure many of its outcome goals before enrollment and after discharge. The T-ASI can be defined as a semi-structured interview tool that was developed to fill the need for a reliable, valid, and standardized instrument for a periodic evaluation of adolescent substance abuse. The T-ASI uses a multidimensional approach of assessment as an age-appropriate modification of the Addiction Severity Index. It yields 70 ratings in seven

domains: chemical (substance) use, school status, employment/support status, family relations, peer/social relationships, legal status, and psychiatric status. [i]

The project reported that the average age of drug usage started as early as 12.5. Clients show being in SUD treatment type services 5 times before enrollment with a rate of 63 days total.

The project was able to capture some of the primary goals and respond by the following indicators:

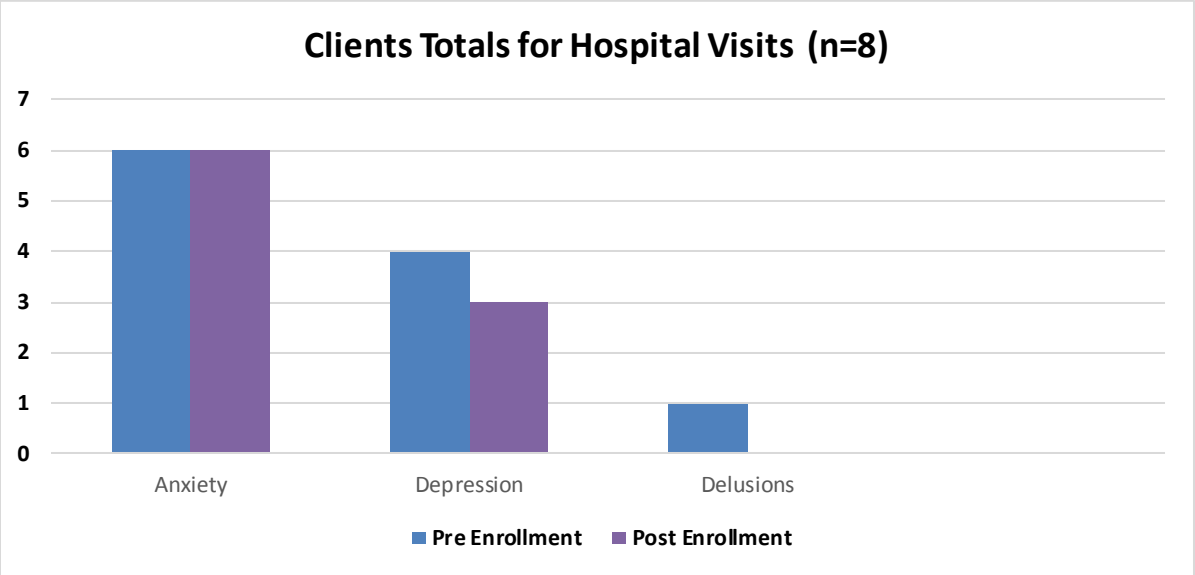
- Reported Drug Usage Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index) Only eight clients completed pre and post data. Both prescription meds and tobacco use show no use after enrollment.



- Reported Mental Health Impact (pre and post via the Teen Severity Addiction Severity T-ASI Index)

This included treatment for any psychological or emotional problems in the hospital for inpatient/outpatient patients. Total visits decreased from 22 to 18 after enrollment.

Table below indicates three clients admitted for anxiety for both pre- and post-enrollment, four pre-enrollment and three post-enrollment for depression, and one pre-enrollment with no post enrollment client for delusions. Admissions decreased overall.



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

CORE provides an extensive intake process when client arrives into the center. Upon intake if the program cannot fit the needs of the client then they will be referred out. Besides residential SUD, CORE refers youth and parents/providers on behalf of youth to the following services:

- WCCAS (West County Child & Adolescent Services) mental health
- WCCAS outpatient SUD
- PES
- Seneca Mobile Response Team
- Kaiser CDRC
- John Muir Behavioral Health
- EBYPAA
- Young People NA
- REACH
- Hanna Boys Center (residential but not primarily SUD)
- Rebekah House (residential but not primarily SUD)
- RYSE
- MISSEY (for CSEC youth)

- Golden Gate Schools/County Office of Ed Alternative Education
- Contra Costa County CFS
- First Hope
- James Morehouse Project
- MH Access Line
- West County Health Center
- Richmond Works Program
- West County High Schools Health Centers
- Monument Crisis Center
- Familias Unidas
- Latina Center

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

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

Youth within the CORE project were asked how the program has changed their life. This was organized through them providing accounts of how they were affected physically, socially, emotionally and academically. Then they were asked how they would feel without the CORE project being available. Responses were given per the following:

Case Vignette 1: 15-year-old LatinX female, who came to the program just days after returning from the streets, where she had been trafficked. History of runaway and a lot of sexual trauma.

Client Statement:

"When I first came to the program, I was very sick and couldn't stop using. I was using marijuana, vape pens, and popping pills. I was losing a lot of weight and my face was full of acne. All I would do is smoke until I passed out. I lost friends that cared for me because they saw how bad I was doing. Emotionally I experienced a lot of depression and anger issues. My school attendance was really bad, and I would not even show up to classes most of the time. CORE has helped me eat better and stay sober. I am starting to socialize more with people and find good friends. I now communicate better with my family and have raised my grades while achieving more credits for high school. Without CORE I would be lost or even dead. I might even be homeless. I thank CORE for helping me find my higher power.

Case Vignette 2: Male who is 16yrs old. When he came to CORE, he had a severe eating disorder and was hanging out with gang members who were pushing him, daily, to quit program ("Don't be a p***y, no one respects you doing that" etc. He started using at age 12.

Client Statement

"When I first came into the program, I was oppositional about almost everything. I wasn't open at all to take suggestions from anyone. I was using marijuana, alcohol and pills. Physically I was skinny and unhealthy and at times looked like a zombie. Most of the time I would be with a group of friends and we would use drugs together. I quit the baseball team because of drugs. I could be calm because I was high, but if something was to make me mad, I would completely blow it out of proportion. Academically my attendance was horrible because I would be at the park smoking or drinking. CORE helped me recover physically by helping me maintain my sobriety by checking in with me and taking me out to do activities. I built relationships and bonds with other people who had the same goal to stay sober and who were on the right path. CORE has helped me emotionally by helping me find ways to control myself. I also have gotten my credits for school back up to where they are supposed to be and turned all of my F's into A's."

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

CONTRA COSTA HEALTH SERVICES

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FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEAR: 2018/19

Agency/Project Name: Contra Costa Behavioral Health/Coaching to Wellness

INNOVATIVE PROJECT TYPE:

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

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

This innovation project was instituted based on a widely recognized disassociation between physical and behavioral health treatment being provided concurrently. The approach was to integrate health care by linking the treatment of physical and mental health to improve the quality of services which lead to better health and mental health outcomes. The innovation project was set in place to test if using Peer Wellness Coaches will improve number of clients that participate in health education and/or wellness activities, improve health outcomes, and enhance recovery and resiliency.

Before the onset of the project it was regarded that mental health clients face physical health problems and engage in risky health behaviors more frequently then the general population. People with severe mental illness (SMI) who receive services from the public mental health systems die, on average, at least 25 years earlier than the general population. Prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure is three-times higher among SMI Medi-Cal population compared to general Medi-Cal population. It was decided based on this collective information that it was imperative to utilize peer providers, as a potential solution to overcoming the barriers states above.

This innovation intervention offers a potential solution to determine if using peer providers trained in wellness recovery and self-management promotes positive health outcomes, including mental health recovery and resiliency. It was the idea to determine if a patient at risk received support for both physical health and mental health would this improve the patient's overall health and ability to lead a functional and successful life within the community.

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

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The Coaching to Wellness project provides an additional level of support for adult mental health consumers who are in need of health care management. Support is provided by a Wellness Team that consists of a Nurse, Mental Health Clinical Specialist and a Community Support Worker. With components from intensive peer support coupled with leveraging existing resources in the County, the Coaching to Wellness project provides a holistic team approach to providing care to consumers. The goals of the project are: 1) Improve client perception of their own wellness and well-being; 2) Increase healthy behaviors and decrease symptoms for consumers; and 3) Increase cross-service collaboration among primary and mental health care staff.

The Coaching to Wellness project began enrolling clients in December 2015. Clients were originally enrolled that had comorbid mental health and primary care need. As the project expanded so did the criteria for accessing this service and it was eventually opened to all clients in need of healthcare management. In general services provided included:

- Facing Up To Health: a peer-led group intervention guides participants through identifying and understanding their personal wellness resources and helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness
- Wellness Management related activities including referrals and linkages to primary care and other medical appointments such as nutrition, dental, optometry, ultrasounds, as well as community resources for food, clothing, smoking sensation, health coaching, mindful movement, exercising, linking family members to family support, housing, etc.
- Individual nurse, clinician and peer support in the home, field, and office to work on goal setting, attainment, Injections, medi-sets, whole health education development of self-management skills, and addressing barriers to wellness such as isolation and financial limitations.
- Clinic groups that include a diabetes group, food is medicine and pain managements
- Alumni Group: a peer-led group that provides regular check-ins on progress and need for support goals while promoting the achievement of wellness, recovery, and chronic disease self-management skills.

PROJECT CHANGES: ☐No changes

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

Over the course of the entire innovation project period many features changed to adapt to the specific needs of the clients. The team faced many challenges and made changes as needed. During the last fiscal year, the project made some final changes to see if these changes would allow for the project to learn some additional aspects making the services viable and sustainable.

- The Project Recommendation Form that was once only required to be filled out by a Psychiatrist was made available for other potential providers within the clinic to complete.

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This would allow for more overall referral to be reached by the team.

- Community Access Tickets Service (CATS) is a service provided that allows for a group to access cultural, recreational and education experiences. The project was able to gain access to these tickets and offer the Coaching to Wellness clients the opportunity to experience positive socialization and community integration opportunities. Clients were recently able to attend baseball games and other theater type events. The event lead to positive outcomes and a greater positive response to the project.
- Post surveys were edited to allow for intimate project feedback. Form was separated out to become its own and be mailed in as a separate document. The team decided this would give clients the necessary privacy that would allow for more return on suggestions.
- The project decided to revisit their outreach efforts within the County. This consisted of presenting the project again to the Primary Care Clinics, Shelters, Detention, and other possible sites that would be able to utilize the service.

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

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

The original learning goals of the project were to learn if and how modifying HARP curriculum and 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. The proposal was written several years before the project was able to be implemented; therefore, the goals were amended by the Coaching to Wellness committee as described in the following.

The Coaching to Wellness pilot has three overarching goals with corresponding indicators:

1. Improve consumer perception of their own wellness and wellbeing.
   - Self-Rated Health and Mental Health (asked at each visit and recorded on Contact Summary Form)

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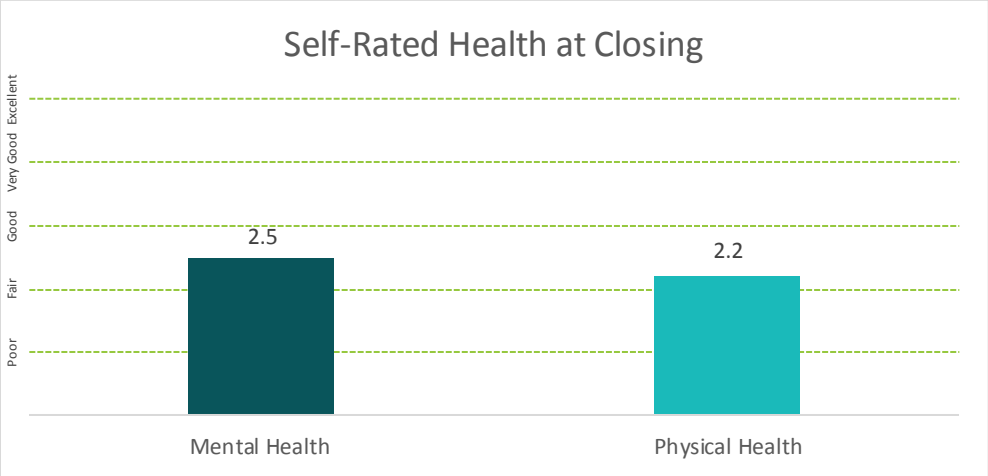
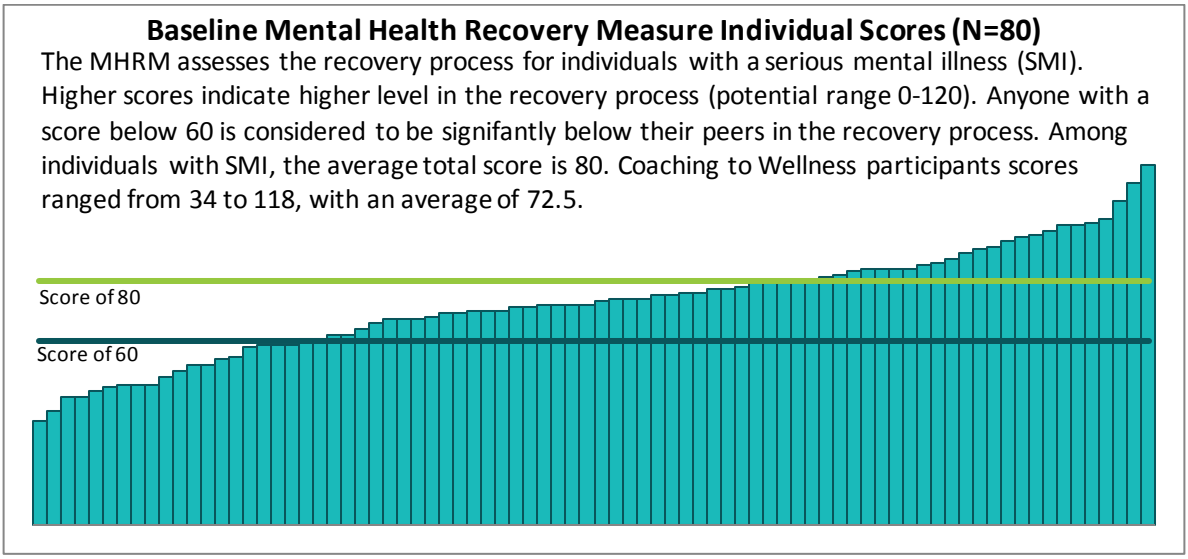
At each individual session, the Wellness Coach and Nurse interviews consumers to ask "In general, would you say your health (5) excellent, (4) very good, (3) good, (2) fair, or (1) poor." This item is used in the National Health Interview Survey and in a number of studies self-rated health has been found to be an excellent predictor of future health.[i] In addition, a similar question is asked regarding mental health, similar to other studies.[ii] Participants were more likely to rate their mental health more positively than their physical health with the majority rating their physical and mental health as "good".

- Perceived Recovery (pre and post via the Mental Health Recovery Measure)





The Mental Health Recovery Measure (MHRM) survey is completed by participants at pre and post and administered by the Wellness Coach. The development of the MHRM involved a grounded theory analysis of qualitative data to develop a model of recovery based upon the experiences of individuals with psychiatric disabilities.[iii] All items are rated using a 5-point Likert scale that ranges from "strongly disagree" to "strongly agree." The MHRM contains 30 items across eight conceptual domains. On average, participants score 8 points lower than the average of most individuals with SMI.

- Functioning (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Basic Functioning domain of the MHRM, with scores ranging from 0 to 16. Individuals scoring high in this domain are getting their basic needs met and are not depending on others for help.

- Quality of Life (pre and post via the Mental Health Recovery Measure)
  At baseline, participants scored an average of 8.7 points on the Advocacy/Quality of Life domain of the MHRM, with scores ranging from 0 to 16. Individuals scoring high in this domain are making the transition into becoming a role model of recovery; they are becoming confident and comfortable in their journey, so they can share that with others and help them progress along their own path.

2. Increase healthy behaviors and decrease symptoms for consumers.
   - Physical Health Vital Signs and Labs (as needed recorded via Nurse Contact and Lab Summary Form)
     With consumer permission, the Wellness Nurse measures vital signs including height, weight, BMI, blood pressure, pulse, and waist circumference and recorded on a Contact Summary form. In addition, the Nurse will ask about the number of days and minutes of physical activity engaged in during the week. Labs (e.g., Cholesterol, HgA1C, etc.) are requested as needed; the Wellness Nurse monitors these requests and enters information into a Participant Lab Summary form. There is not enough post data for pre and post analyses. At baseline:
     - BMI: Of 8 participants with measurements, all but one (87.5%) were overweight (BMI $\geq$ 25) or obese (BMI $\geq$ 30).
     - Blood Pressure: Out of 11 participants, 7 (63.6%) have pre-hypertension and hypertension.
     - Pulse: Of 15 participants, 0 have a high pulse rate. The average pulse is 81.5 beats per minute.
     - Cholesterol: Of 5 participants, 0 have borderline high or high total cholesterol; 60.0% have borderline or very high LDL cholesterol; 100.0% have low HDL cholesterol; and 20.0% have mildly high or high triglycerides.
     - HgA1C: Of 5 participants, 60.0 % of scores indicate diabetes.

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

The project has ended as of August 2019. Overall this project had many challenges throughout the innovation funding period. Initially, the project had a very difficult time hiring a full team and this challenge continued throughout the entire innovation period. While staff were hired many positions still couldn't be filled or staff retention continued as a challenge. The project eventually changed the team's design but by that time the project was already in its third year of funding. Another challenge became when a service that replicated the project in many ways called Community Connect begin its implementation. This created overlap and seemed to support the patients for similar reasons.

Also, what demonstrated to be an additional struggle was the referral and intake process. Many clients didn't meet the criteria and as the innovation period developed it was decided to allow more clients to be able to access the service. Unfortunately, by this time the project was already gearing towards the end of the funding period and the change didn't seem to make a huge improvement. It was decided after the multiple staff left the project it was best to shut the project down. This project will not be sustained.

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

The learning goals established for the project are as follows:

Process-based learning goals:

- Do consumers develop mental health wellness recovery action plans (WRAP)?
  - Do consumers use them regularly and how can we increase their utilization?
- Do consumers develop self-management goals?
  - Do consumers use them regularly and how can we increase their utilization?
- What elements of Facing up to Health are effective?
- What elements of Facing up to Health are not effective?
- Does the use of Peer Wellness Coaches increase the number of referrals made between consumers and community resources?
- By changing the project's criteria does this increase the number of client's utilizing the project.

Outcomes-based learning goals:

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- Does interacting with Peer Wellness Coaches improve primary and mental care providers understanding of the consumer culture and recovery principles?

    - Do consumers achieve their wellness goals through this intervention?
    - Do consumers permanently change their health-related behaviors through this intervention?
    - Do consumers achieve their recovery goals through this intervention?
    - Do consumer's Self-Rated Health and Mental Health scores change through this intervention?
    - Do consumers have improved health outcomes?
    - Is this approach replicable in other integration settings?
    - If the project establishes a limited timeframe for utilization of services will this increase the overall number of clients served?

Summary:

Overall, consumer outcomes showed improvement, but low caseload counts stayed steady. In the last fiscal year of the project, new referrals became very challenging. Numbers lowered and aggregate outcome information became limited. Learning goals could not be entirely achieved because of low intake counts. According to reports, approximately 55 clients received outreach in FY18-19. 31 clients received more than 3 services from CTW clinicians/nurses/coaches. Three contact attempts were made to engage clients.

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

During the innovation funding period all innovation projects are scheduled to discuss updates to the Innovation Committee semi-annually. This committee is apprised of County Staff, stakeholders and members of the community in order to provide feedback, comments or suggestions on any current issues, questions or other applicable information that the project may need to consider. The final report for the project was shared at the innovation committee and discussion around what was learned was reported. Finally, this report will be shared with the Mental Health Services Oversight and Accountability Commission for dissemination through the State by its scheduled submission date.

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VALUABLE PERSPECTIVES:

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

The project was able to collect valuable perspectives from two clients who enrolled during the last fiscal year. Both clients felt that the project had a very positive influence on their life and contributed to many positive outcomes making it easier for them to lead successful lives.

Case #1 - A 63-year-old woman who lives alone in the East Region of Contra Costa County, was diagnosed with heart failure, fatty liver, type 2 diabetes, anxiety, depression with psychotic features, agoraphobia, cognitive disorder, and a panic disorder. Client was isolated at her home with only the once weekly support from her nephew who did not know how or what was going on with her care. With the support of the Coaching to Wellness team and having them meet with the client weekly to help with medication management and teaching she was able to get stable mentally and physically. Additionally, the client also attended the social outings with the wellness coach to learn and use social skills. She now is involved with the choir at the senior living where she resides.

Case #2 – A female woman who lives in the West Region of Contra Costa County, was an avid drinker with mobility issues and a hole in her colon. She stated that she was observing clients using the "Facing up to Health" group part of the Coaching to Wellness project. She noticed a few clients enrolled in the project graduating and many of these clients showed positive changes. This made her decide that she wanted to explore the project further. She said it was the best project she could have enrolled in. She learned how to take better care of herself by making her appointments, seeing a substance abuse counselor and just listening to the overall training given in the class. Since attending the class, she has made substantial improvements. She has been clean and sober for 16 months; she attends college classes to hope to provide peer support and uses the many tools she was given to improve her mental and physical care

[1] Idler, E. L., & Angel, R. J. (1990). Self-rated health and mortality in the NHANES-I epidemiologic follow-up study. *American Journal of Public Health, 80*, 1990, 446-452.

U.S. Bureau of the Census. (1985). *National Health Interview Survey*. Washington DC: U.S. Dept. of Commerce.

Ware, J. E., Nelson, E. C., Sherbourne, C. D., & Stewart, A.L. (1992). Preliminary tests of a 6-item general health survey: A patient application. In A. L. Stewart & J. E. Ware (Eds.), *Measuring functioning and well-being: The Medical Outcomes Study approach* (pp. 291-303). Durham NC: Duke University Press.

[1] Kaiser Family Foundation. (2009). *Survey of healthy San Francisco participants*. Retrieved from http://healthysanfrancisco.org/wp-content/uploads/Kaiser-Survey-of-HSF-Participants-Aug-2009.pdf

Peel Public Health. (2015). *Quick stats: Self-rated mental health*. Retrieved from https://www.peelregion.ca/health/statusdata/pdf/self-rated-a.pdf

[1] Bullock, W. A. (2009). *The Mental Health Recovery Measure (MHRM): Updated normative data and psychometric properties*. Toledo, OH: University of Toledo, Department of Psychology.

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INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 18/19

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

INNOVATIVE PROJECT TYPE:

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

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

Cognitive Behavioral Social Skills Training (CBSST) in Augmented Board and Cares can be described as a new emerging practice that consists of a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem solving therapy (PST) in the County's Board and Care Homes (B&Cs). The project involves a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B&Cs that house CCC consumers.

The project begin implementation in late August 2018 and hired it's first MHCS. The clinician began acclimation of different countywide B&Cs while shadowing the Housing Specialist and other CBSST groups already established within the Mental Health Clinics. In early September, the clinician was pulled away for 11 weeks of Jury Duty, which added to the lengthy process of implementation. Upon return the clinician was able to provide groups but only as a one-person team. Starting early in January, the clinician identified what B&Cs would be a good fit to start and begin groups. After clear assessment of numerous B&Cs the MHCS found approximately five in different regions of the County that would be appropriate.

The CSW was not brought on till May 2019. This was due to original hire falling through and other lengthy hiring processes that were unable to be prevented. The CSW began shadowing the clinician and helping assist with groups already established. This position is now fully implemented within the project and providing peer counseling in a group setting to clients who live in B&Cs.

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

- Served six small (6-bed) ARFs (adult residential facilities)

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- Served 1 large (70-bed) RCFE (residential center for the elderly)
- Provided CBSST individual and group rehabilitation services to 27 individuals
- Support to board and care operators (psychoeducation, partnering on goals utilizing CBSST framework and skills, consultation re: concerns/consumer needs)
- Collateral with Board and Care Operators

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

The project didn't start implementation until August 2018, and even after the initial start it took until January to start seeing clients. This delay resulted in not having a full reporting period in which to learn if the initial set up of the project is operational. During the current fiscal year, the project staff discovered that partnership with the board and care operators/caregivers was an important component. Building trust was gradual and spending time with them separate from the time with the consumers helped with this and allowed room for growth.

Relationships and rapport building with consumer takes time and during engagement after at least four months trust became more evident and secured. Consistence and regularity during engagement was extremely important. Having the two-person team increased ability to be consistent and groups become regular with high client attendance.

Board and cares where the majority of residents are "plugged in" to activities during the day are not always good candidates for onsite CBSST groups. At least three residents are recommended and provided a level of engagement that felt necessary for group modality. Two homes where this was not the case, did not end up being good fits for the project. At one B&C the group was discontinued due to only one resident being present and able to participate. This client was also not a County consumer.

At another B&C continued CBSST was provided individually to one engaged client. This would sometimes be joined by a second client but on a less regular scale. Transitioning such a client to CBSST work with a case manager more quickly when this occurs is definitely something that should be addressed.

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

The project has experienced some initial changes as it has approached the second module leading up to the end of the fiscal year.

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Initially CBSST was only performed in groups but soon after the MHCS discovered that it could be beneficial to run individual therapy with the clients. The project also decided to decrease the time for groups from 150 min to 70 min. This seemed to be a better fit for the population and helped with keeping the group engaged and present.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

The goals of the project are to learn the following:

1) Will the modality of CBSST have an effect on the consumer's mental stability and growth?
2) Will the intervention lead to a higher overall functionality and quality of life?
3) Will the intervention reduce 5150 involuntary holds within the Crisis Services Unit?
4) Will a consumer have fewer evictions or avoid evictions completely?

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

- **PHQ-9 (Patient Health Questionnaire)** assessment monitoring presence/severity of depressive symptoms (self-report, self-administer)
- **GAD-7 (Generalized Anxiety Disorder)** assessment monitoring presence/severity of anxiety symptoms (self-report, self-administer)
- **RAS (Recovery Assessment Scale)** assessment measuring aspects of recovery w/ focus on hope and self-determination (self-report)
- **ILSS (Independent Living Skills Survey)** assessment obtaining individual's view of his/her own community adjustment (self-report structured interview)

We adopted the PHQ-9 and GAD-7 to align with the tools utilized within the regional specialty mental health clinics to track symptoms for all clients. Similarly, the use of the ILSS aligns with those clinics' use of this tool to assess functional impairment primarily for individuals with schizophrenia/related diagnoses. Using the RAS aligns with our goal of increasing recovery orientation for project participants. In line with the recovery model this assessment looks beyond "what's wrong" to participants' view of their own capabilities, hopes and sense of self.

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

completion of the first and second modules. Some participants declined to complete especially at the beginning of our relationship. In many cases, participants did not take each survey at least two times in this reporting period in order to get scores for comparison. Thus, data from this reporting period is not robust.

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

Lessons learned: these surveys especially PHQ-9/GAD-7 may feel intrusive and are better completed when not linked to group sessions. The responses are less likely to be genuine until trust is gained. Completing with an individual 1:1 and reviewing each question out loud, supports comprehension of the questions, increases completion rate and hopefully validity of responses, and also fosters the aforementioned conversations. For the ILSS, the questions provided are at times outdated and do not capture as wide a range of independent living skills as we observe in participants (e.g., education-related activities). These lessons led to development during 2019-2020 of questions to ask as an addendum to the ILSS, as well as plans for proposing a revision of the ILSS to be tested/validated.

Data samples included in this reporting period were minimal due to the small timeline from the inception of the program until end of the fiscal year. Not included in the sample was Concord Hill Home and Monona Care Home.

Table 1. Percentage Change in Average PHQ 9 Scores, January 1, 2019 through June 30, 2020 shows the change in average PHQ 9 scores.

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

Fiscal Year	Average Score of First Survey of the Year	Range	Average Score of Second Survey of the Year	Range	Average Score of Third Survey of the Year	Range	Percentage Change from enrollment
2018/2019 (n=10)	20	(0 to 20)	19	(0 to 18)	11	(0 to 18)	-45%
Board and Care Homes that were not calculated in the totals were missing surveys due to modules not completed.							
PHQ 9 Score Key: 1-4 Minimal depression, 5-9 Mild depression, 10-14 Moderate depression, 15-19 Moderately severe depression, 20-27 Severe depression							

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

All clients that participate in the CBSST group sessions are clients that are connected to the mental health clinics within the County. Many have psychiatrists and/or case managers and have regularly scheduled visits. If a client is not participating in services and needs to be linked the CBSST provider will proceed with joining the client with necessary services toward improving treatment outcomes. This can include the CBSST provider reaching out to clients' assigned clinic and collaborating to engage client with different types of service connections.

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

SC case vignette: the significance of onsite support

SC is a 27 y.o. (at time of admission) Caucasian female who was a resident of Afu's One Voice, 6-bed female board and care facility in Bay Point. She had moved to Afu's in October 2018, shortly before the CBSST program started engaging with the facility. For sixteen months prior, SC lived at Crestwood "The Pathway" enhanced board and care facility in Pleasant Hill, following multiple psychiatric hospitalizations during a time she lived independently. Since SC was 21, she has had multiple stays at both short and longer term residential psychiatric facilities. Afu's One Voice was the first augmented board and care home placement for her, with the idea that more support at this level of care could better help her stabilize vs. being sent again to an enhanced board and care. SC held the goal from the time of arriving at Afu's One Voice, to return to independent living.

During the engagement/assessment period, SC reported quite severe depression symptoms on the PHQ-9 including thoughts of wanting to die. This writer had a further risk assessment interview and intervention with SC to establish ways she could keep herself safe and manage her symptoms. SC was quite fearful that she would be placed on a 5150 hold, be hospitalized and sent back to a higher level of care and that in this happening, she would lose the opportunity to work toward independent living. Based on the risk assessment this did not occur. Having writer present at the home each week provided additional clinical support to help SC maintain at this level of care. Additionally, writer was able to share observations/concerns with SC's case manager, for a richer clinical picture. The case manager had attempted to get therapy approved for SC as part of the step-down plan, but this had not occurred; with writer's advocacy for more support, therapy was approved.

Writer's own alliance with SC felt strong following this event. SC became a motivated, engaged

participant in CBSST group and set a goal of employment, which she felt would help her be more independent and ready to live on her own again. SC did get a job through vocational services, at which point she was a much less frequent participant in CBSST group based on timing. However, she participated intermittently and continued to demonstrate engagement and apparent pride in her ability to set and work toward her goals.

SC is one of the first program participants to step down from the augmented board and care level of placement following CBSST program engagement. The CBSST team was involved in Dec 2019-Jan 2020 in advocating for SC's readiness to accept an MHSA unit when it came available. SC successfully moved to this unit in March 2020 and as of June 2020 continued to be stable with no PES/crisis encounters.

Johnson Care Home: Developing a Recovery Oriented Milieu

Johnson Care Home exemplifies a small board and care that while providing supportive placement for consumers, did not necessarily emphasize the potential for residents to stabilize, develop independent living skills and the capacity to move on to lower levels of care. When our program began working with Johnson Care Home, there was a core group of residents who had lived there for many years; three of the six had been there for over ten years. They were generally psychiatrically stable with no recent psychiatric hospitalizations, and encounters with specialty mental health were mostly limited to medication management. These gentlemen coexisted well, forming a family-like community. As a group however they spent most of their time isolated at home, watching tv or smoking in the yard. The caregivers wanted to establish an expectation for engagement in activities, but struggled to do this in part based on the longstanding culture in the home. Residents identified goals that would require more engagement with the outside world—finishing an associate's degree, returning to employment, stepping down to independent living—but the biggest barrier first and foremost was that they spent their days inside.

We felt the milieu culture would need to change in order to support engagement in any activities outside the home whether the push came from caregiver expectation or from the residents' personal goals. As we developed relationships and the structure for group, we kept this goal of culture change in mind. Having weekly meetings where residents came together began this shift; even just being in community vs. being in their separate spaces other than meals, was a change. CBSST encouraged them to speak openly about goals, modeling for each other that having hope for change is possible. Practicing skills of learning something new reinforced that things *do* change when we act. The social skills module helped participants practicing positive communication and get comfortable looking to others for support. Some residents turned to each other reflecting on the strength of their long-term relationships—noting this as the first time they talked about this.

We also worked with the owner/operator, supporting her efforts to encourage residents to engage in the program at Recovery Innovations-Antioch (RI). Our group became a baseline activity to help remind residents that they could enjoy/benefit from groups or activities. We also linked what they were working on in CBSST, with how they used the program at RI. Five of the six residents at Johnson Care Home in summer 2019 went to RI at least once, with three continuing consistently.

The group also began focusing more on other activities they could do outside of the home. Participants began to take steps on goals that they had held for a long time. One gentleman with high anxiety around leaving the home, got his driver's license renewed and began repairs on his car—both things he had wanted to do for years. These were short term goals on the way to returning to school and finishing his AA. As a group we planned and held on a picnic at a local regional park. For several individuals this meant overcoming significant anxiety about things like being in unknown cars or in unfamiliar places. This picnic was the culmination of the third module on problem solving. We saw it instill hope in the participants that they could engage in the world in a different way. Generally, the home felt more oriented toward hope and the capacity to achieve goals after completing the three modules of CBSST.

EM case vignette: challenging unhelpful thoughts

EM is a 70 y.o. (at time of admission) Caucasian female living at Family Courtyard, a large residential center for the elderly. At time of assessment in Feb 2019 she identified multiple creative talents; EM is a wonderful and prolific painter usually of natural landscapes which she sometimes does from memory of times spent with her mother in bay area hills. In goal setting for CBSST, EM was clear that she would like to sell her artwork—which came across more as the desire to be recognized as an artist, and having an identity expanding beyond the bounds of Family Courtyard. Another goal that evolved during the course of group was to live together with her boyfriend (another resident) in the Marin headlands.

EM also identified writing as a talent, one that she has used throughout her adult life to manage her mood and stay well. This practice is one that she struggled to maintain as consistently as the painting—and she described writing as more of a chosen tool/coping skill that requires effort to remember and utilize; it can fall by the wayside when she is feeling low.
During the first several months of group EM frequently shared about experiencing depressive symptoms. This was wrapped up with having physical ailments, aches and pains; and resulting thoughts about her age, perceived limitations, and living in a facility that places further limitations upon her.

The cognitive skills module of CBSST reinforced how our thoughts/mood/actions are all related, and EM adopted this as a frame of understanding her depressed mood as related to such thoughts.
However, she continued to struggle with really having alternative ways to frame her experience or potential. Her gorgeous landscape paintings cover the walls of the activity room where we do group, but sitting at those tables she could not think her way out of her current living situation.
Taking *action*, that third part of the cognitive triangle, had a big impact for EM. We planned an outing to a regional park with views of the bay, for a picnic. This was a huge endeavor for participants who are physically frail (three of the five utilize walkers) and very limited mobility. EM herself had trouble with significant knee pain that day making for an uncomfortable van ride. However, she filmed the scenery out the window the whole ride into the park to our picnic site; she was ecstatic to get the fresh air and time away from the daily routine. This trip was significant for EM. She wrote an essay following the excursion and stood up in group to read aloud, which she did with confidence. EM gave us permission to share her essay which is also included here.

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This experience seemed pivotal to EM. We saw a shift in her focus to be more on making things happen, whether it was taking steps to address issues with social security or supporting her boyfriend as his "manager" while he pursued his own goal of performing publicly as a singer again. With this shift her mood and sense of self-efficacy was also very much improved.

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2018/19

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

INNOVATIVE PROJECT TYPE:

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

SERVICES PROVIDED:

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

The Overcoming Transportation Barrier (OTB) innovation project began implementation in September 2016 and begin providing services by April 2017. This project was established to help clients build self-sufficiency and apply independent travel skills while increasing access to mental health services. Other goals of the project are to try to find solutions that the clients face when reaching limitations when trying to use types of transportation. As of June 30th, 46 clients accessed help from the OTB team for this fiscal year.

Client services received from the OTB team range from peer support, mapping bus routes, links to resources, referrals, and fare information. Application assistance is provided for discount/disabled transit passes, Regional Transit Connection (RTC), Senior Youth Cards and Paratransit. Clients will typically access some of these services by calling the dedicated phone line for transportation assistance where a Commute Navigation Specialist (CNS) will help with assisting the client's needs. During this call clients will receive one-on-one support on how to access services to get to appointments.

The OTB team presented to the Central Adult and Children's Clinics to provide a project overview and continue outreach within treatment provided services. The presentation offers education about what the project entails and how clinical staff can utilize the project's services to ensure appointment adherence. The project plans on presenting to other regions of the County next fiscal year.

The OTB team presented to the Service Provider Individualized Recovery Intensive Training (SPIRIT) class to provide information on the (RTC) Card. The presentation demonstrated a specific outline around the project's goals, target population, staff roles and tasks. SPIRIT students have lived experience in the mental health field and can use this information in future placements in their careers.

LESSONS LEARNED:

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

The OTB project continues to experience a low volume of calls throughout the year despite numerous outreach efforts. Staff believe this is due to the project not providing direct means of transportation and only putting an emphasis on transportation independence. Although, callers seem appreciative of the additional service provided it doesn't seem to be completely filling the gap for low income households or communities in which public transportation is either vacant or hard to reach. The team finds that there are many other concerns with riding public transportation that callers are still facing, and the hope is that providing more one-on-one peer support might fulfill that need. The team is working towards providing this support for the upcoming fiscal year.

Travel training was initiated during the last fiscal year but provided little to no attendance. The project staff began discussions around hosting a new workshop that would include a training with the possibility of a bike donation. After further deliberation it was decided to postpone training until additional assistance could be provided for clients to attend the training. Staff will address a training for the next fiscal year.

PROJECT CHANGES: ☐No changes

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

The OTB project continues to tackle challenges due to staffing changes. During the end of the last fiscal year the team was impacted by having one CNS leave the project. This put a lot of the project on hold forcing the current CNS to only concentrate on specific immediate needs. It was noted that the hiring process takes a considerable amount of time for these positions. The new CNS started the next fiscal year and began training to cover the East end of the County. The project is working on hiring an additional CSW next fiscal year. This will ensure all regions of the county are covered.

The OTB project started collaborations with another community-based organization to provide flex funding. This funding would cover a one-time cost specific to transportation needs and help provide support to clients who need to get to their appointments. Flexible funds are client specific and are only intended to cover the client lack of funding and/or when there is no traditional payment mechanism available. Flexible funds are for time-limited services or supports; they are not intended to pay for ongoing expenditures. The flex funding will be implemented fully within the behavioral health clinics within the next couple of months. Processes are still being organized and the project is hoping to start by December 2019.

Wallet cards were constructed after feedback that came directly from the transportation sub-committee. Wallet cards are meant to be a tangible item that clients could use when they are

experiencing high stress situations or need a quick relatable reference point. Suggestions on the cards were specific to coping strategies such as: meditation, deep breathing, riding with friends, prayer, listening to music, journaling, reading, and practicing a hobby. Cards were passed out to every clinic and included with bus vouchers upon request.

OUTCOMES AND PROJECT EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

The goals of the project are to learn the following:

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

2) Client support in navigation of the transportation system through education on how to use public transit, read transit schedules, plan travel routes, and apply for discount passes, promoting more efficient use of transportation resources

3) Client application of learned transportation skills to promote productive, meaningful activity, life skills for social engagement, and reduced isolation

4) Reducing no-show rates at county-operated clinics by addressing both physical and emotional safety barriers through development of solutions regarding transportation

5) Reduction of internal stigma among clients through ongoing peer support from Commute Navigation Specialists

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

Transportation remains to be an ongoing barrier for clients. Table. 1., below defines results from surveys that were administered in November 2018 that detailed modes of transportation for missed appointments, bus/Bart/paratransit, friends/family, drive self, clinic staff, walk, bike, ride services, and

taxi. Also, the table is a breakdown of transportation modes that respondents identified. These preliminary results from the November 2018 Service Improvement Survey related to transportation are as follows:

- 37% of the responses identified transportation as a problem for missing a behavioral health appointment.

Table 1.

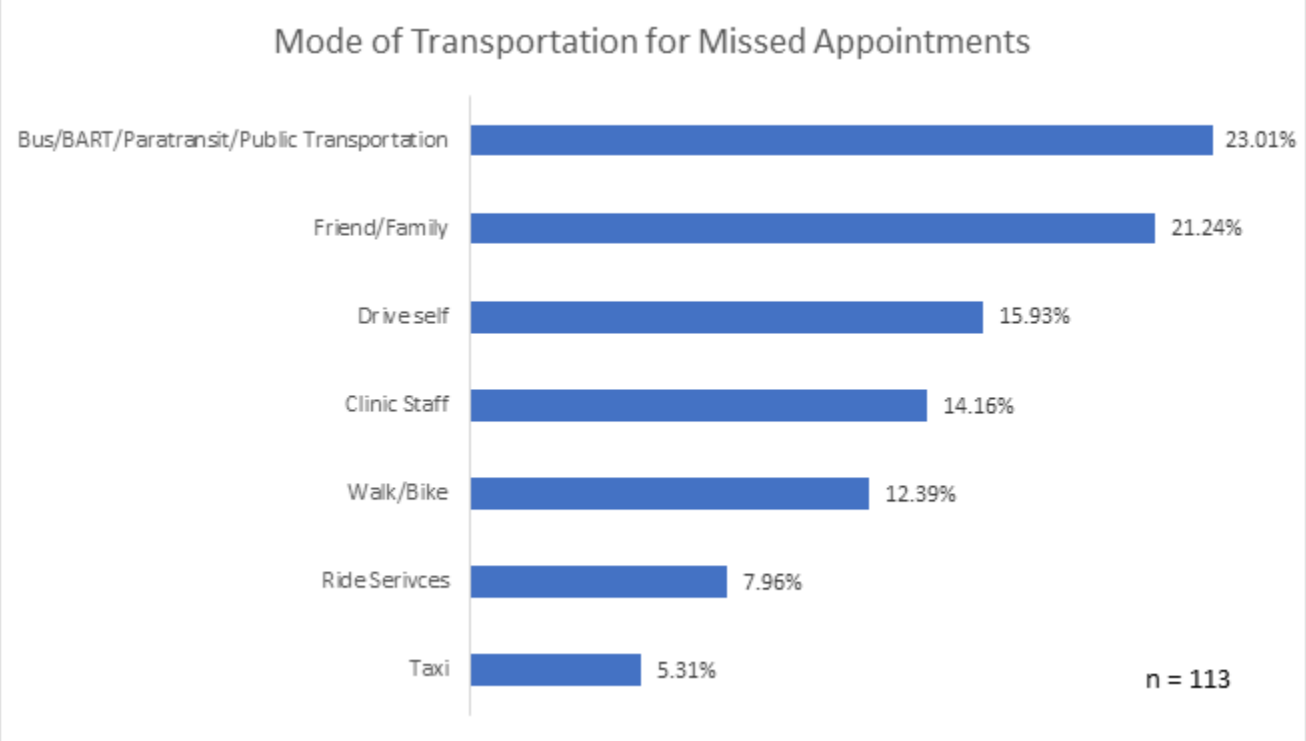


Table 2., below included data for client and staff encounters for the last fiscal year. This table defines the types of services the CNS is providing. Additional types of encounters that were added included peer support as well as "other" encounters. Other can be explained as contacts that didn't have a specific outcome. Although, the team made numerous attempts to contact clients they were not always able to provide adequate contact or assistance.

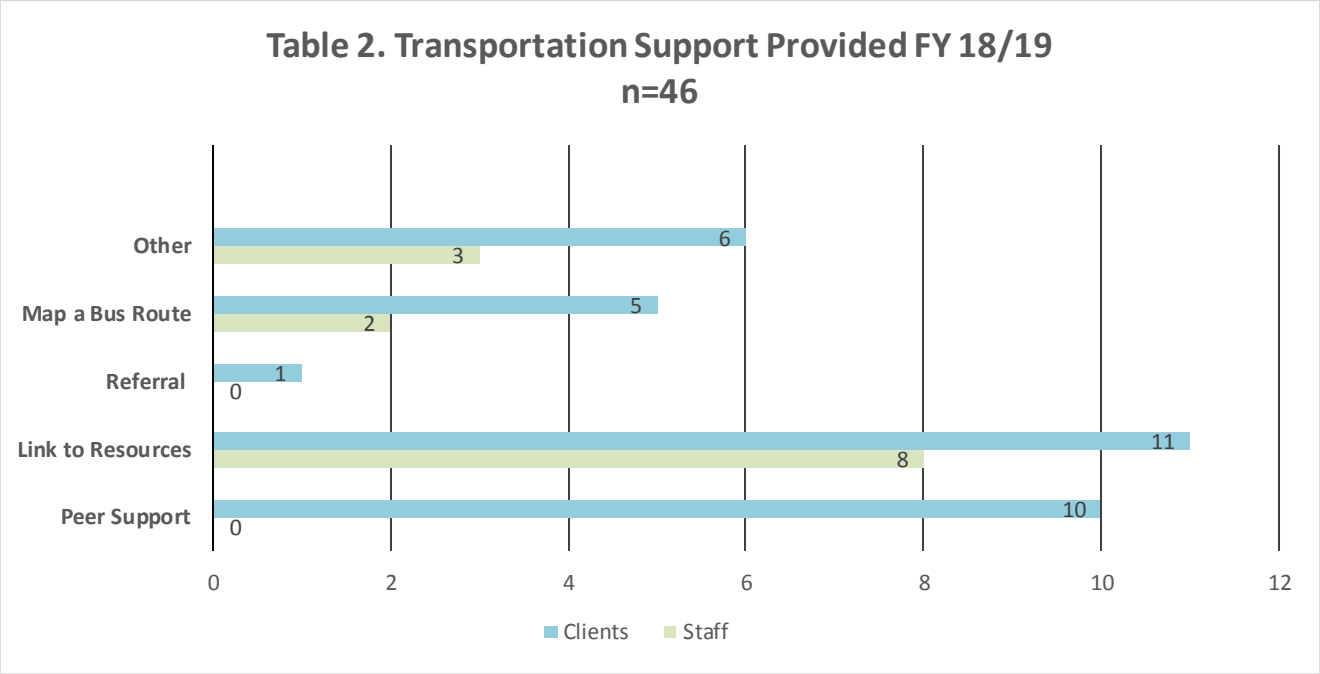
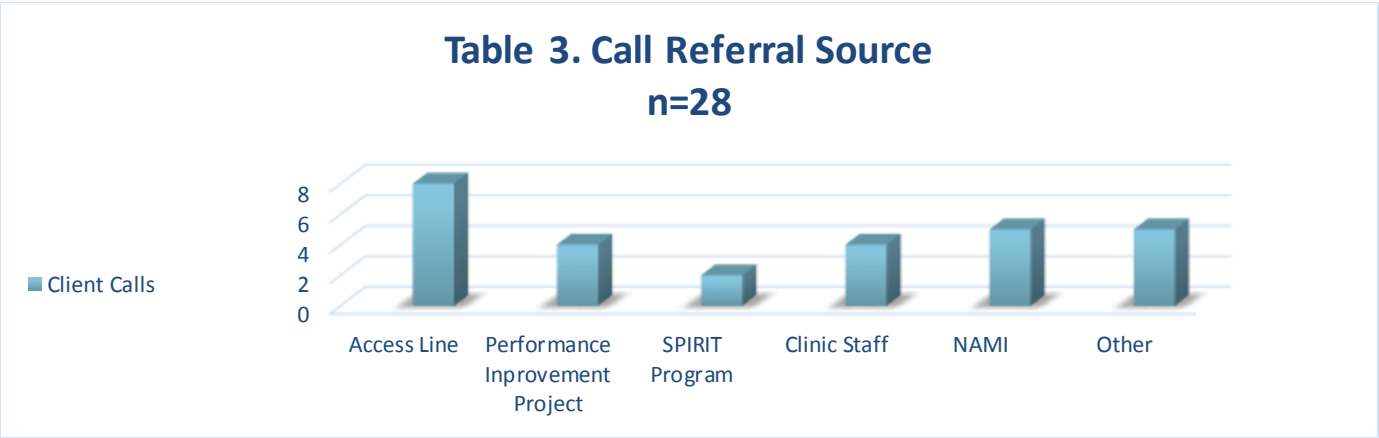


Table 3., below shows total number of calls received by clients and where the referral source originated. Referral source known as "other" describes sources such as family members, friends, word of mouth, presentations or outside therapists.



LINKAGE AND FOLLOW-UP: ☐ Not applicable

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

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

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

VALUABLE PERSPECTIVES:

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

The project was able to collect valuable perspectives from clients who called the project for services and for a Focus Group that was held during the Transportation Subcommittee. Both avenues were meant to support the clients with different means of transportation service resources while gaining helpful insight into the client's perspective. Clients commented on different ways in which transportation could be improved and its overall functionality when provided in order to get to and from appointments.

Client Calls:

Caller 1: requested information on how to get a clipper card. The Commute Navigation Specialist was able to assist by providing the information and ended up sending the caller resource information on how to obtain an RTC Clipper Card and bus maps. Client felt services were helpful and would use resources in the future.

Caller 2: Client requested information on the RTC Clipper Card. The Commute Navigation Specialist (CNS) sent over resource information, but client still had a difficult time filling out paperwork. Client was asked to attend the Transportation Subcommittee and get assisted with completing the paperwork. She said the assistance she received from the specialist was very helpful and felt the resources that she received were useful. She recently passed the resource information on to others who are also in need

of transportation guidance.

Transportation Subcommittee Focus Group:

The Transportation Subcommittee is composed of behavioral health stakeholders such as consumers of behavioral health services (including both Mental Health and Alcohol and Other Drugs Services), their loved ones, and their providers. It is charged with facilitating community input into the Overcoming Transportation Barriers project.

A focus group was held during the Transportation Subcommittee Meeting to get client feedback. The focus group concentrated on the specific following questions:

1) Did you use any of the transportation related resources provided to you during this meeting?
2) Did you find presentations/activities helpful?
3) Have you used the Overcoming Transportation Barriers services outside of the Transportation Subcommittee?
4) What are the biggest transportation barriers in getting to your behavioral health appointments?

Responses to Question 1

- Caught the bus; went to aquarium. Went to Santa Cruz amusement park. Really nice.
- They changed the 9, 18 and other [County Connection] routes; later buses not running.
- Grabbed bus map; went wrong way; map was helpful; showed direction of bus routes; want to know if [County Connection] Route 18 goes to Amtrak.
- Was getting my first Clipper card; roommate encouraged me.

Responses to Question 2

- Sister bought me punch cards to last me until 2020. Takes an hour and a half between buses.
- I find the information very helpful. I come here to stay updated.
- LINK [County Connection paratransit] charges $5; won't let me ride; want to apply.
- If there is a sidewalk nearly, you're less likely to qualify for paratransit.
- There should be a mental health advocate for transportation.

Responses to Question 3

- Disabled Students Programs and Services at Contra Costa College gave me a free Clipper Card [good to pay fare on any Bay Area transit system].

Responses to Question 4

- Need faster buses, longer times so people can get to work.
- Have difficulty paying fares at the end of the day; transit agency stopped giving transfers.
- At Putnam Clubhouse [mental health community-based organization], members lack knowledge of bus routes, timing of buses. They unknowingly go to bus stops on the wrong side of the street and realize it too late.

- Service available to call for rides to appointments. Can no longer use bus transfers to go the entire loop of the routes.

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2018/2019

Agency/Program Name: Partners in Aging

INNOVATIVE PROGRAM TYPE:

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

SERVICES PROVIDED:

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

During FY 18/19, we had one Community Support Worker (CSW) leave our program on 1/31/19. She had been working with our program since September 2016. We hired a new CSW for Partners in Aging in early June 2019, and a second CSW in late July 2019. We had an Intern throughout the Fiscal Year. Our Intern began in her position in September 2018 and continued with the program through the remainder of the fiscal year.

Our CSWs and Intern served 32 clients this fiscal year. Our CSWs can build rapport and provide multiple linkage and rehab services. They connect with clients in different ways than our clinicians since they are in the community with the clients and can relate to them as a peer. They collaborate with the clinicians and provide a valuable perspective. The CSWs have provided assistance in linking clients to important resources such as In-Home Support Services, Contra Costa Interfaith Housing, legal services, Social Security Administration, housing resources (including linking to Housing Navigators at Care Centers and linking to organizations that assist with rent payments), Monument Crisis Center, food banks and medical appointments. They also provide several reminder calls to improve attendance at appointments, and link clients to their appointments with their IMPACT clinicians. Our CSWs have become quite knowledgeable on support service resources for older adults. The CSW that was hired in June 2019 maintains an online resource binder that is used by all of the Older Adult Mental Health staff. This has been very valuable and useful!

When our original CSW left the Partners in Aging Program in January 2019 we lost the frequent communication that she was having with the CSWs at Psychiatric Emergency Services (PES). We will work to re-establish this connection. We did not receive referrals from PES during this reporting period.

Our Intern served a caseload of approximately 10 IMPACT clients. She completed intakes and provided psychotherapy. She was able to develop rapport with a range of clients and make progress towards therapeutic goals. Prior to terminating with her clients, she provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

LESSONS LEARNED:

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

Throughout FY 18/19 we have steadily received an increase in the number of clients referred to our IMPACT clinicians in all 3 regions of the county. Primary Care Providers now make referrals through the Universal Behavioral Health Referral. Most referrals for clients who are 55 and above are routed to IMPACT. We are continuing to work to find ways to manage the large number of referrals. Due to their large caseloads IMPACT clinicians usually see their clients once every 2 to 3 weeks. Our CSWs can assist by checking in with clients in between their sessions with their IMPACT clinicians. They provide peer support, coaching, and mental health rehabilitation. We are continuing to explore ways that our CSWs can assist with managing the large number of referrals.

Barriers continue to exist related to developing a collaborative relationship with PES. We have not received referrals from PES during this reporting period. We will continue to work to strengthen this relationship through outreach. PES serves a high volume of clients in a very quick short-term model; thus, it can be challenging to initiate the referral to IMPACT and PIA under the time constraints of their services. We will continue to work to develop these relationships. As stated above, during this Fiscal Year there was a period when we did not have a CSW for Partners in Aging. We need to work to rebuild the collaborative relationship with the CSWs at PES.

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

PROJECT CHANGES: ☐ No changes

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

There was one significant change to the project in FY 18/19. We expanded the project to include 2 CSWs instead of one. We began the hiring process for this second CSW during FY 18/19, and this second CSW began working in July 2019.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

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

The goals of the project are to learn the following:

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

   Yes. Our CSWs successfully provided services to approximately 25 IMPACT clients to improve their access to IMPACT services during FY 18/19.

2) Do older adults engage in SBIRT?

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

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

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

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

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

4) Do clients develop self-management goals?

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

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

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

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

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

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

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

7) Does social isolation decrease?

Yes, we have observed that social isolation decreases through the support of Partners in Aging. We began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS Questionnaire includes the Patient Health Questionnaire-9 (PHQ-9), and also includes questions on general health, social activities, physical activities and pleasant activities. This questionnaire was developed by researchers at the University of Washington to be used in their community-based, evidence-based treatment program designed to reduce depression in physically impaired and socially isolated people. We have requested a report that will demonstrate the differences in scores from the initial PEARLS assessment to the subsequent assessments. We are actively working with the Business Intelligence Team to complete this report.

8) Does quality of life increase?

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

9) Do older adults have improved depression scores?

Yes, over the 17/18 fiscal year on average 75.8% of IMPACT clients experienced an improvement in depressive symptoms based on their PHQ-9 scores, and 51.6% of these clients experienced a significant improvement (5 points or more). We are currently in the process of requesting a new report to evaluate the PHQ-9 scores over time. When IMPACT started using the Ambulatory Medicine documentation tools, and the Federally Qualified Health Center model of billing in November 2017, they gradually stopped using a PHQ-9 tracker since this data was entered in ccLink.

We are also in the process of separating out the clients who have received Partners in Aging services to determine if their depression scores show a different pattern than the general trends shown for all IMPACT clients. The PEARLS report referenced above will help to address this question.

The indicators that we have used to assess our learning goals include, PHQ-9 scores, chart review to determine numbers of PES visits, Monthly Service Summaries, and qualitative interviews with our staff. The PHQ-9 are administered frequently by the IMPACT clinicians. The PEARLS has been administered with new Partners in Aging clients beginning in August 2017. The plan is to administer the PEARLS every 6 months, or at closing. The outcomes that we are observing appear to be related to the combined efforts of our CSW, Intern, and IMPACT clinicians. Our CSW has expanded our ability as a program to provide linkage and rehab

support, increase the independence of our clients by linking them to resources, and increase their ability to learn and utilize new life skills and self-management tools.

LINKAGE AND FOLLOW-UP: ☐Not applicable

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

Participants are linked to mental health and/or support services by the Partners in Aging CSWs. In addition, the CSWs follow up with consumers by phone, email the IMPACT clinicians, and remain in contact with the referral resources they are linking the consumer to in order to ensure successful engagement of services. Housing applications and brochures, transportation resources, assistance with trips to the DMV, assistance with maintenance of benefits, linkage with Community College classes, Senior Center activities, Meals on Wheels information and Contra Costa Continuum of Services are just a few examples of what resources our CSWs provide as far as linkage and follow up. The CSWs continue to establish relationships with outside agencies that will benefit the older adult population we serve. They have attended various meetings and trainings to gather additional resources, including a Forum on Suicide Prevention, training on 211 resources, the Transportation Subcommittee Meeting, Aging and Older Adult Committee and the Social Inclusion Meeting to continue to learn about new resources.

The average length of time between referral and entry to treatment during FY 18/19 is approximately 4.25 days. Most clients were linked with new referrals within 1 day.

VALUABLE PERSPECTIVES:

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

We have chosen two case vignettes that demonstrate the successful outcomes of the Partners in Aging Innovation Project. Assistance of the Partners in Aging Project has led to improvements in quality of life, independence, and mental health.

One is a 62-year-old Caucasian male diagnosed with Major Depressive Disorder, Recurrent, Moderate, Generalized Anxiety Disorder, Osteoarthritis, Congestive Heart Failure, Morbid Obesity and a recurrent Wound Infection. He has been receiving brief, short-term therapy through the IMPACT Program and support services through the Partners in Aging Project. Our CSW was able to assist this client through coaching and peer support to achieve the ability to use public transportation independently. He is now able to take himself to medical appointments 3 days a week. He also now goes to the store to get food and to the bank on his own. In addition, he has improved significantly in his ability to advocate for his needs with his medical providers.

Another Partners in Aging client is a 60-year-old Afghani-American female diagnosed with Post-Traumatic Stress Disorder, Back Pain, Insomnia, Hyperlipidemia, and a history of a traumatic brain

injury. With the help of our clinician and CSW she has started her road towards financial independence, increasing her feelings of self-worth and self-esteem. This client expressed feeling depressed by depending on her son's family and not being able to provide anything for herself. With CSW support, client has begun the process of obtaining an income, and improving her mental health.

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BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Annual PEI Evaluation Report

Contra Costa Behavioral Health Services

Mental Health Services Act

As submitted for MHOAC
FY 2018-2019

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Executive Summary

Prevention and Early Intervention (PEI) is the component of the Three-Year Plan that refers to services designed to prevent mental illnesses from becoming severe and disabling. This means providing outreach and engagement to increase recognition of early signs of mental illness and intervening early in the onset of a mental illness.

First approved in 2009, with an initial State appropriation of $5.5 million, Contra Costa's Prevention and Early Intervention budget has grown incrementally to $8.6 million for FY 2017-18 in commitments to programs and services. The construction and direction of how and where to provide funding for this component began with an extensive and comprehensive community program planning process that was similar to that conducted in 2005-06 for the Community Services and Support component. Underserved and at- risk populations were researched, stakeholders actively participated in identifying and prioritizing mental health needs, and strategies were developed to meet these needs.

The programs and services described below are directly derived from this initial planning process, and expanded by subsequent yearly community program planning processes, to include current year. New regulations and demographic reporting requirements for the PEI component went into effect on October 6, 2015. Programs in this component now focus their programming on one of the following seven PEI categories:

1) Outreach for increasing recognition of early signs of mental illness
2) Prevention
3) Early intervention
4) Access and linkage to treatment
5) Improving timely access to mental health services for underserved populations
6) Stigma and discrimination reduction
7) Suicide prevention

All programs contained in the PEI component help create access and linkage to mental health treatment, with an emphasis on utilizing non-stigmatizing and non- discriminatory strategies, as well as outreach and engagement to those populations who have been identified as traditionally underserved.

Outcome Indicators.

PEI regulations (established October 2015) have data reporting requirements that programs started tracking in FY 2016-2017. In FY 18-19, over 32,000 consumers of all ages were served by PEI programs in Contra Costa County. This report includes updates from each program and is organized by PEI program category.

The information gathered enables CCBHS to report on the following outcome indicators:

- Outreach to Underserved Populations. Demographic data, such as age group, race/ethnicity, primary language and sexual orientation, enable an assessment of the impact of outreach and engagement efforts over time.
- Linkage to Mental Health Care. Number of people connected to care, and average duration of reported untreated mental illness enable an assessment over time of impact of programs on connecting people to mental health care.

Evaluation Component

Contra Costa Behavioral Health Services is committed to evaluating the effective use of funds provided by the Mental Health Services Act. Toward this end, a comprehensive program and fiscal review process has been implemented to: a) improve the services and supports provided; b) more efficiently support the County's MHSA Three Year Program and Expenditure Plan; c) ensure compliance with stature, regulations and policies. Each of the MHSA funded contract and county operated programs undergoes a triennial program and fiscal review. This entails interviews and surveys of individuals both delivering and receiving the services, review of data, case files, program and financial records, and performance history. Key areas of inquiry include:

- Delivering services according to the values of MHSA
- Serving those who need the service
- Providing services for which funding was allocated
- Meeting the needs of the community and/or population
- Serving the number of individuals that have been agreed upon
- Achieving outcomes that have been agreed upon
- Assuring quality of care
- Protecting confidential information
- Providing sufficient and appropriate staff for the program
- Having sufficient resources to deliver the services

- Following generally accepted accounting principles
- Maintaining documentation that supports agreed upon expenditures
- Charging reasonable administrative costs
- Maintaining required insurance policies
- Communicating effectively with community partners

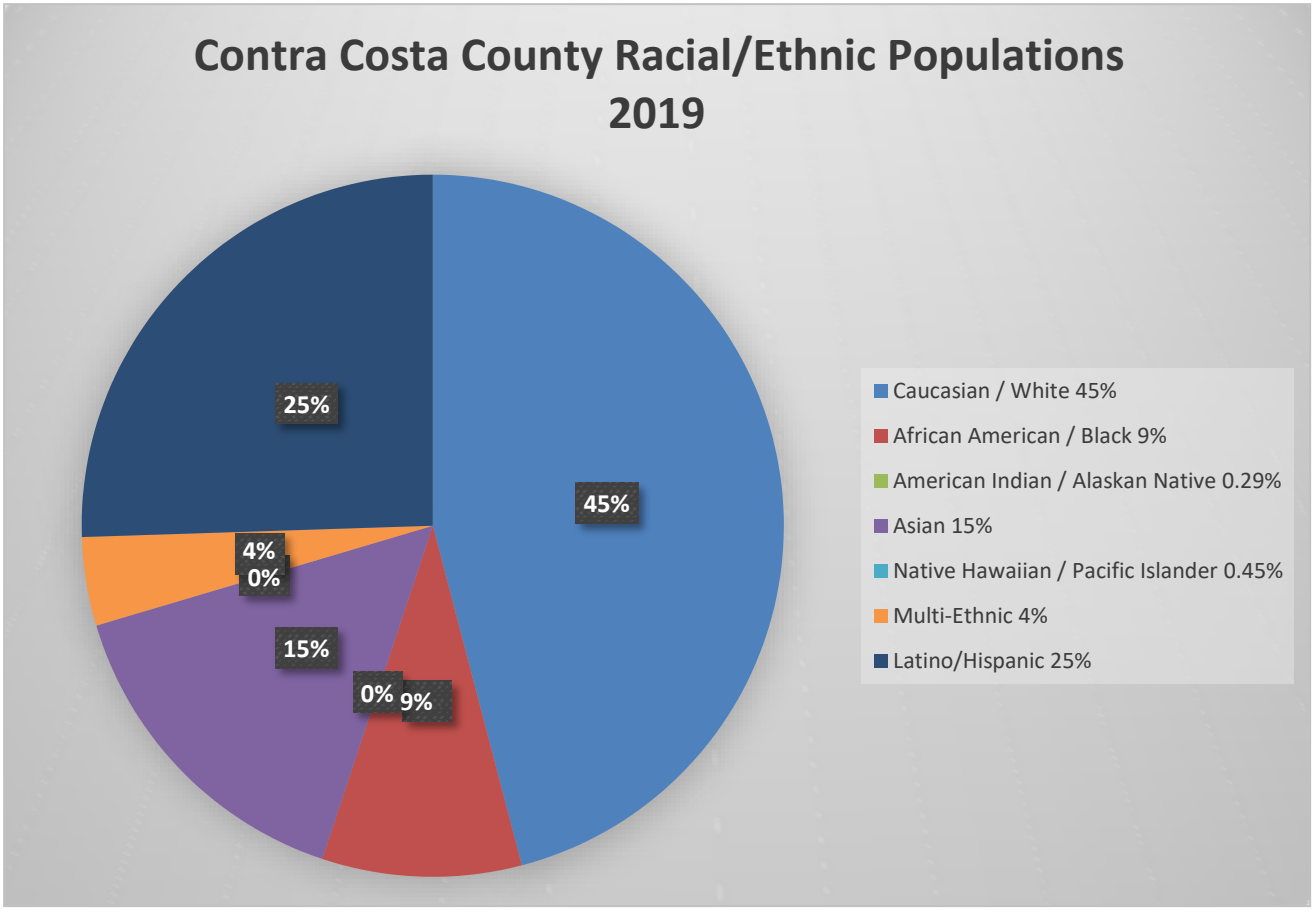
Each program receives a written report that addresses the above areas. Promising practices, opportunities for improvement, and/or areas of concern are noted for sharing or follow-up activity, as appropriate. The emphasis is to establish a culture of continuous improvement of service delivery, and quality feedback for future planning efforts. Completed reports are made available to members of the Consolidated Planning Advisory Workgroup (CPAW) and distributed at the monthly stakeholder meeting, or to the public upon request. Links to PEI program and fiscal reviews can be found here: https://cchealth.org/mentalhealth/mhsa/cpaw/agendas-minutes.php.

During FY2018-19, completed PEI Program and Fiscal Review reports were distributed at the following monthly CPAW meetings: September 2018, February 2019, March 2019, April 2019.

PEI Aggregate Data FY 18-19

Contra Costa is a geographically and culturally diverse county with approximately 1.1 million residents. One of nine counties in the Greater San Francisco Bay Area, we are located in the East Bay region.

According to the United States Census Bureau (https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia), it's estimated that about 9% of people in Contra Costa County are living in poverty and that children, adolescents & young adults (ages 0-25) make up approximately 30% of the population. Roughly 25% of residents are foreign born. The most common languages spoken after English include: Spanish, Chinese languages and Tagolog.



MHSA funded Prevention and Early Intervention (PEI) programs in Contra Costa County served over 32,000 individuals during FY 18-19. For a complete listing of PEI programs,

please see Appendix A. PEI Providers gather quarterly for a Roundtable Meeting facilitated by MHSA staff, and are actively involved in MHSA stakeholder groups including Consolidated Planning and Advisory Workgroup(CPAW) and various sub-committees. In addition, PEI programs engage in the Community Program Planning Process (CPPP) by participating in three annual community forums located in various regions of the county.

The below tables outline PEI Aggregate Data collected for FY 18-19.

Total Served: 32,949
Total Number of Individual Family Members Served: 588

Table 1. Age Group

	# Served
Child (0-15)	2,530
Transition Age Youth (16-25)	5,207
Adult (26-59)	10,831
Older Adult (60+)	2,684
Decline to State	11,700

Table 2. Primary Language

	# Served
English	20,471
Spanish	6,181
Other	642
Decline to State	5,655

Table 3. Race

	# Served
More than one Race	1,014
American Indian/Alaska Native	94
Asian	1,866
Black or African American	3,697
White or Caucasian	11,393
Hispanic or Latino/a	8,377
Native Hawaiian or Other Pacific Islander	103
Other	409
Decline to State	5,996

Table 4. Ethnicity (If Non- Hispanic or Latino/a)

	# Served
African	190
Asian Indian/South Asian	150
Cambodian	7
Chinese	50
Eastern European	29
European	273
Filipino	143
Japanese	8
Korean	13
Middle Eastern	238
Vietnamese	23
More than one Ethnicity	173
Decline to State	3,002
Other	940

Table 5. Ethnicity (If Hispanic or Latino/a)

	# Served
Caribbean	11
Central American	590
Mexican/Mexican American /Chicano	3,784
Puerto Rican	15
South American	162
Other	23

Table 6. Sexual Orientation

	# Served
Heterosexual or Straight	14,997
Gay or Lesbian	220
Bisexual	133
Queer	24
Questioning or Unsure of Sexual Orientation	40
Another Sexual Orientation	168
Decline to State	17,367

Table 7. Gender Assigned at Birth

	# Served
Male	10,289
Female	11,925
Decline to State	18,339

Table 8. Current Gender Identity

	# Served
Man	8,699
Woman	8,801
Transgender	149
Genderqueer	13
Questioning or Unsure of Gender Identity	14
Another Gender Identity	68
Decline to State	15,205

Table 9. Active Military Status

	# Served
Yes	52
No	3,049
Decline to State	29,848

Table 10. Veteran Status

	# Served
Yes	75
No	8,045
Decline to State	24,829

Table 11. Disability Status

	# Served
Yes	360
No	2,660
Decline to State	29,929

Table 12. Description of Disability Status

	# Served
Difficulty Seeing	33
Difficulty Hearing or Having Speech Understood	38
Physical/Mobility	91
Chronic Health Condition	126
Other	406

Table 13. Cognitive Disability

	# Served
Yes	116
No	987

Table 14. Referrals to Services

	# Served
Clients Referred to Mental Health Services	1,850
Clients who Participated/ Engaged at Least Once in Referred Service	1,681

Table 15. External Mental Health Referral

	# Served
Clients Referred to Mental Health Services	18,464
Clients who participated/ engaged at least once in referred service	191

Table 16. Average Duration Without Mental Health Services

	Week Totals
Average Duration for all Clients of Untreated Mental Health Issues (In weeks)	17.6

Table 17. Average Length of Time Until Mental Health Services

	Week Totals
Average Length for all Clients between Mental Health Referral and Services (In weeks)	4.4

PEI Programs by Component

PEI programs are listed within the seven categories delineated in the PEI regulations.

Outreach for Increasing Recognition of Early Signs of Mental Illness

Programs in this category provide outreach to individuals with signs and symptoms of mental illness so they can recognize and respond to their own symptoms. Outreach is engaging, educating and learning from potential primary responders. Primary responders include, but are not limited to, families, employers, law enforcement, school, community service providers, primary health care, social services and faith- based organizations.

Seven programs are included in this category:

1) Asian Family Resource Center provides culturally sensitive education and access to mental health services for immigrant Asian communities, especially the Southeast Asian and Chinese population of Contra Costa County. Staff provides outreach, medication compliance education, community integration skills, and mental health system navigation. Early intervention services are provided to those exhibiting symptoms of mental illness, and participants are assisted in actively managing their own recovery process.

2) The Counseling Options Parenting Education (COPE) Family Support Center utilizes the evidence-based practices of the Positive Parenting Program (Triple P) to help parents develop effective skills to address common child and youth behavioral issues that can lead to serious emotional disturbances. Targeting families residing in underserved communities this program delivers in English and Spanish a number of seminars, training classes and groups throughout the year.

3) First Five of Contra Costa, in partnership with the COPE Family Support Center, takes the lead in training families who have children up to the age of five. First Five also partners with the COPE Family Support Center to provide training in the Positive Parenting Program (Triple P) method to mental health practitioners who serve this at-risk population.

4) Contra Costa Interfaith Housing provides on-site services to formerly homeless families, all with special needs, at the Garden Park Apartments in Pleasant Hill, the Bella Monte Apartments in Bay Point, and Los Medanos Village in Pittsburg. Services

include pre-school and afterschool programs, such as teen and family support groups, assistance with school preparation, and homework clubs. These services are designed to prevent serious mental illness by addressing domestic violence, substance addiction and inadequate life and parenting skills.

5) Jewish Family and Community Services of the East Bay provides culturally grounded, community-directed mental health education and navigation services to refugees and immigrants of all ages in primarily the Afghan, Bosnian, Iranian and Russian communities of Contra Costa County. Outreach and engagement services are provided in the context of group settings and community cultural events that utilize a variety of non-office settings convenient to individuals and families.

6) The Native American Health Center provides a variety of culturally specific methods of outreach and engagement to educate Native Americans throughout the County regarding mental illness, identify those at risk for developing a serious mental illness, and help them access and navigate the human service systems in the County. Methods include an elder support group, a youth wellness group, a traditional arts group, talking circles, Positive Indian Parenting sessions, and Gatherings of Native Americans.

7) The Latina Center serves Latino parents and caregivers in West Contra Costa County by providing culturally and linguistically specific twelve-week parent education classes to high risk families utilizing the evidence-based curriculum of Systematic Training for Effective Parenting (STEP). In addition, the Latina Center trains parents with lived experience to both conduct parenting education classes and to become Parent Partners who can offer mentoring, emotional support and assistance in navigating social service and mental health systems.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Asian Family Resource Center	Countywide	238	142,055
COPE	Countywide	226	245,863
First Five	Countywide	(included in COPE)	81,955

Contra Costa Interfaith Housing	Central and East County	445	80,340
Jewish Family & Children's Services	Central and East County	224	174,485
Native American Health Center	Countywide	101	238,555
The Latina Center	West County	327	111,545
Total		**1,561**	**$1,075,076**

Prevention

Programs in this category provide activities intended to reduce risk factors for developing a potentially serious mental illness, and to increase protective factors. Risk factors may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequality, substance abuse, domestic violence, previous mental illness, prolonged isolation, and may include relapse prevention for those in recovery from a serious mental illness.

Five programs are included in this category:

1) The Building Blocks for Kids Collaborative, located in the Iron Triangle of Richmond, train family partners from the community with lived mental health experience to reach out and engage at-risk families in activities that address family mental health challenges. Individual and group wellness activities assist participants make and implement plans of action, access community services, and integrate them into higher levels of mental health treatment as needed.

2) Vicente Briones Continuation High School in the Martinez Unified School District provides career academies for at-risk youth that include individualized learning plans, learning projects, internships, and education and counseling support. Students, school staff, parents and community partners work together on projects designed to develop leadership skills, a healthy lifestyle and pursuit of career goals.

3) People Who Care is an after-school program serving the communities of Pittsburg and Bay Point that is designed to accept referrals of at-risk youth from schools, juvenile justice systems and behavioral health treatment programs. Various vocational projects are conducted both on and off the program's premises, with selected participants

receiving stipends to encourage leadership development. A licensed clinical specialist provides emotional, social and behavioral treatment through individual and group therapy.

4) Putnam Clubhouse provides peer-based programming for adults throughout Contra Costa County who are in recovery from a serious mental illness. Following the internationally recognized clubhouse model this structured, work focused programming helps individuals develop support networks, career development skills, and the self-confidence needed to sustain stable, productive and more independent lives. Features of the program provide respite support to family members, peer-to-peer outreach, and special programming for transition age youth and young adults.

5) The RYSE Center provides a constellation of age-appropriate activities that enable at-risk young people in Richmond to effectively cope with the continuous presence of violence and trauma in the community and at home. These trauma informed programs and services include drop-in, recreational and structured activities across areas of health and wellness, media, arts and culture, education and career, technology, and developing youth leadership and organizing capacity. The RYSE Center facilitates a number of city and system-wide training and technical assistance events to educate the community on mental health interventions that can prevent serious mental illness as a result of trauma and violence.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated FY 18-19**
Building Blocks for Kids	West County	438	216,897

Vicente Briones High School	Central County	121	185,763
People Who Care	East County	207	223,102
Putnam Clubhouse	Countywide	322	582,859
RYSE	West County	720	503,019
Total		**1,808**	**$1,705,143**

Early Intervention

Early intervention provides mental health treatment for persons with a serious emotional disturbance or mental illness early in its emergence.

One program is included in this category.

The County operated First Hope Program serves youth who show early signs of psychosis or have recently experienced a first psychotic episode. Referrals are accepted from all parts of the County, and through a comprehensive assessment process young people, ages 12-25, and their families are helped to determine whether First Hope is the best treatment to address the psychotic illness and associated disability. A multi-disciplinary team provides intensive care to the individual and their family, and consists of psychiatrists, mental health clinicians, occupational therapists and employment/education specialists. These services are based on the Portland Identification and Early Referral (PIER) Model, and consists of multi-family group therapy, psychiatric care, family psycho-education, education and employment support, and occupational therapy.

The allocation for this program is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
First Hope	Countywide	900	2,651,791
Total		**900**	**$2,651,791**
Decline to State			0

Access and Linkage to Treatment

Programs in this category have a primary focus on screening, assessment, and connecting children and adults as early as practicable to necessary mental health care

and treatment.

Three programs are included in this category:

1) The James Morehouse Project at El Cerrito High School, a student health center that partners with community-based organizations, government agencies and local universities, provides a range of youth development groups designed to increase access to mental health services for at-risk high school students. These on-campus groups address coping with anger, violence and bereavement, factors leading to substance abuse, teen parenting and caretaking, peer conflict and immigration acculturation.

2) STAND! For Families Free of Domestic Violence utilizes established curricula to assist youth successfully address the debilitating effects of violence occurring both at home and in teen relationships. Fifteen-week support groups are held for teens throughout the County, and teachers and other school personnel are assisted with education and awareness with which to identify and address unhealthy relationships amongst teens that lead to serious mental health issues.

3) Experiencing the Juvenile Justice System. Within the county operated Children's Services five mental health clinicians support families who are experiencing the juvenile justice system due to their adolescent children's involvement with the law. Three clinicians are out-stationed at juvenile probation offices, and two clinicians work with the Oren Allen Youth Ranch. The clinicians provide direct short-term therapy and coordinate appropriate linkages to services and supports as youth transition back into their communities.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
James Morehouse Project	West County	416	102,897
STAND! Against Domestic Violence	Countywide	1903	134,113
Juvenile Justice System – Supporting Youth	Central County	300	695,855
Total		**2,619**	**$932,865**

Improving Timely Access to Mental Health Services for Underserved Populations

Programs in this category provide mental health services as early as possible for individuals and their families from an underserved population. Underserved means not having access due to challenges in the identification of mental health needs, limited language access, or lack of culturally appropriate mental health services. Programs in this category feature cultural and language appropriate services in convenient, accessible settings.

Six programs are included in this category:

1) The Center for Human Development serves the primarily African American population of Bay Point in Eastern Contra Costa County. Services consist of culturally appropriate education on mental health issues through support groups and workshops. Participants at risk for developing a serious mental illness receive assistance with referral and access to County mental health services. In addition, the Center for Human Development provides mental health education and supports for gay, lesbian, bi-sexual, and questioning youth and their supports in East County to work toward more inclusion and acceptance within schools and in the community.

2) The Child Abuse Prevention Council of Contra Costa provides a 23-week curriculum designed to build new parenting skills and alter old behavioral patterns and is intended to strengthen families and support the healthy development of their children. The program is designed to meet the needs of Spanish speaking families in East and Central Counties.

3) La Clinica de la Raza reaches out to at-risk Latina/os in Central and East County to provide behavioral health assessments and culturally appropriate early intervention services to address symptoms of mental illness brought about by trauma, domestic violence and substance abuse. Clinical staff also provide psycho-educational groups that address the stress factors that lead to serious mental illness.

4) Lao Family Community Development provides a comprehensive and culturally sensitive integrated system of care for Asian and Southeast Asian adults and families in West Contra Costa County. Staff provides comprehensive case management services, to include home visits, counseling, parenting classes, and assistance accessing employment, financial management, housing, and other service both within and outside the agency.

5) Lifelong Medical Care provides isolated older adults in West County opportunities for social engagement and access to mental health and social services. A variety of group and one-on-one approaches are employed in three housing developments to engage frail, older adults in social activities, provide screening for depression and other mental and medical health issues, and linking them to appropriate services.

6) Rainbow Community Center provides a community based social support program designed to decrease isolation, depression and suicidal ideation among members who identify as lesbian, gay, bisexual, transgender, or who question their sexual identity. Key activities include reaching out to the community in order to engage those individuals who are at risk, providing mental health support groups that address isolation and stigma and promote wellness and resiliency, and providing clinical mental health treatment and intervention for those individuals who are identified as seriously mentally ill.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Child Abuse Prevention Council	Central and East County	164	125,109
Center for Human Development	East County	342	156,936
La Clinica de la Raza	Central and East County	6960	280,558
Lao Family Community Development	West County	125	190,416
Lifelong Medical Care	West County	138	130,786
Rainbow Community Center	Countywide	1174	759,362
Total		**8,903**	**$1,642,624**

Stigma and Discrimination Reduction

Activities in this category are designed to 1) reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to having a mental illness, 2) increase acceptance, dignity, inclusion and equity for individuals with mental illness and their families, and 3) are culturally congruent with the values of the population for whom changes, attitudes, knowledge and behavior are intended.

The County operated Office for Consumer Empowerment (OCE) provides leadership and staff support to a number of initiatives designed to reduce stigma and discrimination, develop leadership and advocacy skills among consumers of behavioral health services, support the role of peers as providers, and encourage consumers to actively participate in the planning and evaluation of MHSA funded services. Staff from the OCE support the following activities designed to educate the community in order to raise awareness of the stigma that can accompany mental illness.

1) The PhotoVoice Empowerment Project enables consumers to produce artwork that speaks to the prejudice and discrimination that people with behavioral health challenges face. PhotoVoice's vision is to enable people to record and reflect their community's strengths and concerns, promote critical dialogue about personal and community issues, and to reach policymakers to effect change.

2) The Wellness Recovery Education for Acceptance, Choice and Hope (WREACH) Speakers' Bureau forms connections between people in the community and people with lived mental health and co-occurring experiences, using face to face contact by providing stories of recovery and resiliency and current information on health treatment and supports. Other related activities include producing videos, public service announcements and educational materials.

3) The OCE facilitates Wellness Recovery Action Plan (WRAP) groups by providing certified leaders and conducting classes throughout the County. Staff employ the evidence-based WRAP system in enhancing the efforts of consumers to promote and advocate for their own wellness. OCE also supports a writers' group in partnership with the Contra Costa affiliate of the National Alliance on Mental Illness (NAMI).

4) The Committee for Social Inclusion is an ongoing alliance of committee members that work together to promote social inclusion of persons who receive behavioral health services. The Committee is project based, and projects are designed to increase

participation of consumers and family members in the planning, implementation and delivery of services. Current efforts are supporting the integration of mental health and alcohol and other drug services within the Behavioral Health Services Division. In addition, OCE staff assist and support consumers and family members in participating in the various planning committees and sub-committees, Mental Health Commission meetings, community forums, and other opportunities to participate in planning processes.

5) Through the Each Mind Matters initiative California Mental Health Services Authority (CalMHSA) will provide technical assistance to encourage the County's integration of available statewide resources on stigma and discrimination reduction and suicide prevention. For FY 2017-20 CCBHS will partner via Memorandum of Understanding (MOU) with CalMHSA to link county level stigma and discrimination reduction efforts with statewide social marketing programs. This linkage will expand the County's capacity via language specific materials, social media, and subject matter consultation with regional and state experts to reach diverse underserved communities, such as Hispanic, African American, Asian Pacific Islander, LGBTQ, Native American and immigrant communities. Primary focus will be to reach Spanish speaking Latina/o communities via social media and materials adapted specifically for this population.

The allocation for stigma and discrimination efforts are summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
OCE	County Operated	Countywide	270,628
CalMHSA	MOU	Countywide	78,000
Total			**$348,628**

Suicide Prevention

There are three plan elements that augment the County's efforts to reduce the number of suicides in Contra Costa County. 1) augmenting the Contra Costa Crisis Center, 2) dedicating a clinical specialist to support the County's adult clinics, and 3) supporting a suicide prevention committee.

1) The Contra Costa Crisis Center provides services to prevent suicides by operating a certified 24-hour suicide prevention hotline. The hotline connects with people when they are most vulnerable and at risk for suicide, enhances safety, and builds a bridge to community resources. Staff conduct a lethality assessment on each call, provide support and intervention for the person in crisis and make follow-up calls (with the caller's consent) to persons who are at medium to high risk of suicide. MHSA funds enable additional paid and volunteer staff capacity, most particularly in the hotline's trained multi-lingual, multi-cultural response.

2) The County fields a mental health clinical specialist to augment the adult clinics for responding to those individuals identified as at risk for suicide. This clinician receives referrals from psychiatrists and clinicians of persons deemed to be at risk, and provides a short-term intervention and support response, while assisting in connecting the person to more long-term care.

3) A multi-disciplinary, multi-agency Suicide Prevention Committee has been established, and has published a countywide Suicide Prevention Strategic Plan. This ongoing committee oversees the implementation of the Plan by addressing the strategies outlined in the Plan. These strategies include i) creating a countywide system of suicide prevention, ii) increasing interagency coordination and collaboration, iii) implementing education and training opportunities to prevent suicide, iv) implementing evidence-based practices to prevent suicide, and v) evaluating the effectiveness of the County's suicide prevention efforts.

The allocation for this category is summarized below:

Program	**Region Served**	**Numbers Served FY 18-19**	**MHSA Funds Allocated for FY 18-19**
Contra Costa Crisis Center	Countywide	18,128	310,685
County Clinician	Countywide	NA	133,742
Suicide Prevention	Countywide	NA	Included in PEI administrative cost
Total		**18,128**	**$444,427**

PEI Administrative Support Mental Health Program Supervisor position has been allocated by the County to provide administrative support and evaluation of programs and plan elements that

are funded by MHSA. The allocation for this activity is summarized below:

Program	**Region Served**	**MHSA Funds Allocated for FY 18-19**
Administrative Support	Countywide	135,607
Total		**$135,607**

Prevention and Early Intervention (PEI) Summary for FY 2018-19

Outreach for Increasing Recognition of Early Signs of Mental Illness	$1,075,076
Prevention	$1,705,143
Early Intervention	$2,651,791
Access and Linkage to Treatment	$932,865
Improving Timely Access to Mental Health Services for Underserved Populations	$1,642,624
Stigma and Discrimination Reduction	$348,628
Suicide Prevention	$444,427
Administrative Support	$135,607
Total	**$8,926,161**

Appendix A
Program Profiles

Asian Community Mental Health Services A-1

Building Blocks for Kids (BBK) A-3

Center for Human Development (CHD) A-5

Child Abuse Prevention Council (CAPC) A-7

Contra Costa Crisis Center A-8

Contra Costa Interfaith Housing (CCIH) A-10

Counseling Options Parent Education (C.O.P.E.) A-12

First Five Contra Costa A-14

First Hope (Contra Costa Behavioral Health) A-15

James Morehouse Project at El Cerrito High, YMCA East Bay A-16

Jewish Family and Community Services East Bay (JFCS/ East Bay) A-18

Juvenile Justice System – Supporting Youth (Contra Costa Behavioral Health) A-19

La Clinica de la Raza A-20

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Native American Health Center (NAHC) A-29

Office for Consumer Empowerment (Contra Costa Behavioral Health) A-30

People Who Care (PWC) Children Association A-32

Putman Clubhouse A-33

Rainbow Community Center (RCC) A-35

RYSE Center A-36

STAND! For Families Free of Violence A-38

Vicente Martinez High School - Martinez Unified School District A-39

Asian Community Mental Health Services (ACMHS)

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

1. General Description of the Organization

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

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

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

b. Target Population: Asian and Pacific Islander immigrant and refugee communities

(especially Chinese and Southeast Asian population) in Contra Costa County

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

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

Building Blocks for Kids (BBK)

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

1. General Description of the Organization

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

2. Program: Not Me Without Me - PEI

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

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

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

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

e. Outcomes:

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

Center for Human Development (CHD)

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

1. **General Description of the Organization**

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

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

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

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

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

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

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

Empowerment Program. Outcomes:

i. Wellness Program

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

ii. Empowerment Program

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

Child Abuse Prevention Council (CAPC)

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

1. General Description of the Organization

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

2. Program: The Nurturing Parenting Program - PEI

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

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

Contra Costa Crisis Center

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

1. General Description of the Organization

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

2. Program: Suicide Prevention Crisis Line - PEI

a. Scope of Services:

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

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

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

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

Contra Costa Interfaith Housing (CCIH)

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

1. General Description of the Organization

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

2. Program: Strengthening Vulnerable Families - PEI

a. Scope of Services:

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

about family members' mental health, as they arise. CCIH staff is also able to help community providers be aware of early signs of mental illness in their clients, and support sensitive care and timely treatment for these issues.

b. Target Population: Formerly homeless/at-risk families and youth.
c. Payment Limit: FY 18-19: $80,340
d. Number served: In FY 17-18: 428 clients
e. Outcomes:

- Improved school functioning and regular attendance of school-aged youth in afterschool programs.

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

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

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

1. General Description of the Organization

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

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

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

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

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

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

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

e. Outcomes:

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

First Five Contra Costa

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

1. General Description of the Organization

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

2. Programs: Triple P Positive Parenting Program - PEI

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

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

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

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

e. Outcomes:

- Completed 17 parenting classes for East and West County parents of children age 0–5 (C.O.P.E.)
  i. Clinical Highlights for FY 17-18:
    - **Depression** – parents self-report on symptoms such as hopelessness and dysphoria, decreased by 41% overall
    - **Anxiety** – parents self-report on symptoms such as anxiousness and situational anxiety, decreased by 34% overall
    - **Stress** – parents self-report on symptoms such as nervousness, muscle tension and inability to relax, decreased by 33% overall
    - **Intensity of Behavior Problems** which measures the frequency of each problem behavior, decreased by 19% as indicated by the chart above
    - **Behavior Problems** which reflect parent tolerance of the behaviors and the distress, decreased by 43%

First Hope (Contra Costa Behavioral Health)

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

1. General Description of the Organization

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

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

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

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

b. Target Population: 12-25 year old transition age youth and their families

c. Total Budget: FY 18-19: $2,651,791

d. Staff: 14 FTE full time equivalent multi-disciplinary staff

e. Number served: FY 17-18: 118 clients and their families served (assessments and clinical services). On any given day, between 55 and 70 clients and their families are open to services. Additionally, First Hope provided ongoing outreach education reaching 224 participants in the community and 179 initial phone screenings and consultation to at risk individuals, families, or providers.

f. Outcomes:

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

g. Long Term Public Health Outcomes:

- Reduce conversion rate from Clinical High Risk symptoms to schizophrenia
- Reduce incidence of psychotic illnesses in Contra Costa County
- Increase community awareness and acceptance of the value and advantages of seeking mental health care early

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

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

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

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

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

b. Target Population: At-risk students at El Cerrito High School
c. Payment Limit: FY 18-19: $102,897
d. Numbers Served: For FY 17-18: 413
e. Outcomes:

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

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

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

https://jfcs-eastbay.org/

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

1. General Description of the Organization

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

2. Program: Community Bridges - PEI

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

- Provided assessment and short-term intervention to 141 bilingual clients.
- Provided individual health and mental health navigation services to 141 clients.
- Provided 4 trainings on cross-cultural mental health concepts for 35 to 40 frontline staff from JFCS East Bay and other community agencies.
- Provided 2 (2-hr) mental health education classes to 20-24 Arabic-speaking clients.
- Provided 4 (2-hr) mental health education classes to 10-12 Dari/Farsi-speaking seniors.
- Provided 4 (2-hr) Dari/Farsi-bilingual parenting classes to 10-12 Afghan & Iranian parents
- Provided 4 (2-hour) mental health education classes to 10-12 Russian-speaking seniors.
- Referred 27 high-risk individuals to bilingual therapy services with JFCS East Bay's bilingual therapist.

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

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

1. General Description of the Organization

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

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

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

a. Scope of Services:

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

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

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

- Help youth address mental health & substance abuse issues that may underlie problems with delinquency
- Increased access to mental health services and other community resources for at risk youth
- Decrease of symptoms of mental health disturbance
- Increase of help seeking behavior; decrease stigma associated with mental illness

La Clínica de la Raza

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

1. General Description of the Organization

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

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

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

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

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

- 100% of parents reported increased knowledge about positive family communication
- 100% of parents reported improved skills, behavior, and family relationships
- Offered 955 screenings for youth, 185 assessments for youth, 262 follow-up visits with families

LAO Family Community Development

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

1. **General Description of the Organization**

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

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

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

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

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

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

e. Outcomes:

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

The Latina Center

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

1. General Description of the Organization

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

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

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

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

Lifelong Medical Care

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

1. General Description of the Organization

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

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

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

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

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

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

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

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

Native American Health Center (NAHC)

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

1. General Description of the Organization

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

2. Program: Native American Wellness Center – PEI

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

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

b. Target Population: Native American residents of Contra Costa County (mainly west region), who are at risk for developing a serious mental illness.
c. Payment Limit: FY 18-19: $238,555
d. Number served: In FY 17-18: 162
e. Outcomes:

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

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

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

1. General Description of the Organization

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

2. Program: Reducing Stigma and Discrimination – PEI

a. Scope of Services:

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

3. Program: Mental Health Career Pathway Program - WET

a. Scope of Services:

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

by the County.

4. Program: Overcoming Transportation Barriers – INN

a. Scope of Services:

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

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

c. Total MHSA Funding for FY 2018-19: $270,628

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

e. Outcomes:

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

People Who Care (PWC) Children Association

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

1. General Description of the Organization

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

2. Program: PWC Afterschool Program (PEI)

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

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

Putman Clubhouse

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

1. General Description of the Organization

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

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

a. Scope of Services:
   i. Project Area A: Putnam Clubhouse's peer-based programming helps adults recovering from psychiatric disorders access support networks, social opportunities, wellness tools, employment, housing, and health services. The work-ordered day program helps members gain prevocational, social, and healthy living skills as well as access vocational options within Contra Costa. The Clubhouse teaches skills needed for navigating/accessing the system of care, helps members set goals (including educational, vocational, and wellness), provides opportunities to become involved in stigma reduction and advocacy. Ongoing community outreach is provided throughout the County via presentations and by distributing materials, including a brochure in both English and Spanish. The Young Adult Initiative provides weekly activities and programming planned by younger adult members to attract and retain younger adult members in the under-30 age group. Putnam Clubhouse helps increase family wellness and reduces stress related to caregiving by providing respite through Clubhouse programming and by helping Clubhouse members improve their independence.
   ii. Project Area B: Putnam Clubhouse assists the Office for Consumer Empowerment (OCE) by providing career support through hosting Career Corner, an online career resource for mental health consumers in Contra Costa County, and holding countywide career workshops.
   iii. Project Area C: Putnam Clubhouses assists Contra Costa County Behavioral Health in a number of other projects, including organizing community events and by assisting with administering consumer perception surveys.
   iv. Project Area D: Putnam Clubhouse assists Contra Costa County Behavioral Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support.
b. Target Population: Contra Costa County residents with identified mental illness and their families.
c. Payment Limit: FY 18-19: $582,859
d. Number served: In FY 17-18: 308
e. Outcomes (FY17-18):

- 70 new members enrolled and participated in at least one activity
- Held 4 career workshops
- Prepared 9,000 meals for members
- Provided 54,437 hours of Clubhouse programming to members
- Clubhouse membership made a positive impact by decreasing hospitalizations

Rainbow Community Center

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

1. General Description of the Organization

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

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

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

b. Target Population: LGBTQ community of Contra Costa County who are at risk of developing serious mental illness.
c. Payment Limit: FY 18-19: $759,362 for PEI, including counseling and case management services onsite and at Contra Costa schools.
d. Number served: In FY 17-18: 1460
e. Outcomes:

- Rainbow held 28 trainings during the year
- Rainbow's Inclusive School Coalition served the following four districts: Mt. Diablo, Pittsburg, Acalanes, West Contra Costa Unified
- Youth Support Programming served: 144 youth via outreach; 176 youth in groups; 43 through one on one work; 387 through school-based outreach; 118 through mental health services, and 65 through psycho-social groups
- Pride & Joy program reached 1,054 members of the community through events/groups; 387 through brief intervention; and 204 through individual services

RYSE Center

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

1. General Description of the Organization

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

1. Program: Supporting Youth – PEI

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

b. Target Population: West County Youth at risk for developing serious mental illness.
c. Payment Limit: FY 18-19: $503,019
d. Unique Number served: In FY 17-18: 680 young people
e. Outcomes:

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

model

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

STAND! For Families Free of Violence

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

1. General Description of the Organization

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

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

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

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

Vicente Martinez High School - Martinez Unified School District

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

1. General Description of the Organization

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

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

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

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

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

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

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

- Goals: Students enrolled in Vicente and Briones will: Develop an

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

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

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FY 18-19

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CONTRA COSTA HEALTH SERVICES

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM FISCAL YEAR: 18-19

Agency/Program Name:
Asian Community Mental Health Services / Asian Family Resource Center

PEI STRATEGIES:
Please check all strategies that your program employs:
X Provide access and linkage to mental health care
X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Within the past reporting period, the potential responders we have reached primarily consist of multilingual and multicultural individuals and families (specifically of Chinese, Vietnamese, Laos, Khmu, and Mien backgrounds) currently living in Contra Costa County (with the majority residing in the western region of the county). These groups and individuals are frequently underserved as a result of language barriers and cultural differences. We hold regular group sessions at our offices in Richmond weekly to reach our target audience.

Our primary method of outreach and engagement with potential responders were program brochures. These brochures were printed in several languages, such as Chinese, Vietnamese, Lao, and Mien to reach a wider range of potential responders. These brochures consisted of our mission, the types of services we

offer under this program, the language we speak, and our contact information.

These brochures are placed in areas that attract high concentrations of the APIC population such as public libraries, supermarkets, restaurants, adult schools, housing complexes, the faith community, weekend community events, and distributed to the participants at diverse community activities. In addition, the brochures are distributed to participants who attended our outreach events in previous years.

We also hold collaborative efforts with other community agencies such as the Family Justice Center Richmond and Concord, Regional Center of East Bay, Senior Peer Counseling, Bay Area Legal Aid, local school districts, SSA, and housing corporations for service resources and case referrals in order to further engage with our community.

Furthermore, we hold psychoeducation workshops for community members with regards to the importance of prevention and early intervention relative to mental health, as well as self-care and human wellness. The workshops also touch on cultural/historical issues and family/parenting issues. These workshops also touch on cultural/historical issues and family/parenting issues. These workshops raise the attendees' awareness and understanding of the early signs of mental health issues, increase their knowledge about mental health, and reduce the stigma that surrounds the topic of mental health. Additionally, we provide information about where and how to get help if needed, particularly for those who may feel limited due to language barriers.

Several strategies are utilized to provide access and linkage to treatment. We assess the needs of the individual, set up services goals for them, provide the services required or otherwise refer them to appropriate programs to service their needs. For instance, if there is a potential case that needs mental health assessment and treatment, it would be transferred to another program we offer, Medi-Cal recipients. For those individuals who are not qualified for this treatment program, of immediate risk, or are having difficulties accessing or receiving services in English because of language and cultural barriers, they are encouraged to receive individual/family consultation for up to one year under the PEI program, or participate in wellness support groups in a variety of Asian languages (this program is also under the PEI program.) We regularly follow up with the individual to assess if program is meeting their needs. Internally, we perform quality assurance by periodically meeting with staff and participants to get feedback to incorporate into our best practices.

We perform a variety of things to improve timely access to services for the underserved populations. i) We regularly attend community meetings, to allow our potential client to be aware of our services and accessibility to them. ii) We attend workshops to receive training for new and updated information about laws, public benefits, social services, etc. to be equipped with information that may have an impact on the population we serve. This way we, as providers, can develop a better understanding of the needs and services for underserved populations, and provide more catered and supportive services. iii) Our agency also hosted several events throughout

the year, to allow the community of underserved population to come together, so we may engage

On August 23, 2018, our agency hosted an outdoor event for the community at Alvarado Park in Richmond, CA. People from all backgrounds, young and old, joined us at the picnic. 52 people attended the event, including those from Chinese, Vietnamese, Lao, Khmu, and Mien communities. It was a fun day for all, filled with an abundance of food and activities. Our attendees enjoyed spending quality time talking and eating with good friends and good food. The picnic was a success, bringing many different people together for a day of fun. It was our pleasure to share resources with all.

On November 30, 2018, our agency facilitated a community wellness event at Family Justice Center in Concord, CA. The activities included health screening, community wellness resources, and introduction to our programs and missions, and a workshop on" Understand Financial Literature, How to grow/save money, and Free Eye Exam by Dr. Viet Ho," There were a total of 47 attendees most of them are Vietnamese and Chinese guest that participated in the events.

On June 27, 2019, our agency hosted outdoor event for the community at Alvarado Park Richmond, CA. We had attendance of 47 people including those from the Chinese, Vietnamese, and Laos. We had games activities and raffle for price for the winner. It was our pleasure to share the resources and have fun with the community.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

We utilize the Demographics Form to conduct evaluation and measure outcomes. Some questions in the form have been modified to better reflect cultural competency. Some of the qualitative data we collect include primary language spoken, race, ethnicity, gender, sexual orientation. Our quantitative data includes the number of individuals that attend groups, their ages, and the number of hours attended. The Demographics Form does not include the client name so their information will always be confidential. We use one form per individual per contact. The data is compiled at end of the month and analyzed.

DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Reported on separate form.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our program reflects the values of wellness, recovery, and resilience. We base our work on our agency's mission statement, which emphasize the need to provide and advocate for multilingual and multicultural family services that empower people in Contra Costa County to lead healthy, contributing and self-sufficient lives. The services we provide always aim to assist, educate, and eliminate the stigmas of mental health-related issues. Our doors are always open to anyone that seeks assistance, regardless of race, color, ethnicity, religion, sexual orientation. With the assistance of our bilingual staff, we are able to provide language-based and culturally competent care and service, something we value deeply. We truly believe we provide a safe place for the underserved population who ESL and need theseservices

VALUABLE PERSPECTIVES:

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

Client is a 78 years old female who speaks Mandarin primarily and some limited English. Client is currently living alone in a house especially her husband who was her main support died couple years ago. Client reported having two adult children whom she barely has contact with. Her older son has lived in the Bay Area but she stated she didn't have much contact with since him. She stated, "in Chinese culture, you didn't tell bad news to your family, you only said good news". Her younger son currently is missing, and she stated her son has been suffering from mental health illness. She has been worrying about him. Client is currently living on SSI and SSA with no other types of support.

Client came to AFRC since April 2017 for case management such as senior housing and translation for letters. For about more than a year, client came with only those needs, she often presented herself with a heavy sense of shame about seeking for services and help. She would reject any other services providing to her and stated, "l didn't deserve help". At the group, one of the peers also stated the client has difficulty asking for help. Therefore, the services at AFRC were provided to client based on the client's requests and client often turned down other suggestions from the staff. After a year of services, client started to build up a sense of trust with the staff at AFRC and client would contact and come to the office for seeking help more frequently. For the recent six months, client used the services at AFRC for about 1-5 times a month. Therefore, the service goals at AFRC were 1. Provided case management to meet with client's basic needs such as food stamp, energy bill deduction, SSl renewal process etc. 2. Reduce client's level of anxiety and depressed mood which was triggered by her external stressors. 3. Establish a rapport with the client through case management and assist client to reduce her sense of shame when seeking help. 4. Provide resources and referral for the client

for other services.

The recent services AFRC provided including case management, brief counseling, money management, psychoeducation, wellness education, screening for mental health needs, and providing referral for resources and mental health therapy. In the year 2018-2019, client has responded with an increasing level of trust to the staff and she stated revealing more about her struggles. Client would contact the staff at AFRC asking for assistance and she was more proactive about asking help for her needs. Moreover, AFRC staff assisted client to resolve her SSI penalty and client's level of stress has decreased which client responded "I really appreciate (AFRC] staff for helping me to resolve the issues; otherwise, I couldn't stop thinking about it. And now, I have felt more secure when I come to see you. My worries got lessen because of the help here." Around May to June 2019, staff suggested client to seek for mental health therapy. Client agreed with the suggestions and she will be connected to Medi-care for therapy.

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: Building Blocks for Kids

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

☐ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

1) Ensure BBK Zone families are knowledgeable about and have access to a network of supportive and critical health and mental health information and services.

During the 2018-2019 fiscal year Health & Wellness Team members met with 22 community organizations, government agencies and individuals to strengthen our relationships with them and better understand how to connect Richmond residents to their services. The services include: mental health and wellness providers, access to health information, access to low-cost or free food, early literacy support, financial crisis support and housing. Additionally, Health and Wellness team members attended various networking events and trainings offered by community partners. They included: a trauma informed training focused on the effects of trauma on health and on the brain organized by the Family Justice Center and a training on the impact of witnessing family violence on young children and helpful solutions, a trauma informed training on how trauma impacts young children's brain development and strategies on building supportive relationships and nurturing environments organized by Lotus Bloom and Youth Uprising, a training organized by Village Connect on the Culture Based Transformative Coaching model that empowers individuals, families, groups, and community to move beyond embraced

cultural norms that stand in the way of achieving success. These trainings helped our staff develop a model for the way in which we interact with families that participate in our programming. This fiscal year, our team members attended the Community and Family Engagement Conference. At this conference our staff attended a training on the development of the Growth Mind Set in families, a training on building successful father engagement, and a training on how to build culturally-competent programming.

Summer Program at Belding Garcia Park

In July 2018, Building Blocks for Kids continued the work at our Summer Program at Belding Garcia Park in Richmond. The focus of the summer program was to ensure that children in the Belding Woods neighborhood had access to at least one healthy meal per day and that family members had access to health promoting activities that they can do individually or together as a family. Three times a week we invited different organizations to visit the park and inform families about the services they provide in the community. In the month of July 2018 we served an average of 95 children under the age of 18 at the park. During the program, we collaborated with: Native American Health Center, Child Abuse Prevention Council, Inspiring Communities, YES Nature to Neighborhoods, East Bay Regional Park District, The Watershed Project, West Coast Chess Alliance, the Richmond History Museum and Tandem-Partners in Early Literacy. They facilitated activities with families that focused on health & wellness which included: workshops on healthy eating and living, team building activities, reading circles for children and families. Another component of the summer program was our developmental playgroups for families who had children ages 0-5. In addition to providing playgroups at Belding Garcia we also provided them at the Monterey Pines Apartments in South Richmond. Twice a week for seven weeks, parents received hands-on, bilingual guidance for building language and literacy through everyday activities. In July 2018, a total of 155 unduplicated participants attended a playgroup. Many participants of the playgroups were Nurturing Parenting class parents interested in picking up additional skills. In June 2019, Building Blocks for Kids continued the Summer Program at Belding Garcia Park.
During the first month of programming, we served an average of 87 children under the age of 18. BBK also collaborated with: White Pony Express, SparkPoint Financial Services, East Bay Regional Park District, Fresh Approach, Tandem-Partners in Early Literacy, The Watershed Project and Family Zumba. These partner organizations facilitated activities with families that focused on health & wellness which included: workshops on healthy eating and living, workshops on financial health, free food and produce, family Zumba classes, and family reading circles. This summer we also continued our developmental playgroups for families who had children ages 0-5. In addition to providing playgroups at Belding Garcia we also provided them at the Monterey Pines Apartments in South Richmond. Twice a week for seven weeks, parents received hands-on, bilingual guidance for building language and literacy through everyday activities. In June 2019, a total of 75 unduplicated participants attended a playgroup.

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Sanctuary

From the start of the fiscal calendar year, in July 2018, 93 women participated in a total of 32 Black Women's and Latinx peer sanctuary support groups received facilitated support for self-care, advocacy for self and family, setting personal goals and reclaiming positive cultural practices.

The women report loving the opportunity to have this time to connect with other women in their community. Consequently, they show up regularly and bring other women to participate in these sessions. The Sanctuary has become a space and a community for women to receive emotional support and encouragement during challenging as well as during promising times. During this period, women participating in two groups have created or refined their existing plans to promote and improve their mental health and emotional well-being. They work with Sanctuary facilitators and other group participants to support them with their wellness goals.

2) Train and support families to self-advocate and directly engage the services they need.

The women in the Sanctuary groups continue to build a network that can regularly share information about resources, such as school events, workshops and community events with other group participants. In addition to sharing information within the Sanctuary groups, participants have displayed self-agency and personal empowerment with planning topics that are covered in the groups. In the Latina Sanctuary group, participants have been very clear about the topics and resources they are interested to learn more about, including an informational workshop on financial health given by SparkPoint Financial Services and women's sexual health. Women have shared that they want to learn more about sexual health and are feeling more comfortable talking about it in the group.

3) Provide a range of parent support services for parents/primary caregivers, including cumulative skills-based training opportunities on effective parenting approaches.

Nurturing Parenting

During the 2018-2019 fiscal year, BBK and the Child Abuse Prevention Council continued our Nurturing Parenting program. We continued to offer two classes for Spanish speaking parents called Crianza Con Cariño. These classes were offered at Chavez Elementary School in Central Richmond at our Health & Healing Center. In addition to the Spanish classes, we also offered the Nurturing Parenting class at Monterey Pines Apartments, a housing development in South Richmond. During the last fiscal year, 58 parents/caregivers successfully completed the 22-week program between the three community spaces in Richmond. During the mid-point check-in one parent stated: "I love this class. It has taught me to do something for myself which was something I didn't do it all before I started coming." "I have a really good relationship with my kids now. I try to watch what I say and how I say it."

When asked how the class had helped them, a parent shared, "This class is teaching me to be more conscious of the words I use when I communicate with my children, criticize less, be more tolerant, and listen better." Another parent shared, "I'm more conscious of my actions, and I'm learning to be more loving to myself. I understand that loving myself first will help me with my kids." Lastly, a parent shared, "I'm more patient, understanding, and most of all a better listener. This class has helped me to pause and take a moment before taking any actions or saying any words that I might regret later. I'm a better person, and a better mother because of this class."

Family Engagement Night (FEN)

During the 2018-2019 fiscal year, FEN remained focused on providing a safe, affirming environment during which families – parents and children together – are able to share a healthy meal and engage in interactive activities with service providers. Each month, a host organization provided information and materials regarding resources available to participating families and answered questions about challenges or needs. Host organizations included: BBK, the Richmond History Museum, Lifelong Medical Care, Wells Fargo, and First 5. Each host organization is a community partner with expertise in some aspect of family engagement and support and other content areas. In addition to Family Engagement Nights, BBK also provided families monthly Family Sanctuary nights. Family Sanctuary is a gathering where we invite families to strengthen their family bond. Families participate in activities that focus on deepening their relationships, strengthen their communication, and build a culture of positive social and emotional well-being within the family unit. Our ultimate goal is to offer a safe space where families feel comfortable spending quality time with their loved ones and build on their social and emotional skills to strengthen their family communication. Topics that were covered in Family Sanctuary included: Celebrating our Family History, Family Game Night, and Family Tree of Positivity. During this reporting period, we hosted 10 Family Engagement Nights at Monterey Pines Apartment with an average attendance of 15 participants at each event for a total of 146 participants. At our BBK location we hosted 11 Family Sanctuary events with an average of 19 participants at each event for a total of 215 participants.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

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Outcomes

A. Parents develop knowledge base on child development and positive parenting skills

Since July 2018, 58 adults have successfully participated in a 22-week positive skills parenting class. 155 adults participated in a parent-child, skills development playgroup during the summer months of 2018. In the month of June 2019, 75 adults participated in the parent-child, skills development playgroup.

B. Service providers are responsive to mental health needs and requests of Central Richmond families.

BBK Zone families are increasingly accessing mental health services. In the last year, we have seen an increase in the confidence that Central Richmond families have in our partner mental health organizations' ability to respond to their needs. Many of our partners have improved their responsiveness by following up with us right away when asked for their assistance in guiding or referring a family who needs support. They have also been willing to come to planned activities that put them in front of families where they are able to make important connections and build rapport. We see this is as an important evolution however; it has become apparent that responsiveness doesn't quite capture all that families are looking for in mental and emotional health support. It makes sense that Central Richmond families, especially those who are high need, have a minimum expectation that they're going to be able to connect to a provider who can help them when a need arises. Getting a friendly initial response might even be enough to solve some short-term problems, but many families are looking for more from providers. Responsiveness is what families expect, but resolution is what they really need.

Measures of Success

Sanctuary

Success Measure: 100% of the mothers participating in Sanctuary report a plan for supporting mental wellness for themselves
Result: 100% of the mothers participating in Sanctuary report a plan for supporting mental wellness for themselves

Success Measure: 80% of mothers will report progress on achieving at least one wellness goal.

Result: 100% of mothers reported progress on achieving at least one wellness goal.

All mothers reported that there is at least one other person from the group that they feel comfortable checking in with about their mental and emotional state, which was a goal for all participants.

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Parent Partner

Success Measure: 75% of parents that work with a Parent Partner will report that they feel safe, confident and more knowledgeable about how to advocate for mental health services for themselves, their child or other family members.
Result: Of the parents that responded to this question, 100% reported that they feel safe, confident and more knowledgeable about how to advocate for mental health services for themselves, their child or other family members. However, many of the undocumented Latinx families reported that they still did not know where to go to get services.

Parenting Support Services

Success Measure: 85% of all participants will report an increase in their use of positive parenting skills with their children
Result: At our midpoint check-in for our most recent parenting session, 100% of parents reported that there was an increase in their use of positive parenting skills with their children.

Linkages with Service Providers
BBK will establish procedures for identifying those individuals/families that need more intensive mental health support and hence referrals to other service providers.

Families and individuals were identified from Sanctuary and Parenting Classes and referred for services by members of the Health and Wellness team. It continues to be difficult to refer undocumented families for mental health services because of the dearth of services available to them.

Success Measure: 70% of families identified as needing mental health services will be successfully linked to providers.

It continues to be difficult to refer undocumented families for mental health services because of the dearth of services available to them. During this reporting period, two (2) program participants were referred to external mental health support services. Referral were made to Youth Service Bureau and the Center for Recovery and Empowerment (C.O.R.E).

Many BBK participants were referred to external support services such as those helping with, legal issues, childcare and short term financial crisis. From July 2017 to June 2018, BBK staff made five (5) referrals to internal and external support services. (For a total of 26 unduplicated clients.) Many BBK families consistently experience income volatility and are vulnerable and are negatively impacted when monthly income dips or there are unexpected increases in rent. Gentrification and displacement impacting the Bay Area region are currently impacting Richmond families. For our participants, the well-founded fears of losing their housing or difficulty finding money to cover a $100+ rent increase is extremely stressful and hard to mitigate. These financial pressures greatly impact the emotional and mental well-being of the families we serve.

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DEMOGRAPHIC DATA: ☐ *Not Applicable (Using County form)*

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Unduplicated BBK program clients
1 July 2018 – 30 June 2019

From July 2018 to June 2019, BBK served a total of 438 unduplicated West Contra Costa County residents. Among the participants, 205 (52.21%) were under the age of 18 and 224 (47.79%) were adults.

Race & Ethnicity

Overall, BBK's participants closely reflect the racial and ethnic demographics of Richmond's Iron Triangle neighborhood. Latinx comprised 73.74% of program participants and 61.1% of residents in the Iron Triangle census tracts. African Americans represent 20.95% of participants in the 2018-2019 fiscal year. and 24% of Iron Triangle residents. According to 2017 U.S. census estimates, ninety-four (94%) percent of South Richmond residents are people of color; 37% are African Americans and 49% are Latinx.

	BBK Clients		Iron Triangle Residents*	South Richmond Residents**
	Count	%		
African American	79	22.19%	24.7%	37.7%
Asian Pacific Islander	2	0.56%	6.9%	7.16%
Caucasian	0	0%	4.6%	4.27%
Latino/a	258	72.47%	61.1%	49.6%
Other Specified	17	4.78%	.5%	1%
Unspecified	0	0%		

*Source: US Census. 2012-2016 American Community Survey 5-year estimates. Includes CT3760, CT3770, CT3790, CT3810, CT3820. (details)

Monthly Client Counts

BBK served on average, between 148 and 278 residents each month — (BBK's large community summertime events make this number difficult to generalize.)

Gender

Most of BBK's clients are women and girls. 269 (72.51%;) percent of participants are female. 102 (27.49%;) percent of participants are male – these are mostly boys in BBK's childcare and family programs. (The gender of 17 clients was unspecified.)

Language Spoken

Because of the changing demographics of the Iron Triangle neighborhood and talents of the bilingual/bicultural staff at BBK, more than 229 (64.87%) of BBK program participants speak Spanish as their preferred language. 123 percent (34.84%); speak English. (The preferred language spoken was categorized unknown or unselected by 85 clients)

BBK's successful Belding-Garcia Park Playgroups and Latina Women's Sanctuary are attended mostly by Spanish-speaking women and the children in their care. This is due largely to the location of the programs at/near Cesar E. Chávez Elementary School. During the school year, eighty-nine percent (89%) of the students at Chávez Elementary are Latinx. Sixty-four percent (64%) of students are English Language Learners. Nearly all (94%) students at Chavez Elementary are low-income based on qualifying for free and reduced lunch. (Source:http://www.ed-data.org)

Justification for Selected Demographics.

1. Collecting extensive demographic information from our drop-in clients has been unfeasible and not suitable or proper in specific programmatic circumstances.

BBK's mental health prevention work is offered only in group settings (both small and large groups.) We have found that collecting detailed demographic information regarding each person's ethnicity, sexual orientation, gender at birth, and disability status using a self-administered MHSA demographic form was not feasible. At the time of BBK program registration, we are consistently limited to less than 1 minute per individual. Adults typically register themselves and each of their children (often up to 4).

It is important for BBK to understand who our clients are and to assess that we equitably serve Richmond families. As detailed in the report above, we routinely collect essential demographic fields (adult/child, race, gender, preferred language) on specially tooled dual-language sign-in sheets. (Available upon request.) Many of our participants are not strong readers in English or in Spanish. All self-administered forms must be simple and easy to understand/complete within a room full of distractions.

With the exception of the adults attending our Nurturing Parenting classes (only during weeks 6 through 22) –all other BBK program participation is on a drop-in basis. Many drop-in clients find even

the most familiar demographic information too personal or immaterial to their attendance. Sometimes it is necessary to piece together a client's demographic profile over time using personal identifiers and sequential sign-in sheets. We view this as part of building a trusting client relationship, and is only possible among clients who continue their group participation.

2. Some demographic information is not pertinent to most of the individuals and families we serve and not an efficient use of time and resources

BBK serves very few or no veterans. They are not excluded from our programs, just uncommon in the populations we serve. As stated above, we serve women and children who live in the Iron Triangle neighborhood (CT3760, CT3770, CT3790) and the nearby Belding-Garcia neighborhood (CT3730.) In these census tracts, the percent of female veterans is estimated U.S. Census Bureau to be 0%-0.7%. We served very few adult men in our programs. Men constitute 80%-100% of U.S. veterans living in our program service area. In FY 2018-2019 BBK can expect to serve fewer than 2 veterans among our total estimated 500+ clients based on Census data.

The inconvenience to clients to request additional information that is not pertinent to them and repetitive data entry for a null value isn't the best use of the limited time that families spend during BBK programs. Therefore, we do not include veteran status among the demographic variables we collect. (Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates)

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

The Nurturing Parenting classes that we offer families is an evidence-based program for parents and caregivers and their children to learn positive and caring nurturing skills. Nurturing Parenting is a trauma informed, family-based program designed for the prevention and treatment of child abuse and neglect. Family Development Resources, Inc. provides programmatic materials, training and ongoing technical assistance to support program implementation. Training and support are also provided by Family Nurturing Centers, International which are organizations licensed by the Family Nurturing Center's national office to provide training, technical assistance, and services by nationally and internationally recognized trainers and consultants. Our team meets weekly to plan activities for the children's program and e use the Nurturing Parenting program manual to ensure that all activities are aligned with what is being taught in the parent program.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Since its founding in 2005, BBK has been a community of social innovators working to support Black and Latin families in Central Richmond. We support families to use their voices and experiences to directly inform the systems they interact with and which impact them.

Beginning last fall, BBK launched a strategic planning process to guide our theory of change for the next 3-5 years. We identified programmatic shifts to achieve a values-aligned structure and practices that support our new mission and vision. BBK envisions empowered communities that are wellness-centered and have equitable access to high-quality education, where healthy families blossom to realize their dreams and full potential. An important outcome of our strategic planning process was for BBK to have organizational clarity that allows integration and innovation of community change strategies that result in improved well-being for children and families in Richmond and surrounding West Contra County. Moving forward, our three core strategies are parent-led advocacy, healing-centered care and leadership development. These strategies drive our mission to amplify the voices of parents/caregivers of color and partner with them to advance equitable access and opportunities for all youth to have a quality education and all families to achieve emotional and physical well-being. Our staff will continue to keep families' health & wellbeing at the forefront of our work in all of our programming. Our new approach continues to align with and bolster MHSA's PEI goal of **providing activities intended to reduce risk factors for developing a potentially serious mental illness, and to increase protective factors**.

BBK's theory of change is simple and enduring: by providing healing centered care, leadership development, and activating inclusive parent-led advocacy, we support the personal and collective transformation of parents and caregivers as they reclaim their power. Furthermore, we seek the transformation of education and health systems, so that all youth achieve success and all families experience positive emotional and mental well-being. We collaborate with families to overcome trauma and barriers so that they may strengthen their ability to support their children, family, and community toward healthy, successful development. Efforts focus specifically on ensuring the well-being of parents and supporting parents to determine long term success for their children. We do this by offering nurturing and culturally responsive environments where parents can heal and identify practices that promote well-being. We also help parents make direct linkages to mental health tools and resources that may not otherwise be accessed. Furthermore, we provide skills-based training that develop the leadership capacity of parents/primary caregivers. Our ultimate aim is that Richmond and West County parents/primary caregivers' effect positive changes in home, schools and neighborhoods to ensure that they are responsive to the needs of families and children.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those

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of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.

BBK continues to commit to the growth and development of our program participants such as Rihana Idris and her family. Through our work at Monterey Pines Apartments we had the honor of meeting. Rihana when she registered for Nurturing Parenting classes. Rihana built relationships with BBK staff, fellow classmates and neighbors and became very interested in BBK programming at Monterey Pines and became a regular participant in the Black Women's Sanctuary group and Family Engagement Night. Rihanna always invites family members, friends and neighbors to our events and activities. Recently Rihana shared that, "the Nurturing Parenting Program and the Family Engagement Night events have helped me be closer with my children and devote more quality time to myself and them." "I really value what I have learned in class." "I now take the time to take care of myself and do things to make me feel relaxed, like go to the movies for example." "I feel very excited and motivated to continue to learn. As a result of taking the Nurturing Parenting program, I signed up for English classes at Berkeley Adult School."

We have had the pleasure of working with Claudia Castro another program participant. Claudia was introduced to BBK at Chavez Elementary School, the school her son attended. Claudia is a regular participant of the Latina Sanctuary group and the Crianza Con Cariño classes. She shares that participating in BBK programming has helped her have a better relationship with her family and believe and value herself. She shares that before she participated in BBK programming she felt very depressed and alone because she does not have a lot of family, but now all that has changed. She says that the groups have allowed her to see that there's a world outside of her family, and has learned who she is as an individual. "These programs have helped me value myself and get rid of the negativity." "They've also helped me be a better mom and wife." "I no longer feel alone." As a result of participating in BBK programming and her increased confidence, she is now taking English classes at her son's school. She's gotten a part- time job at a local restaurant, and volunteers at her son's school. She is making positive changes in herself, her family, and her school community.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: Center for Human Development - African American Wellness Program

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **Provide access and linkage to mental health care**

☑ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Center for Human Development's African American Wellness Program provides prevention and early intervention services that empowers clients to: 1. Increase emotional well-being. 2. Decrease personal stress and isolation. 3. Increase their ability to access culturally appropriate mental health services.

During the course of the contract, staff will provide MHSA-PEI services to African Americans living in Bay Point, Pittsburg and surrounding East County Communities. The annual goal is to reach 200 unduplicated individuals From July 1, 2018 through June 30, 2019.

Key activities included culturally appropriate education on mental health topics through three open ended Mind, Body and Soul support groups; community health education workshops; outreach at health –oriented community events; and navigation assistance for culturally appropriate mental health referrals.

Taylor Morgan, former Community Health Advocate, Risha LaGrande, and Michelle Moorehead, current Community Health Advocates, co facilitated the services listed below from January 1, 2019

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through June 30, 2019. Ms. Morgan was a full-time employee of the Center for Human

Development, working with Risha LaGrande and our participants of the Mind Body and Soul support group. East County Office location is at the Sparkpoint Center in Bay Point. Through collaboration with Sparkpoint and seeing the valuable resources that the African American Wellness Program provides to participants and the local community. We are able to have office space while collaborating with their services.

The program activities during the 6 month period included the following:

Facilitate four Mind, Body, and Soul support groups in four separate locations:

- **Pittsburg Health Center**, Pittsburg, first and third Monday evening, 12 open-ended, ongoing sessions.
- **Ambrose Community Center**, Bay Point, first and third Wednesday afternoon, 12 open-ended, ongoing sessions.
- **Pittsburg Senior Center**, second and fourth Wednesday afternoon, Pittsburg, second and fourth Wednesday afternoons, 12 open-ended, ongoing session.
- **Antioch Library, Antioch**, second and fourth Thursday evening, 12 open-ended, ongoing sessions.

Facilitate Community Mental Health Education workshops based and community-based organizations in East Contra Costa County.

Conduct outreach services at community events in East Contra Costa County.

Provide navigation of health services, including mental health referrals, for new and continuing clients in East Contra Costa County.

The four Mind, Body, and Soul support groups follow the same format. Often the same topics are presented in the different groups. The topics are related to “Emotional Wellness” which is the term that is more welcoming than “Mental Health” for many African Americans. Guest speakers are often featured as well. Besides the topic and discussion, each session includes a “fellowship” time with healthy refreshments. This “fellowship” time is culturally appropriate for African American participants and is an initial “draw” to the groups.

As of January 1, 2019, the African American Wellness Program went through a few changes to the Mind Body and Soul Support Groups that Ms. Morgan and Mrs. LaGrande facilitated. One of Ms.
Taylor’s objectives were to reduce the stigma attached to the label “mental health” for participants in the Mind Body and Soul Support Group. Another objective was to make the support groups more accessible. Morgan and LaGrande attempted to increase the participation young adults from the community. The changes were made to the scheduled meeting times for the Pittsburg Health Clinic. The afternoon group switched to an evening time slot to appeal to a younger demographic who were either at school or work during the day. Also, a group was added to serve the residents of Antioch.

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During this six month period starting January 1, 2019 through June 30, 2019, Taylor Morgan created a curriculum for the support groups to grow in areas of self-worth and knowing their true value.

Curriculum

Always reiterate self-worth, give value to one another and allow them to envision the benefits of taking care of themselves is a necessary part of life. Sharing daily with the group shows they are worth it and reminds them that helping others mean they have to help themselves first.

1. ***Pittsburg Health Clinic, Mind, Body, and Soul Support Group***, first and third Monday evening, seven (7) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 7 times. Two (2) of the location's group days fell on a Holiday both in the months of January and February which is the reason for minimum groups.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

2. ***Ambrose Community Center, Mind, Body, and Soul Support Group***, first and third Wednesday afternoon, twelve (12) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 12 times.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

3. ***Pittsburg Senior Center, Mind, Body, and Soul Support Group***, second and fourth Wednesday afternoon, nine (9) open-ended, ongoing sessions.

From January 1, 2019 through June 30, 2019, the group met 10 times. Two of the days missed were due to facilitators out sick and the community center repainting interior building.

- Topics presented: Life Cycle and the Whole Person; Hypertension Prevention; Social Health; Powerful vs. Un-Powerful People (KYLO chapter 1); Emotional Wellness-Processing Emotions; Spiritual Wellness-How to Fill Your Spiritual Tank; Overall Wellness for "The Whole You"

4. ***Antioch Library, Mind Body and Soul Support Group***, second and fourth Thursday evening, six (6) open-ended ongoing sessions.

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From January 1, 2019 through June 30, 2019, the group met 6 times. Some groups during the month of May and June were cancelled due to transitional period between the former Community Health Advocate, Taylor Morgan and the current Community Health Advocate Michelle Moorehead.

The African American Wellness Program has a goal to facilitate Community Mental Health Education Workshops, attend outreach events, and community-based organizations in East Contra Costa County. Unfortunately, no workshops were offered during the first half of the fiscal year. The program made an effort to make up missing workshops in the following six-months of the fiscal year.

From January 1, 2019 through June 30, 2019, one (1) health-oriented workshop event was conducted to educate the community.

- ***Hello Me! Wellness Workshop***- May 11, 2019; Community Awareness Reached 15 people

From January 1, 2019 through June 30, 2019, six (6) community outreach services were conducted Locations and Topics included below.

- ***Job Club Presentation***- February 04, 2019 Reached 7 people
- ***Black History Event***- February 16, 2019 Reached 104 people
- ***Sexual Assault Awareness Event***- February 27, 2019 Reached 18 people
- ***Mother's Day Gala***- May 4, 2019 Reached 35 people
- ***Memorial Celebration***- May 27, 2019 Reached 14 people
- ***Unity In Community***- June 22, 2019 Reached 77 people

The African American Wellness Program provided navigation of health services, including Mental Health referrals, for new and continuing participants in East Contra Costa County, for a minimum of 90 clients.

From January 1, 2019 through June 30, 2019, Mental Health service referrals were provided to 17 new clients.

From January 1, 2019 through June 30, 2019, Community Support Service referrals were provided to 16 new clients. The combined Mental Health referral and community resource/referral total to 33 new client referrals.

Referrals, including mental health referrals, were made to these groups: Crisis Center 211, Contra Costa Mental Health Access Line and community resources. It is important to consider all referrals due to the necessity of immediate needs, such as food, water, shelter, and regular physical medical care being met before mental health can be addressed and maintained.

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

For July 2018 to December 2018, the program served 147 individuals, however only 107 individuals are accounted for on the roster; the data and percentages that were calculated are based on these numbers recognized on the roster. The African American Wellness Program underwent a transition when the previous community health advocate, Cynthia Garrett, left her position at the Center for Human Development in July of 2018 and the new community health advocate, Taylor Morgan, started in the position on September of 2018. Due to the transition there were some missing files/names that were unaccounted resulting in individuals recognized as unduplicated in monthly reports to be unrepresented in the reports and roster. As mentioned before, there were fewer workshops and outreach events completed during the first half of the fiscal year.

Going forward, date will be saved in triplicate on the computer, on a thumb drive, as well as in a hard copy file system according. The numbers reported in this narrative and the reporting forms represent program participants and community members, which were identified as needing Mental Health services and support provided by the African American Wellness Program: the Mind, Body & Soul Psycho-educational Support groups, Community Education Workshops, Community Outreach, including health fairs and similar events, and one-on-one consultations for referrals and system navigation.

CHD has been working with an evaluator to develop Pretest and Posttest surveys to measure the knowledge, awareness, attitude and behavior change for participants in Mind, Body and Soul groups. The instrument has 17 questions, which can be compared after the Posttest has been tabulated.

CHD will use Posttest tabulated to complete results June 2019 for the final results.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

African American Wellness Program Roster for Support Groups from July 2018 through June 2019 totals 123 unduplicated attendees. For the year including the workshops and events we totaled 342 people and 114 of our outreach came from our newly added Social Media page on Facebook.

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This was another addition that began in the month of February 2019 to strictly outreach and get the young adults to gather in person for our Mind Body and Soul Support Groups in one of our four locations.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants, who attend the Mind, Body & Soul Support Groups, receive an assessment tool to identify barriers. Participants are individually provided services to help them to address the current issues they are facing. Participants are referred to Contra Costa Crisis Center 211, Mental Health Access Line and community resources. The program manager and resident leader assist participants by helping them to navigate through the systems so that they can receive care and learn to advocate and navigate for themselves in the future. The community health advocate will call the Mental Health Access Line with participant, ensuring participant to get an appointment. The community health advocate also supports clients by attending their doctor's appointments to help in supporting and advocating for the client's care and help to create effective communication and mutual understanding between the client and their provider.

The appointment is scheduled from initial phone call. The time for scheduling an appointment and seeing a therapist or other provider time frame is up to 3 weeks. The program manager and resident leader follow up with participants within a week to check on progress.

The Healthy living questionnaire is administered to every Mind, Body & Soul Support Group participant in the beginning of the year. Based on the assessment this tool provides staff with information about participant's emotional wellness and the need for individual check in and possible referrals.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The African American Wellness Program serves adults ages 18 and older, living in East Contra Costa County. African American Wellness Program supports their clients and participants by empowering them to recognize and achieve inner strengths, use coping strategies to maintain emotional wellness, and providing tools, resources, and referrals for increasing their emotional wellness and reducing client stress and isolation. The program creates a welcoming, safe and confidential environment for their participants.

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The Mind, Body & Soul Support Group helps give the participant hope, while facing challenges by helping them to address and overcome barriers such as; homelessness, no medical coverage, lack of transportation, lack of shelter and lack of food. African American Wellness Program supports their participant's needs by linking clients, who are low income and disadvantaged due to lack of resources. The African American Wellness Program serve the community by reaching out to many people have lack of outreach engagement to Mental Health Services, Community Resources and referring them to the appropriate medical service providers. Participants enter the program through word of mouth, referrals, community outreach and mental health Pittsburg Health Clinic. The key activities are as follows: Outreach at Community Events, Culturally appropriate education on mental health topics through the Mind, Body & Soul Support Groups, Community Health Education Workshops in accessible and non-stigmatizing settings. We offer navigating assistance for the culturally appropriate, Mental Health Referrals as early in the onset as possible.

Participants in Mind Body & Soul Support Groups generally report a feeling of resiliency. In other words, the group is the supportive system they need to begin the healing process from the hardship or trauma that may have encountered their lives unexpectedly. We strive to teach the very tools and techniques that will help to defuse a crisis situation by using some of our self-care practices such as breathing, mindfulness, taking a brief walk, etc. The Mind Body & Soul Support Groups attempted to appeal to young adults ages 18-29 years, with new evening classes as well an online way to inform the community of our services. We got inquiries from numerous interested participants from a Social Media page. Although, we found many were not comfortable with participating in an in-person group setting. We were able to provide linkages to needed resources and referrals. Former Community Health Advocate, Taylor Morgan, conducted one-on-ones to assess health needs and basic needs, collect intake information and follow-ups, and provide navigation and referral information.

Our numbers dropped significantly due to a change of time for the Pittsburg Health Clinic Group and an added, still forming group located in the Antioch area. Community Health Advocate, Michelle Moorehead, reconnected with the Pittsburg Clinic to arrange a new day and time to meet. Now that we have ongoing classes at the clinic, the numbers have picked up again and we are confident that the Mind Body & Soul Support Group will continue to grow. As of September 2019, we have located another site for Antioch group, which we also hope will boost attendance.

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

Success Stories:

Story #1

R.M. is one of our male participants, age range 26-59 years old. He has attended the Mind, Body and Soul (MBS) Support Group. He is a long term participant of the program. R.M. came to the group for support for depression, and heart disease. During his time attending he was diagnosed Diabetes and High blood pressure. He was given referrals for diabetes classes, and hypertension classes. As a result, R.M. has managed to learn how to eat better, and walk more. His health has improved from the changes he has made attending the support group, and using the referrals, tools and techniques learned in our support group.

Story # 2

V.M. is one of our female participants, age range 60+ years old. She has attended the Mind, Body and Soul (MBS) Support Group. She is a long term participant of the program. V.M. came to the group from a referral from another participant. She needed emotional support regarding daughter diagnosed with Cancer. V.M. was given referral to Mental Health Services Access line. V.M. has improved from counseling and attending M.B.S. support group. She also has been walking, and eating healthier, which is helping her a great deal emotionally. She continues to attend the group because of the warm family atmosphere.

Story # 3

V.T. is one of our female participants, age range 26-59 years old. She has attended the Mind, Body and Soul (MBS) Support Group. She is a long term participant of the program. V.T. came to the program for support for anxiety. During her time attending she was diagnosed with High Blood Pressure. She was given a referral for a Hypertension class. V.T was assisted in changing her Primary Care Dr. Her new doctor helped her focus on her current health challenge better. V.T. has improved a great deal attending M.B.S Support group. She has changed her eating habits to a Low-Salt diet, working with her Primary Care doctor and receiving emotional support from the group. She can now face her health challenges.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: Center for Human Development – Empowerment Program

PEI STRATEGIES:
Please check all strategies that your program employs:

☑ **Provide access and linkage to mental health care**

☑ **Improve timely access to mental health services for underserved populations**

☑ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Center for Human Development's Empowerment Program provides weekly support groups, youth leadership groups, and mental health resources for lesbian, gay, bisexual, transgender, queer, questioning (LGBTQ+) youth and their heterosexual allies, ages 13 – 18, in East Contra Costa.

The annual goal is to reach 80 unduplicated youth from July 1, 2018 through June 30, 2019. During the course of the contract, staff will provide the following services:

Component 1: Facilitate educational support group sessions at Pittsburg High School in Pittsburg, twice per week during the academic school year, totaling at least forty (40) but not more than fifty (50) open-ended group sessions.

Component 2: Facilitate one (1) weekly educational support group sessions at Deer Valley High School, Antioch during the school year; totaling at least twenty (20) but not more than twenty-five (25) sessions.

Component 3: Facilitate one (1) weekly educational support group at Rivertown Resource

Center (or satellite office) in Antioch, Wednesday afternoons totaling at least thirty (30) but not more than thirty-six (36) open-ended ongoing sessions; this group meets year round; educational support groups contain a social-emotional support component along with educational discussions, workshops, activities related to LGBTQ identity, culture, relationships, mental health and wellness.

Component 4: Facilitate twice-monthly youth leadership groups totaling at least sixteen (16) but not more than twenty (20) ongoing sessions at Rivertown Resource Center, Antioch.

Component 5: Facilitate four (4) per year youth-led community service projects and skill-building field trips.

Component 6: Refer youth to culturally appropriate mental health services on an as needed basis including referral support to a minimum of 15 youth.

Component 7: facilitate monthly educational workshops and/or informational speakers at Rivertown Resource Center including nine (9) workshops annually.

Component 8: Facilitate community educational outreach/psycho-educational workshops including four (4) per year.

Kevin Martin, Empowerment Program Coordinator, facilitated the following services from January 1, 2019 through June 30, 2019. Mr. Martin is a full-time employee, working 40 hours per week on the project. During this reporting period, Empowerment has worked with 91 unduplicated youth, for an annual total of 137, which far exceeds our annual goal of 80 unduplicated youth.

Component 1: Facilitate 40 to 50 weekly meetings at Pittsburg High School, Pittsburg for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location helps to increase access in several ways: it eliminates the need for additional transportation, as students are already at school; there is a network of supportive school staff and service providers working at Pittsburg High School, allowing for expedient linkage to additional support services as needed; and youth are more inclined to engage in support services, including Empowerment, when they can do so with, or supported by their peers and with reduced anxiety of being "outed" to their parents, or guardians.

> From January 1 through June 30, 2019, Kevin Martin facilitated 21 sessions of youth support groups on the campus of Pittsburg High School, for an annual total of 31. The number of meetings is below the goal of 40 to 50 sessions for the year. This is primarily due to conflicts with students' class schedules; several students note not being willing or able to be pulled from certain required classes. For this reason, Kevin was not able to form a second group until late in the year. Also, although the school has designated one classroom for support programs to facilitate groups, there is still a shortage of confidential meeting space at this site; service providers and school staff are constantly juggling

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available space and time to meet with students. Even with this challenge, CHD staff continues to receive new referrals from school staff, students and service providers on campus, and, as previously noted, has establish a regular time to meet with a second group at Pittsburg High School, in order to meet this need. The average group attendance for this period was 5. Low attendance was 2 and high attendance was 8. These groups did not meet during "dead week" (final exam prep), during finals week, or while the school was closed for recess in April and June. Staff continued to work closely with school staff and other service providers on campus to secure space for groups, as providing services at Pittsburg High School fills a need for youth who have difficulty with transportation to Antioch, and/or are not "out" in some aspect of their life (i.e. peers, family, or community). CHD also staff conducted 68 individual check-ins and one-on-one assessments with students during this period.

Topics for the Pittsburg group included: group development, establishing group norms, conflict after relationships end, addressing personal boundaries with friends, characteristics of healthy friendships, closing unhealthy relationships, healthy romantic relationships, social group conflict, disconnecting from peers after graduation, closing relationships with friends (how to have difficult conversations), sharing mental health concerns with family, coming out to family, stress management, time management, identity, reconnecting with family after coming out, coming out to extended family, applying for a job, LGBTQ Pride, self-care, end of year concerns, Prom, mental health awareness, group closure.

Component 2: Facilitate 20 to 25 weekly meetings at Deer Valley High School, Antioch for LGBTQ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location helps to increase access in a few ways: it eliminates the need for additional transportation, as students are already at school; youth are more inclined to engage in support services, including Empowerment, when they can do so with, or supported by their peers and with reduced anxiety of being "outed" to their parents, or guardians; and until very recently, CHD's Empowerment Program has been the only external mental health service providers working with LGBTQ+ youth at Deer Valley High School, allowing LGBTQ+ students access where otherwise there would not be any.

From January 1 through December 30, 2019, Kevin Martin facilitated 17 sessions of youth support groups on the campus of Deer Valley High School, for an annual total of 24. The number of meetings meets our goal of 20 to 25 sessions for the year. This group saw exponential growth during this period, largely due to word of mouth by participants and referrals from school counselors. This school runs on a block schedule, group is held during the final hour of the school day. Staff continued to receive referrals from school staff and students right up to the end of the school year, indicating the high level of need for this population in this area. Average group attendance for this period was 9. Low attendance was 5 and high attendance was 13. This group did not meet during "dead

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week", during finals week, or while the school was closed for recess in March and June. CHD also staff conducted 25 one-on-one meetings with students during this period.

Topics for the Deer Valley group included: group development, highs and lows of winter break, artistic expression, identifying feelings, characteristics of healthy friendships, characteristics of healthy romantic relationships, Queer Black History, gender versus sexual orientation, health issues for youth at Deer Valley High School, stress management, time management, Spring break highs and lows, "Every 15 Minutes" and alcohol awareness, communicating in relationships (asking for what you want), LGBTQ Pride, group closure.

Component 3: Facilitate 30 to 36 weekly meetings at Rivertown Resource Center, Antioch for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Providing services at this location has challenges, but is the only year round, drop-in support program for LGBTQ+ youth in East Contra Costa County, providing access to youth from Bay Point, Pittsburg, Antioch, Oakley, and Brentwood.

From January 1 through June 30, 2019, Kevin Martin facilitated 20 sessions of youth support group in Antioch, for an annual total of 42. The group met at Rivertown Resource Center at 10th and D Streets. The number of meetings exceeds the goal of 30 to 36 sessions for the year. There was a shift in attendance during this period, with a slight increase toward the end of the year. This shift was due to several factors, increased family obligations, a lack of consistent transportation to and from group sessions, after school conflicts, and lack of parental or guardian support. The increase was due to the school year coming to a close and an increase in parental support for help seeking. This group had an average attendance of 5 youth per session for this reporting period. Low attendance was 2 and high attendance was 11. Staff noted that attendance spiked when schools were not in session and when special social events were scheduled. Staff addressed the challenge of transportation by utilizing CHD's agency van to pick up and drop off youth for this group. CHD staff also conducted 50 one-on-one meetings with youth during this period.

Topics for the Rivertown group included: group development, highs and lows of the holidays, creative expression through art, self-care, characteristics of healthy friendships, characteristics of healthy romantic relationships, Queer Black History, stress management, LGBTQ Pride artistic expression, "Love Simon" movie screening, avoiding isolation, mental health awareness, deterrents to seeking mental health support, Empowerment art project, processing grief and loss of a close friend, "The Pride Movement" film screening, LGBTQ Pride, "Milk" film screening, LGBT activism, and highs and lows of the East County LGBTQ+ Youth Pride "Justice" Prom.

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Component 4: Facilitate 16 to 20 twice-monthly youth leadership groups to foster community involvement. These groups meet at Rivertown Resource Center and are held in conjunction with support group meetings discussed in Component 3.

From January 1 through June 30, 2019, the youth leadership group met 3 times, for an annual total of 7 sessions, which is below our goal of 16 to 20 sessions for the year. The group met at Rivertown Resource Center at 10th and D Streets. The average attendance was 2, with 2 being a low and 2 being a high. Consistent attendance to Leadership sessions has been a challenge, so staff is to meet with Leadership around regular Empowerment group meetings at Rivertown Recourse Center. This is exposing more members to Leadership and helping to address challenges associated with jobs, after school schedule conflicts and transportation hurtles, which are also noted challenges for Component 3.

Though engaging a group for Leadership was a challenge, staff was able to identify a dedicated Youth Leader, who was tasked with leading the planning and coordination of our LGBTQ+ Youth Pride "Justice" Prom, with the support of staff and in collaboration with Rainbow Community Center staff. Staff met and worked with this Youth Leader several times, for a total of 31 hour, throughout April, May and June. This Youth Leader was given a stipend for their work and leadership on this project.

When Leadership met, they focused on activities to support and promote our LGBTQ+ Youth Pride "Justice" Prom and our fieldtrip to the Castro District and GLBT History Museum. CHD staff also conducted 4 individual 1-on-1's meetings with youth during this period

Component 5: Facilitate 4 youth-led community service events or fieldtrips to foster community involvement. These events occur in various locations, increasing East Contra Costa County LGBTQ+ youth's knowledge, experience of, and access to a range of surrounding communities, programs and support services.

With 2 youth-led events or fieldtrips during this period, we met our goal of 4 events or fieldtrips for the year.

June 14 - East County LGBTQ+ Youth Pride "Justice" Prom. In collaboration with our community partner, Rainbow Community Center, our Youth Leader and staff planned and hosted the only Pride Prom for LGBTQ+ youth in East Contra Costa County. The event was held at Community Presbyterian Church, and open, welcoming, and LGBT affirming church in Pittsburg. The event was held from 6pm to 10pm and was attended by 58 area youth. This event gives area LGBTQ+ youth an opportunity to celebrate LGBT Pride month locally in a safe and supportive environment. Youth were engaged in group games, music and dancing, an affirmation wall, a photo/selfie booth, and fun contests. All

attendees were given safety/self-care resources and promotional materials for the Empowerment Program and Rainbow Community Center services.

June 26 – Fieldtrip to the Castro District and GLBT History Museum, in San Francisco. Empowerment took 16 youth and 4 adult chaperones to the Castro District, in San Francisco using public transportation. Youth gained knowledge and experience using both BART and MUNI public transit systems. Upon arrival in the Castro District, attendees were treated to lunch at "Harvey's Restaurant", a local bar and restaurant themed to honor San Francisco's first Gay Supervisor, Harvey Milk. Attendees were then taken on a guided walking tour of several of the district's LGBTQ+ historical sites. Guided by a "Cruisin' the Castro" guide, attendees visited the Pink Triangle Garden (a memorial garden honoring the more than 15,000 gay men who were imprisoned and killed during the Holocaust), the building where the Name Project started the Memorial AIDS Quilt, Lyric's youth center, the Harvey Milk Civil Rights Academy (the district's elementary school with a specific focus on civil rights and activism celebrating diversity and inclusion), and the Human Rights Campaign's (HRC) store located in the location of Harvey Milk's camera shop and campaign headquarters. At the conclusion of the walking tour, attendees visited the GLTB History Museum, the country's first dedicated to the LGBTQ+ history and civil rights movement. Here attendees received a tour led by a docent who shared historical information and stories for each of the displays in the museum.

Component 6: Refer youth to culturally appropriate mental health services on an as needed basis, referral support to a minimum of 15 youth.

Specific referrals for new mental health support were made for 3 youth during this period, for a total of 7 for the year. This number is short of our target of 15 annual referrals. One was made for youth at Pittsburg High School, one was made for a youth at Rivertown Resource Center, and one was made for a youth at Hillview Junior High School. Referrals were made to SEEDS for peer conflict mediation, Rainbow Community Center for therapy, and Community Violence Solutions for therapy. All Empowerment participants also receive an emergency phone list with listings for the Contra Costa Crisis Center, Trevor Project, GLBT Youth Talk-line, Planned Parenthood, Homeless Hotline, Run Away Hotline, Community Violence Solutions, and STAND Against Violence.

It is important to acknowledge that many of Empowerment's participants, this year, were referred to CHD's Empowerment program for additional social-emotional support from other mental health providers. Thus, these participants were already connected and engaged in culturally appropriate mental health services, rendering additional referrals unnecessary.

Component 7: Facilitate monthly educational workshops and/or informational speakers at Rivertown Resource Center including nine (9) workshops annually.

As was noted in our semi-annual report, due to the attendance and transportation

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challenges noted in components 3 and 4, staff has held off scheduling outside speakers and presenters this year. As an alternative, staff started a new educational support group at a new school, Hillview Junior High School, in Pittsburg, CA, in response to a call for support from the school's administrators, after a series of bullying incidents. This was not only an opportunity mitigated challenges with transportation to Rivertown Resource Center, in Antioch, but also directly meets current needs in the community while increasing the reach and potential impact of CHD's Empowerment Program serves.

Staff held 9 group sessions, beginning in March, for LGBTQ+ youth and their allies to promote emotional health, positive identity, and reduce isolation through life skill development. Although this is a new group and location, participation grew quickly, with an average attendance of 6. The low attendance was 2 and the high was 10. Participants came to this group primarily through referrals from the school's counseling staff, administrators and teachers, as well as from other service providers working with students at the school, including: CHD's Project Success program, CHD's Four Corners program, Contra Costa Health Services Mobile Clinic staff, Lincoln Children's Services clinicians and JFK University clinicians. CHD staff also conducted 24 one-on-one meetings with youth during this period.

Topics covered in this group include: group development, establishing group agreements, identity development, bullying, grief and loss of loved ones, gender versus sexual orientation, LGBT history and icons, gender transitioning, mental health awareness, appreciations and group closure.

Research is increasingly showing that junior high is a significant period of heightened bullying, stress and trauma related to gender identity/expression and sexual orientation. Staff believes this is an ideal point to introduce Empowerment's prevention and early intervention supports to help manage stress, mitigate trauma, increase social-emotional supports, connectedness, and life skills, reducing the potential development of serious mental health disorders.

Component 8: Facilitate community educational outreach/psycho-educational workshops including four (4) per year.

From January 1 through June 30, 2019, Kevin Martin facilitated 1 educational outreach/psycho-educational workshops, for an annual total of 3. This is just short our goal of 4 workshops for the year.

May 23: Kevin co-facilitated an all-day Inclusive Classrooms training for teachers and staff of Pittsburg Unified School District (PUSD), at the PUSD offices, in collaboration with Rainbow Community Center training staff. Approximately 30 teachers, staff and district administrators, representing all schools in the district, elementary through high school, attended.

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Information on mental health topics and services comes up "naturally" during the weekly support groups so this is not seen as a "stand alone" component by staff. However, regular, periodic check-ins and occasional one-on-one meetings and assessments are provided when staff identifies possible "red flags", such as symptoms of anxiety, depression, and suicidal ideation, or youth are distressed. During check-ins and one-on-one meetings, staff always inquires as to youth's experiences, interest, and willingness to participate in mental health services, outside and in addition to Empowerment's programming. Staff also periodically administers the Adolescent Mental Health Continuum Short Form (MHC-SF) during one-on-one meetings to help assess need for referral to mental health services. Staff has had 171 individual one-on-one meetings with youth during this reporting period, as noted in the individual components above, for a total of 286 for the year.
As noted in the previous section, specific referrals for new mental health support were made for three (3) youth during the second half of the year. The current average length of time between report of symptoms onset and entry into treatment is 1.4 months; 1 entered treatment after 1 week, 1 was waitlisted due to staff shortage and one did not enter treatment after referral. The methodologies used during treatment are generally unknown to Empowerment staff, as Empowerment staff does not provide therapy, and all mental health referrals are made to external providers.

DEMOGRAPHIC DATA: ☑ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

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LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

As noted previously, all Empowerment participants receive an emergency services "Phone Tree", including contact information for CHD's Empowerment Program, Contra Costa Crisis Center, The Trevor Project, Planned Parenthood, Community Violence Solutions, STAND Against Violence, Runaway Hotline, Homeless Hotline, as well as having space to add information for trusted adults and friends. Additional referrals and linkages are provided as needed, and upon participant assent. Direct linkages are made via phone, fax or in person, such as during Care Team meetings at school sites.

1) General encouragement of all participants to seek services that could be of support to them is continual during all group sessions. Specific and direct encouragement and referrals are offered to participants during one-on-one check-ins and assessments by Empowerment staff. Staff administers the Adolescent Mental Health Continuum Short Form (MHC-SF) periodically during one-on-one meetings to help assess need for referral to mental health services.

2) Empowerment staff follows up, verbally, with participants regarding referrals to external services on a weekly basis until participant successfully engages in services, or no longer wishes to engage services. Individual check-in and follow ups are provided monthly, or as need arises, thereafter. The current average length of time between referral and entry into treatment is 1.4 months. Methodologies used are determined by participants and the external service provider with whom they enter into treatment.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Empowerment is a social-emotional and educational support program for LGBTQ+ youth, ages 13 to 20, in East Contra Costa County, which is a highly diverse community in regard to ethnic makeup and socio-economic status, with large percentages of Latino/a, black, and low-income families. Youth enter the program through referrals from self, peers, family, school staff, and other service providers. Staff works hard to create safe, welcoming, confidential spaces for all who attend Empowerment. This is facilitated by the development of group norms, which all attendees agree to adhere to. During groups and during one-on-one sessions youth work to identify and process challenges and struggles they face, then identify

and develop internal strengths, coping mechanisms and tools for building resiliency and working through challenges, with the encouragement of Empowerment staff and peers. Through the process noted above, when youth are identified to need or would benefit from support services beyond the capacities of Empowerment staff, referrals and linkages are made to culturally appropriate service providers. All youth in Empowerment are treated with respect as individuals, and staff makes a concerted effort to do so without bias or judgment. All LGBTQ+ youth, ages 13-20, and their heterosexual friends are welcome to join Empowerment's groups and their level of participation is completely voluntary.

In Empowerment, LGBTQ+ youth are engaged in discussions topics, workshops and activities that are common to the LGBTQ+ community, such as: identity development, the process of coming out, rejection and fear of rejection, isolation, harassment, bullying, discrimination, anxiety, depression, suicidality, healthy relationships, relationship violence, community development and engagement, leadership and activism, physical, mental and sexual health and safety.

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

This year, Empowerment staff was approached by administrators at Hillview Junior High School to help them support their LGBTQ+ students after reports were made of several incidents of bullying, "outing" and cultural insensitivity by both students and school staff. Staff has been welcomed into the school's COST team, where staff can share information and support staff and receive referrals for students who might benefit from Empowerment program support. Students have also been receptive to having an Empowerment group and individual support on campus. According to participant comments given on post-survey, participants were very happy to have a safe space to talk about sexual orientation and gender identity without judgement, or fear of being harassed by others. Even though this group only met for a short time, 3 months, participants from diverse backgrounds and social groups were able to come together amicably, were willing to discuss difficult and sensitive topics, and were able to offer support to one another. School administrators, staff, students and service providers all expressed their hope and support for CHD's Empowerment to continue to support Hillview Junior High students in the upcoming year.

RH, is a 15 year old, gay identified male at Pittsburg High School (PHS). He was referred to Empowerment staff by his guidance counselor after a bullying incident. RH was out to his peer at school, but not to his family. Though RH always believed his parents would accept and support him, he held a lot of anxiety that their Hispanic cultural beliefs might cause a negative response. RH first attended group in December, just prior to the winter recess break. He was very quick to develop trust in the group and openly shared his experiences with a former

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romantic relationship and the bullying that ensued after the relationship had ended. In March, he shared that thanks to the support he received from the Empowerment group he was able to come out to his parents and family. He was excited that his family accepted him and grateful for the groups support of him. In his post-survey comments, he noted, "This program helped me come out to the people I love."

AW is 16 year old trans-male identified student at Deer Valley High School (DVHS). This is his third year attending Empowerment group at DVHS. AW is out to his family, friends and community; however his parent is not accepting of his trans-identity. AW frequently noted, this year, his frustration that his parent is not accepting and that school, and specifically, Empowerment group is his only opportunity to be himself. Even with the lack of acceptance at home, AW is very well adjusted, intelligent, and is focused on their future. They express excitement about pursuing transition once they turn 18.

DP is senior at DVHS. He identifies as straight. He was referred to Empowerment group by this guidance counselor, who expressed concern that DP might be depressed and thought Empowerment staff might be able to help, noting that DP presented with many stereotypically effeminate mannerisms. DP was adamant that he identifies as straight, but was happy to join the group, noting that he had questioned his sexual orientation in the past. DP attended each weekly group meeting at DVHS since joining in September and was very supportive to other participants. DP also referred several of his friends to the group. In their post survey comments, they noted, "I will work on things as I progress through the real world. Thank you."

YL is a Junior at PHS. She identifies as bisexual, Hispanic and has been attending Empowerment group at PHS for 2 years. The first year that YL attended group, she was reserved. She would often "pass" during check-in and would only share with Empowerment staff in private 1-on-1 meetings. Toward the end of last year, YL asked if she could switch to the second Empowerment group at PHS, suggesting that being in a group with people she does not know might help her to open up more. In the new, smaller, group she expressed being more comfortable. This year, YL was excited for the group to start again at PHS. Staff noticed a shift in their self-confidence and self-esteem. Throughout the year YL became more vocal and opened up more to the group. In March, they too, shared with the group that they "finally" came out to their parent, sibling and extended family. Prior to group closing for the summer, she noted that she now feels very comfortable sharing with her family, and she frequently receives genuine questions from her parent about LGBTQ+ topics.

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PEI SEMI-ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS
REPORTING FORM **FISCAL YEAR: 2018 - 2019**

Agency/Program Name: Child Abuse Prevention Council/Nurturing Parenting Program
Reporting Period (Select One): X☐ Semi-Annual Report #1 (July – Dec)
☐ Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental healthcare

X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

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SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Child Abuse Prevention Council - CAPC reached out to the Latino community in Central and East County to offer The Nurturing Parenting Program (NPP). From July to December a total of 50 parents and their 42 children enrolled to participate in the 22-week parenting education program offered in the evening at Vintage Parkway Elementary School in East and at the Concord First 5 Center in Central County. NPP collaborated with community based agencies and school districts such as First 5 Center, Head Start, WIC, Antioch Unified and Oakley Elementary School District to promote this program. Parents enrolled in the NPP reported that hearing other parents' opinion and comments about this program motivated them to enroll. A total of 30 parents successfully completed and graduated from the program, 16 shared they were experiencing challenges to participate and dropped, 2 parents transferred to a different NPP to fit his needs and 2 parents partially completed the program, participated less than 50% of the 22 week program due to work schedules. CAPC staff offered education for 22 consecutive weeks following the fidelity of the NPP evidence based curriculum to increase parenting skills, decrease isolation within this population, decrease stigma related to accessing mental health services for self or child.

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Our staff follows and utilizes curriculum and materials recommended by the Nurturing Parenting Program. Parents are given the opportunity to share areas of concerns in accessing community resources; to meet this need each parent received the Surviving Parenthood Guide to facilitate access to community based organizations providing a wide variety of services at no cost or sliding scale to encourage parents to connect and explore preventive/intervention programs. . NPP staff offered guidance to parents by providing the Mental Health access number as well as the process of advocating for services. NPP collaborated with other agencies and welcomed guess speakers to share information and psycho-education to help identify mental health/behavioral challenges that may need professional support. NPP has been enhanced by the collaboration of Dr. Hector Rivera-Lopez. Dr. Rivera's experience working with the Latino community in Contra Costa County offers participants an opportunity to identify possible behavioral/mental health needs that in the past were perceived as just "part of their "cultural beliefs".

The NPP supervisor not only oversees sessions, she also offers direct services to help parents feel more comfortable and confident when accessing resources. NPP evaluates each case to offer linkages to the appropriate resources. Linkage includes but was not limited to the following: Access Line, Medical, Children Mental Health Services, Crisis Center, Food Bank and Community Based Organizations.

At the end of the program the NPP staff meets with parents to explore supportive services that they accessed and/or if they encounter challenges receiving services.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The Nurturing Parenting Program offered two 22 week sessions starting in July, ending in December. Parents were administered the evaluation tool AAPI "A" at the beginning of the program and AAPI "B" at completion of each program. Results of the AAPI forms are entered in a password protected data base (Assessing Parenting) which analyzes the results and provides a chart reflecting variation of participants starting and ending the program. Upon completion of the program staff reviews results which reflect areas of improvement and measures the "risk" of child abuse and neglect in the home. In the event that parents may score as "high risk", an invitation is offered to them to participate in the program one more time as well as additional resources to address their needs. All data entered in the Assessing Parenting site is password protected and only authorized personnel has access to these records.

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The Nurturing Parenting Program focuses and encourages participants in developing skills along five domains of parenting: age appropriate expectations; empathy, bonding/attachment; non-violent discipline; self-awareness and self-worth and empowerment, autonomy, and independence.

Responses to the AAPI provide an index of risk in five parenting constructs:

A - Appropriate Expectations of Children. Understands growth and development. Children are allowed to exhibit normal developmental behaviors. Self-concept as a caregiver and provider is positive. Tends to be supportive of children.

B – High Level of Empathy. Understands and values children's needs. Children are allowed to display normal developmental behaviors. Nurture children and encourage positive growth. Communicates with children. Recognizes feelings of children.

C – Discipline/ VALUES ALTERNATIVES TO CORPORAL PUNISHMENT Understands alternatives to physical force. Utilizes alternatives to corporal punishment. Tends to be democratic in rule making. Rules for family, not just for children. Tends to have respect for children and their needs. Values mutual parent-child relationship.

D - APPROPRIATE FAMILY ROLES tends to have needs met appropriately. Finds comfort, support, companionship from peers. Children are allowed to express developmental needs. Takes ownership of behavior. Tends to feel worthwhile as a person, good awareness of self.

E - VALUES POWER-INDEPENDENCE Places high-value on children's ability to problem solve. Encourages children to express views but expects cooperation. Empowers children to make good choices.

AAPI Results

Construct	*A*	*B*	*C*	*D*	*E*
Form A	*7.50*	*7.33*	*7.50*	*8.67*	*7.42*
Form B	*7.57*	*7.43*	*8.00*	*8.71*	*5.00*

- *Scale 1 – 10 (Higher the score, lower the risk).*

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DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Form attached

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The CAPC Director and The Nurturing Parenting Program Supervisor continue to meet regularly to discuss program outcomes, challenges and to ensure staff offering direct services receive support and guidance thought out the course of the session. We have learned the value of communication and collaboration as we offer this important service to our community. Staff meet regularly to discuss issues parents identify as "triggers" of stress in their daily life. This program offered a safe place to identify staff challenges and receive support to decrease the risk of emotional fatigue which we often experience in this field. Staff brainstormed ideas to address the emotional needs parents are experiencing while maintaining the fidelity of the Nurturing Parenting curriculum.
The Child Abuse Prevention Council staff agreed to continue being proactive in finding resources for the Latino community who has reported challenges accessing mental health services that are culturally appropriate. Staff has learned of challenges parents are facing in trying to connect adults to mental health resources. To support this need staff has worked with parents by linking them to resources as they wait for clinicians to be open to new clients. CAPC links parents to support groups in their area creating opportunity for families to connect with families in their own neighborhood. CAPC strongly believes in building community connections to increase children's safety. Staff recognizes the areas in which they can help in building bridges to connect the underserved population to the services much needed.

VALUABLE PERSPECTIVES:

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

CAPC and the NPP valued parents' feedback to help us learn more about the outcomes of this program. Below you will find the translation of just a few letters parents have written for the program. Originals of the following letters and more are available to you upon request.

Parent 1

Grandparents raising 12 year old grandson, expressed finding this program valuable and in great sadness with tear in his eyes grandpa shared "I wished I had this support when I raised my daughter, she would be here with us raising her son".

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

SUICIDE PREVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Contra Costa Crisis Center

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include who the program has targeted and influenced, as well as, any methods or activities used to change attitudes, knowledge and/or behavior.

1) The provision of 24-hour telephone response to mental health crisis calls via all local and toll-free hotlines. Our staff and volunteer Call Specialists are ALL cross trained, silent monitored and supervised in an intervention modality consistent with best practices/industry standards as set by the American Association of Suicidology. Services were provided in the manner agreed upon in the contract – language, follow-up, lethality assessments, etc.
2) Link callers in need to mental health services via referrals and warm transfers as appropriate for each call.
3) Continued staff in-service training regarding stigma and discrimination reduction; addressed service delivery to underserved population – LGBQT, Homeless, people living with mental illness. Focused training was provided around Grief and Loss and Suicide Prevention.
4) Continued to evaluate our repeat caller policies and adherence to providing services based on respective individual needs vs. call volume.
5) Continued to provide trainings for service providers throughout Contra Costa County on the warning signs of suicide, suicide risk assessment, and cultural competency and awareness when assessing for suicide risk.
6) The Crisis Text service continues to be provided and monitored 24/7/365.
7) Continued co-chair responsibilities with MHSA for the monthly Suicide Prevention Committee.
8) Worked closely with MHSA, mental health, and statewide suicide prevention agencies to create a plan to review and update the suicide prevention strategic plan for county administration.
9) Coordinated with the county board of supervisors and other county agencies to organize, promote and facilitate the showing of the "S Word" movie in the Board Chambers.
10) With American Foundation for Suicide Prevention (AFSP), hosted "Survivor Day" at John Muir Hospital to provide support to survivors of suicide loss and to promote suicide prevention awareness.

CONTRA COSTA HEALTH SERVICES

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OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Please detail any methods used in evaluating change in attitudes, knowledge and/or behavior, and include frequency of measurement***
- ***How have your selected methods proven successful? Please reference any evidence- based, promising practice or community practice standards used, as well as how fidelity to the practices have been ensured.***
- ***How does the program evaluation reflect cultural competency and protect the integrity and confidentiality of the individuals served?***

- A risk assessment is provided for every suicide call. Callers with a plan to end their life are asked for a self-rating scale of 1-5 for how likely they are to go through with their suicide plan both at the beginning and at the end of the call to help assess the level of risk and if the caller is feeling better at the end of the call.
- Methods of intervention and lethality assessment are done in accordance with industry standards set by AAS. Monitoring of the calls and the data/call records indicates that fidelity to the model is being well maintained. We are happy to report 0% completed suicides by those who are assessed as at risk.
- Confidentiality - Our policies (HIPAA and clinical license standards informed) ensure confidentiality – including use of technology, storage of records, destruction of records, subpoena response, record keeping, report writing, and (non)use of identifying client information on server.
- Competency – Our supervision is informed by ongoing in-service trainings and professional development opportunities regarding multiple populations and social issues. Our staff and volunteers are diverse in regard to country of origin, languages spoken, culture, gender, religion, sexual orientation and class.
- Our core values of compassion, integrity, inclusion, accessibility, and collaboration along with continuous cultural competency development is written, spoken and practiced. Our policies, protocols, and office environment support these values.

DEMOGRAPHIC DATA: X Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

See County Aggregate Data Form

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VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our services are designed based on the belief that emotional support can make huge difference in a caller's ability to self-manage and minimize psychiatric hospitalization (5150) visits when the support is available any time it is needed 24/7/365. Our vision is that people of all cultures and ethnicities in Contra Costa County are in a safe place emotionally and physically. Because we also provide the entire county with 211 Information and Referral services, we have a well-maintained database from which to refer and link our callers.

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

Call record #264701
The caller was a 21-year old female, crying and extremely distraught when she called the Crisis Line. The Call Specialist quickly developed rapport and was able to calm the caller down enough to understand what she was saying. The caller was feeling stressed about her new job, had an argument with her boyfriend, and then another disagreement with her mother when visiting for emotional support that escalated to the point of the mother telling her to leave the house. The caller was feeling very alone, had thoughts of suicide, and was feeling the way she had felt when she had attempted suicide in the past several years ago. Her mother doesn't understand her feelings, thinks she is "being dramatic" and doesn't realize how much the caller depends on her for emotional support.
The Call Specialist spent time talking with the caller, providing active listening and emotional support and hearing about the caller's past struggles and coping strategies. She asked for the Call Specialist to provide a three-way conference call conversation with her mother since her mother blocked her calls after their fight. The caller, mother, and Call Specialist were able to have a three-way conference call mediation conversation over the phone and the caller agreed to a follow-up call the following evening.

During the follow-up call the Call Specialist learned that the caller is currently feeling safe and that she will work on her relationship with her mother and siblings. She asked for second follow-up call at the end of the week.
On the second follow-up call, the Call Specialist learned that things were going smooth with the caller's new job and that she is still working on her relationship with her mother with the help of her grandmother as an outside mediator. She was grateful for the support of the Crisis Line and will call again for emotional support or when she needs help.

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Call Record #: 296089

The caller was a 56-year old male and began the call very angry. He feels like no one cares for him, he hates his job and his boss, he experienced sexual abuse in the past, and is now questioning his religious faith. After spending time listening and developing rapport with the caller, he confided with the Call Specialist that he was having suicidal thoughts and on a self-rated scale of 1-5 of 5 being the highest, he rated himself as an 8. They spent time talking and the Call Specialist was able to explore his reasons to live and what made him feel happy such as his dog that was 7-years old that he loved dearly, listening to music, being creative, and helping others (especially people who are homeless).

The Call Specialist continued to provide active listening and emotional support throughout the call, and at the end of the call, the caller self-rated his thoughts of suicide was now reduced to a 1, and he was incredibly grateful for our service. His plan for the remainder of the evening was to spend time with his dog, get some rest for work the following day, and begin look for a new job. The caller declined a follow-up call but agreed to stay safe for the evening and to call us call this line again before acting upon thoughts of suicide or anytime he needed support.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name:

Contra Costa Interfaith Housing, Strengthening Vulnerable Families

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

During the past contract year (7/18 – 6/19) Contra Costa Interfaith Housing, Inc. (CCIH) has provided an array of on-site, on-demand, culturally appropriate and evidence-based approaches for its "Strengthening Vulnerable Families" program, which serves formerly homeless families and families at risk for homelessness and for mental illness. CCIH has provided these services on-site in 4 affordable housing settings and case managers have been available fulltime to residents. This structure has helped to eliminate barriers to timely access to services. Culturally responsiveness youth enrichment and case management providers have assisted youth and families to access a multitude of community services, including mental health treatment. By incorporating these services among general support, potential stigma related to mental health referrals is reduced. By providing services to all residents living at each site, potential biased or discriminatory service delivery is avoided.

1) Responders that this program reached included affordable housing staff and residents living in 274 units of housing designed for low-income families (235 units of affordable housing) and units designated for formerly homeless families with disabilities (39 units of permanent

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supportive housing). Most of the disabilities identified among the permanent supportive housing households included mental health challenges. With on-site case managers and youth programming and monthly case management meetings with property management at these sites, housing staff, parents and youth in resident families were all potential responders that we reached with offered services. Specifically, 215 families have been served with 4003 hours of case management services across the 4 housing sites.

2) Methods used to reach potential responders were providing on-site service staff in the housing settings where residents live. Case managers were trained and supervised by licensed clinicians to recognize mental health problems and assist residents to access services. Case managers were available 40 hours/week, by appointment or drop in. Additionally, parent support groups were offered at each site, in Spanish and in English as needed, and this allowed residents to get to know the case managers and youth enrichment staff and build the trust needed to share concerns including worries about mental health. Afterschool programming was also offered on-site at these housing settings. Regular contact was maintained with the property managers and if there were behavioral or financial problems that put resident housing at risk, case managers were able to reach out to the households and assess and support them. Some of these problems were based in the need for mental health support, and these referrals were made as needed.

3) Strategies used to provide access and linkage to treatment included forming trusting relationships with the residents to start. When a resident who had come to know the case manager requested mental health resources the case manager would offer to assist the resident to access these services in numerous ways including assisting with calling the ACCESS line to obtain an appointment with a clinician, transportation to appointments, financial support for transportation (bus passes/gas cards) to get to appointments as needed, emotional support and discussion about the value of counseling or other treatment. Staff were trained in the understanding that many populations have concerns about accessing mental health resources due to stigma or other misgivings. With ongoing presence and relationship support these issues could be addressed.

   In the afterschool program parents would approach the youth enrichment coordinator with concerns related to family dynamics or youth behavioral issues or problems at school. The youth enrichment coordinator was available to support the families to access mental health resources as needed. The case manager and youth enrichment coordinator met to discuss resident needs weekly, and issues related to mental health were addressed and plans for how to support residents in this area were made. During the contract year 170 youth have received youth enrichment support with 2095 hours of programming.

4) Strategies used to improve timely access to services that were used included assistance in navigating the system of obtaining a mental health appointment, education about the mental health system and resources available, transportation when needed and emotional support to consider this resource. Financial support was offered for transportation or other relevant expenses as needed. Follow up with residents after referrals were made to mental health

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resources were done to support the residents as well.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Indicators of success for this program include improvements on a standardized assessment tool related to self-sufficiency and improvements in youth academic achievement. These outcomes are reported below. Additionally, stability of housing, stability and improvement of income level and improvements in parental stress levels are all tracked with ongoing logic model goals and evaluated semi-annually. Feedback from residents on satisfaction surveys and at the end of group programming is also solicited. All data related to outcomes is analyzed and discussed among the service delivery teams, and plans for improvements and innovations are made as needed. Resident participants give feedback about desired topics for support groups and activities in monthly resident meetings and in annual satisfaction surveys.

Case managers in these programs over the last year included a licensed psychologist, a licensed Marriage and Family Therapist, two experienced case managers (one of whom is bi-lingual/bi-cultural) and two mental health, post-masters interns. The youth enrichment coordinators are all experienced educators. The racial/ethnic background of the staff include 2 African Americans, 2 Latinas, one bi-racial Latina/African American, 1 Native American, and 2 Caucasian staff members and 1 Asian American. Several of the staff in this program live in the communities they are serving. In addition to working with the families in these affordable housing sites, the Youth Enrichment Coordinators and Case Managers also work with a number of community resources as referring partners and family advocates. In this role, CCIH staff are able to help community providers be aware of early signs of mental illness in their clients, and support sensitive care and timely treatment for these issues.

Cultural responsiveness is an ongoing area of training for all staff, starting with training at hire and continuing with trainings throughout the year. This past year the entire CCIH staff participated in a day long training related to cultural awareness provided by Circle Up. This was funded with a grant obtained for the specific purpose of providing this important training to the organization as a whole.

All staff are trained during their orientation in HIPAA levels of information and record management. Maintaining the confidentiality of resident information is required of all staff. Records are kept in password protected computers and/or locked files in locked offices.

Outcome objectives for the ***Strengthening Vulnerable Families*** program were:

A. At least 75% of the youth regularly attending homework club will achieve six or more academic benchmark skills during the school year ending in June 2019.

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Youth who regularly attend our youth enrichment and afterschool programs have been assessed for reading levels and for base-line academic benchmark skills. 86% (56/65) have achieved at least 6 new academic benchmarks, and have improved in their reading level.

B. At least 75% of the families with children, in residence at Garden Park Apartments, will show improvement in at least one area of self-sufficiency as measured annually on the 20 area, self-sufficiency matrix within the fiscal year, 2018 to 2019.

While this contract outcome focuses on the Garden Park Apartments community, we are reporting on all the residents that engaged in more intensive case management at the 4 housing sites supported by this grant. The Self Sufficiency Matrix (SSM) is an evidence-based assessment tool that gives a score of "crisis to thriving" on a five-point Likert scale for twenty areas of basic life skills including parenting, mental health and child education. All families served with intensive case management in the first six months established a baseline on the SSM. Final outcomes for this measure are 97%, 103/106 improved in at least one SSM category. (Not all families engage in services to the point of filling this measure out. Some are served just once or twice a year with emergency services, especially in the affordable housing sites. Others engage in more ongoing services and this measure is used to assess progress with those families. Most of the residents living in the permanent supportive housing units are reflected in this outcome).

In addition to these outcomes we achieved the following outcomes related to the parent support groups provided at these sites:

Many of the families we serve have histories of inadequate parenting including exposure to domestic violence, out of home placements with foster care, and unstable family support. These parents report that they find the Community Café and other parenting groups very helpful as they work to provide their children with loving, supportive parenting. (Community Café is an evidence-based program promoting initiative and community collaboration among parents. The curriculum is based in Resiliency Theory).

100% of the parents in the Community Café groups (32/32) report that the group is useful. Additionally, we are instituting a new assessment tool called the Parental Stress Index that assesses parental stress in the community and in parent-child relationships. As of the end of the year we had 4 initial assessments and follow up assessments and 3 of the 4 (75%) showed lower stress. Because this is our first year using this tool, we have initial assessments (baseline) for an additional 23 parents. We will use these scores to compare to scores at the end of next year to assess the impact of our programming on parent stress levels.

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Many residents at GPA cope with the challenges of mental health and substance use issues. At this site we offered an 8 week wellness/harm reduction group. The focus of this group was to support parents with coping skills for managing depression and anxiety and cravings/relapse triggers related to substance use. Activities included mindfulness exercises, discussion of triggers and parents gave each other feedback about strengths in a circle. Discussion topics included managing conflicts, parenting challenges, struggles with money and with relationships. 80% (8/10) of the participants in this group reported finding the topics and skills learned in the group useful and also that they used coping skills learned in the group to support their sobriety and/or moderate substance use.

Two (2) family vignettes , showing the improvements and positive outcomes of the work of this project (including GPA, Lakeside, LMV, and BMA communities) are attached with this fiscal year final report.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

MHSA aggregate reporting form attached with this report.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The Strengthening Vulnerable Families program reflects MHSA values of wellness, recovery and resilience by providing on-site, on-demand support when residents need it. By being available immediately and in a timely manner when problems begin to emerge, we are able to improve the trajectory of problems with early interventions that are embedded in the housing community where residents live. When mental health care is needed support staff in this program are ready and available to assist residents with information about possible resources, with transportation, and with educational

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and emotional support that is culturally responsive and respectful of the concerns different populations have about accessing this type of resource. By providing an array of supports and services

(employment support, financial support, educational support, basic needs like food, healthcare, childcare access, and social/community activities) when the need for mental health support arises the resident is not singled out or identified with this particular need. By having a trusted, long-term relationship with an on-site case manager, residents can develop trust and be able to move past fears of stigma or discrimination as they seek mental health assistance.

VALUABLE PERSPECTIVES:

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

Two vignettes are attached, including a talk presented at the MHSA housing forum in San Pablo earlier this year.

Thank you for your support to help us with this program. We look forward to our continued collaboration.

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One Resident's Story

Good afternoon. I have lived at Garden Park Apartments since January 2015. I live there with my girlfriend and her daughter, who was 2 when we got together.

Before I moved to GPA I was homeless, on and off, for most of my life. I left home when I was in my early teens. Sometimes I would move back to my parents' house for a while. Sometimes I would work. Sometimes I had a job while I was homeless. I slept on park benches and in tents. Sometimes I could stay at friends' houses. Nothing lasted too long. I was using drugs, and I wasn't receiving any mental health care, so my life was pretty erratic.

I knew my girlfriend since we were in high school together. We dated a while in our early 20's, but drifted apart. We were both homeless and using drugs. She got her life together when she gave birth to her daughter, and moved to Garden Park. I ran into her again in January of 2015, and we have been together ever since.

I was able to stop using drugs with her help, and after a while I was added to the lease at GPA. I had a daughter, who was 5 when I came to Garden Park, and she was able to visit regularly. She was welcomed in the activities at the property and a year and a half ago I was awarded part-time custody of my daughter.

Since living at GPA I have been able to turn my life around. I stopped using drugs, which I used since my early teens, to self-medicate. I have been able to work in the landscaping field. I got hurt on the job, and when I was applying for disability, I was diagnosed with mental health problems for the first time in my life. I was 30 years old. I have received medications since then that have helped me with my moods.

Garden Park has on-site services that have made a huge difference for me and my family's life. When I feel worried or down about things, I know there is someone we can talk to in the office. I feel safe, knowing someone is always there. The staff is also available to support us in other

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ways. One of the staff took me to homeless court and I cleared up some of my old legal problems.

Most of my friends from my old life are still using, so my girlfriend and I stay to ourselves a lot. But we go to the social events at the property like pumpkin carving and winter holiday bingo and those are a lot of fun. We talk about making happy memories for our daughters, because we didn't have a great childhood ourselves. That is more important than ever now, because a few weeks ago we found out that we are having a baby!
(pause for applause….)

I'm grateful for what we have. I don't know where we'd be without the stable, affordable housing and support that we have at Garden Park. It has made a huge difference for us, and now it will be making a difference for our children. I was reluctant to speak like this in front of a big group, but I wanted you guys to know how important this kind of housing is.
Thank you.

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Lakeside Vignette

Mr. Sai, aged 65, moved to Lakeside Apartments 13 years ago. He was self-sufficient and spent long periods of time with a sister and brother-in-law in San Francisco. He did not access the on-site service support until just a few months ago.

At that time his brother-in-law became ill and he was not able to visit them in SF. With the loss of that structure he had a hard time managing his physical and mental health. At that time he came to the attention of the on-site case manager who received a referral from the property manager. Mr. Sai had complained to property management that there were people coming to his apartment. He described a woman entering his apartment and when questioned about this situation he reported that she would just appear at times. He also reported seeing racoons and cats in his apartment.

The case manager reached out to him and visited his apartment to be sure he had adequate food and other supports. While there Mr. Sai directed the case manager's attention to the floor and asked if she could see the cats and the visitors in the apartment. There were no cats or visitors there at that time.
At that point it was clear that the resident was having hallucinations. The case manager asked if the resident was on medication and he said that he took medication for epilepsy. The Case manager called the mental health crisis line for assistance and they came to assess Mr. Sai. The crisis team said they couldn't 5150 him, but recommended mental health services.

The case manager assisted Mr. Sai to make an appointment with County Mental Health and provided transportation to the appointment. While waiting for this appointment date Mr. Sai continued to come to the case manager's office complaining that people were assaulting him and robbing him. He taped his money to his body to protect himself. He had bruises and bumps on his body.

At the appointment with mental health they found that Mr. Sai had been seen by a therapist in Concord. However, that therapist was not available at the appointment time and Mr. Sai was told that the therapist was retiring. Mr. Sai went through an intake process to be assigned to a new therapist.

At this time the case manager is working with the county to have a public health nurse visit his home to assist with his daily medication. It appears that he is having seizures daily and has many bumps and bruises from falls. A team from mental health came to assess him in his home and he is in line to be assigned a new therapist. The on-site case manager is also working to have the Mr. Sai's mental health counselling offered in his home, and to have an IHSS worker help him with his household tasks.
The case manager has also been able to help Mr. Sai get to an appointment with his primary care physician and his epilepsy medication has been adjusted. The case manager helped Mr. Sai reach out to his sister and brother-in-law and they have been more available to this resident. With this support and with collaboration with the property manager this resident has been stabilized and his housing remains secure, thanks to the on-site case management support partially funded with MHSA funding.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: C.O.P.E. Family Support Center/Triple P, Parent Education

PEI STRATEGIES:
Please check all strategies that your program employs:

- ✓ **Provide access and linkage to mental health care**
- ✓ **Improve timely access to mental health services for underserved populations**
- ✓ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / STRATEGIES:

Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Types and Settings of Potential Responders

Demographic Highlights:

- 45% of participants identified as Hispanic/Latino/a; 20% identified as Caucasian; 15% identified as More than One Race/Ethnicity; 12% identified as African American; 4% identified as Asian
- 54% of participants reported household income below the California state poverty level
- 37% of participants reported completing at least two years of college (or more)

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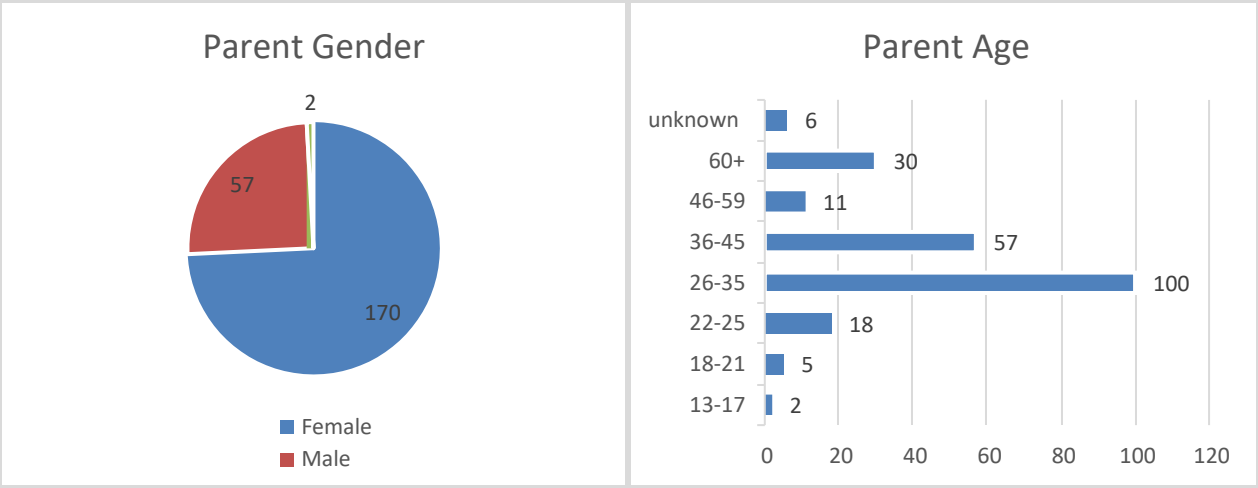
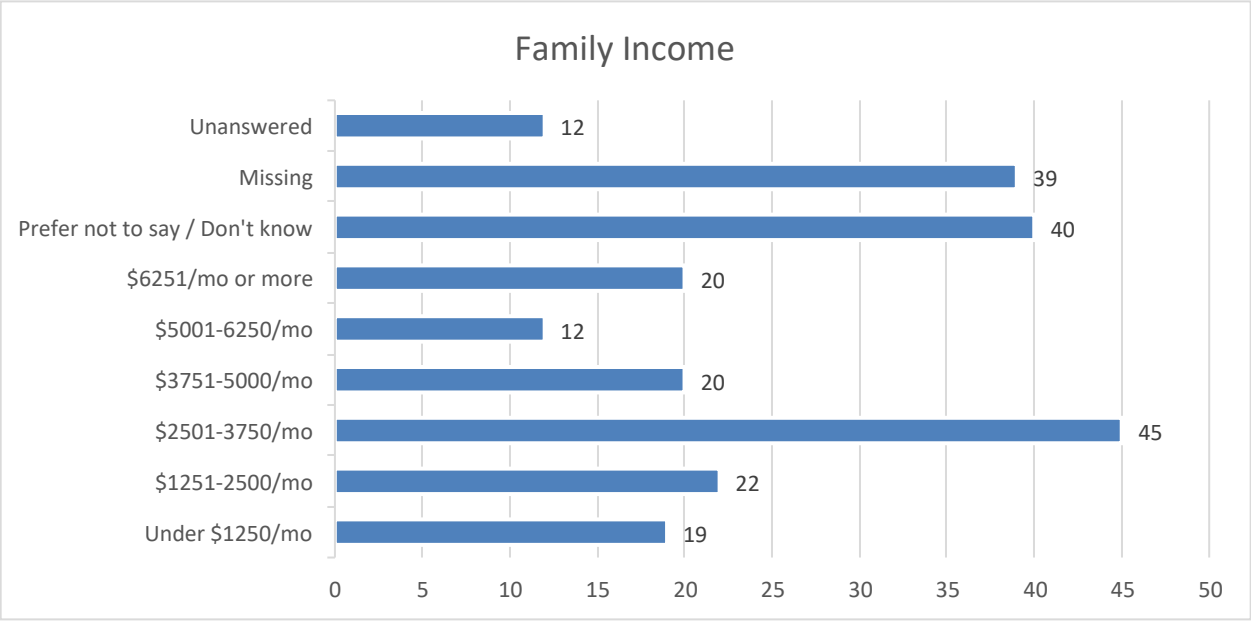
1a) Demographic information below depicts the types of potential responders and is organized by Ethnicity, Gender, Education, Income, Language Age and Location:

First 5 Overall Demographics





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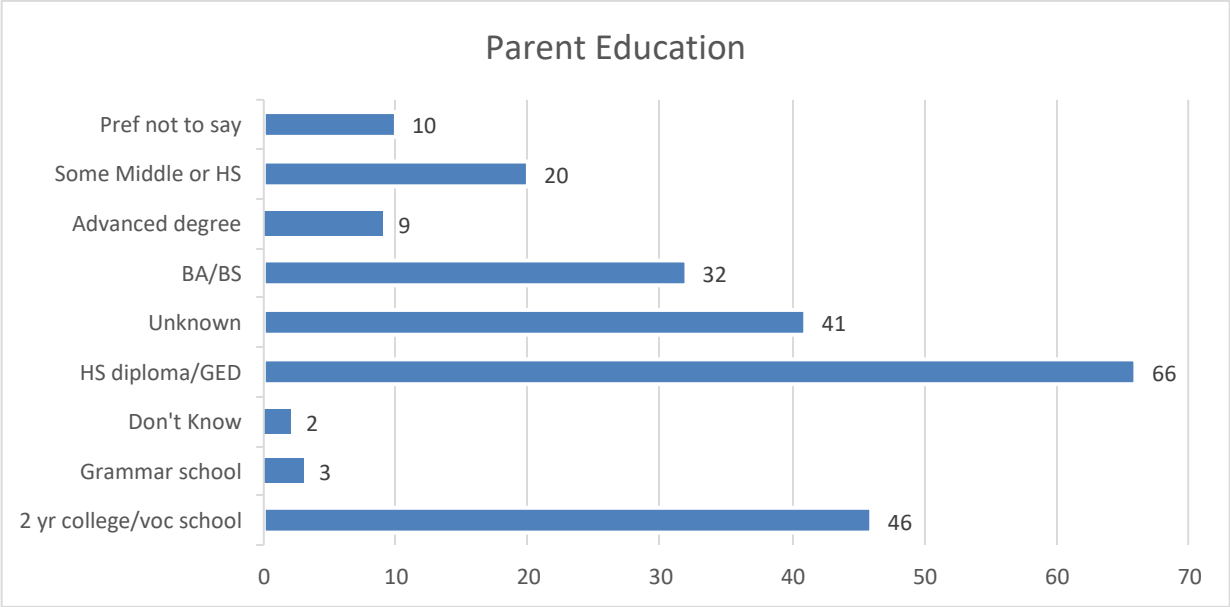
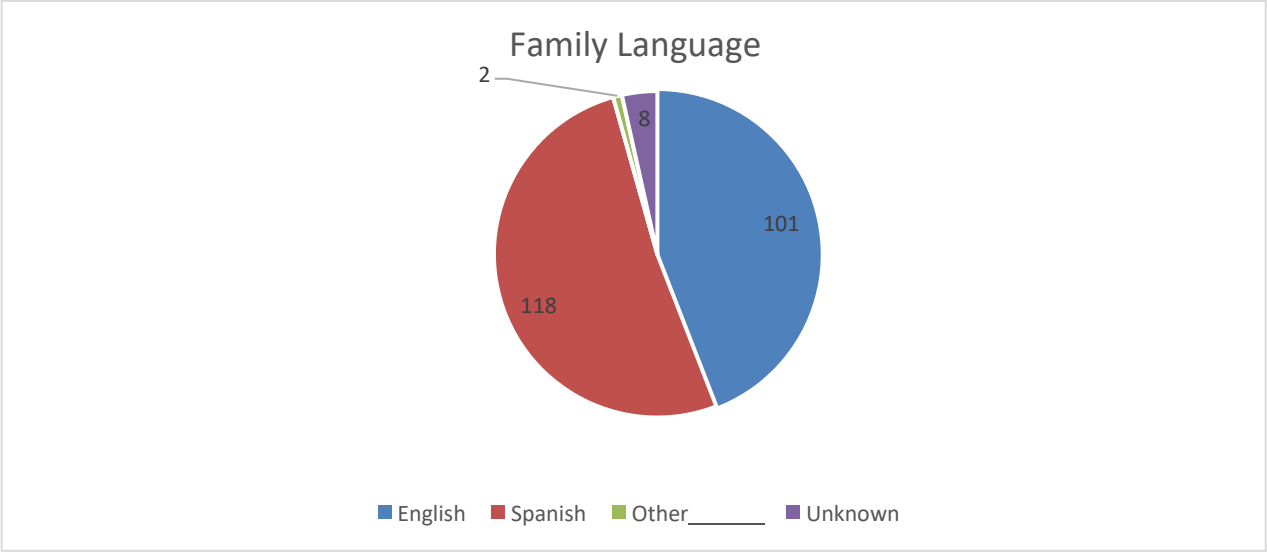
First 5 Overall Demographics, cont.





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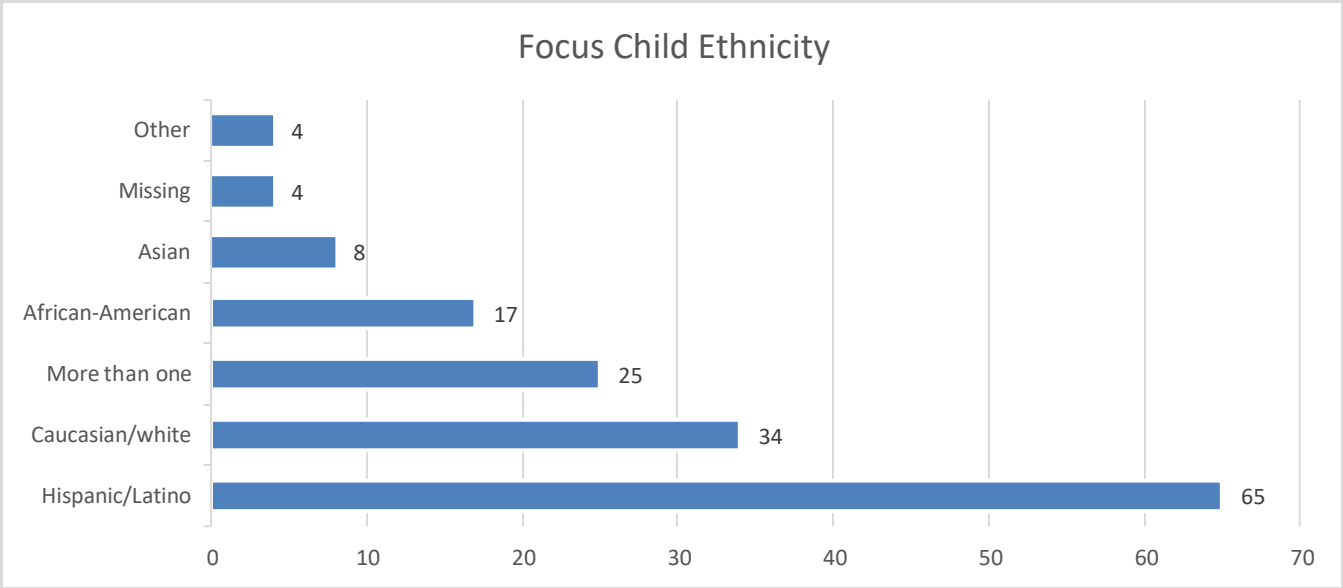
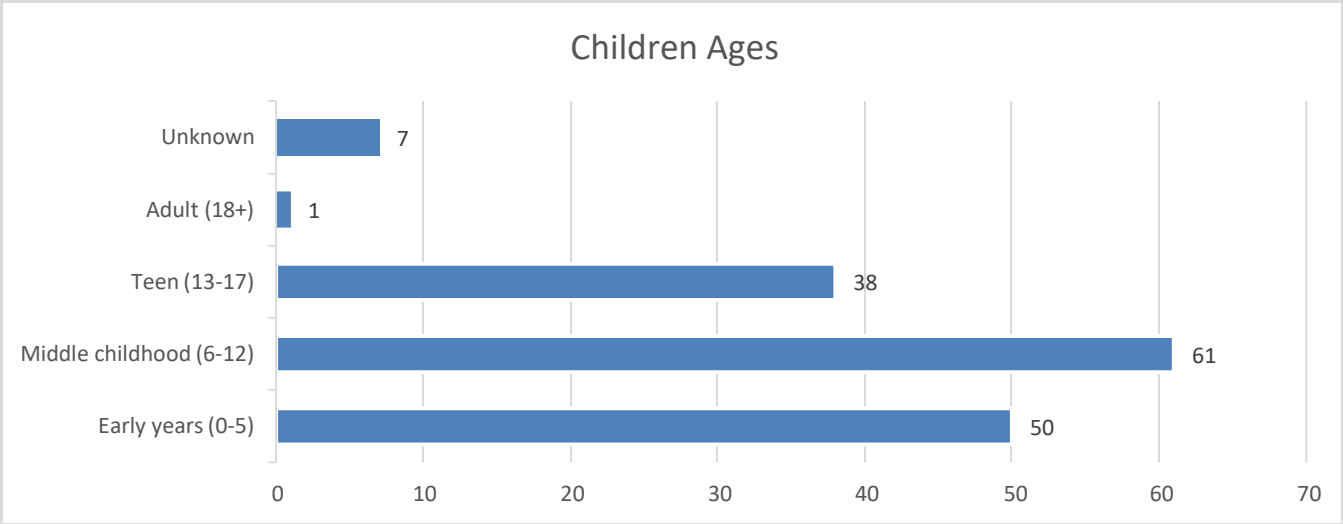
First 5 Overall Demographics, cont.





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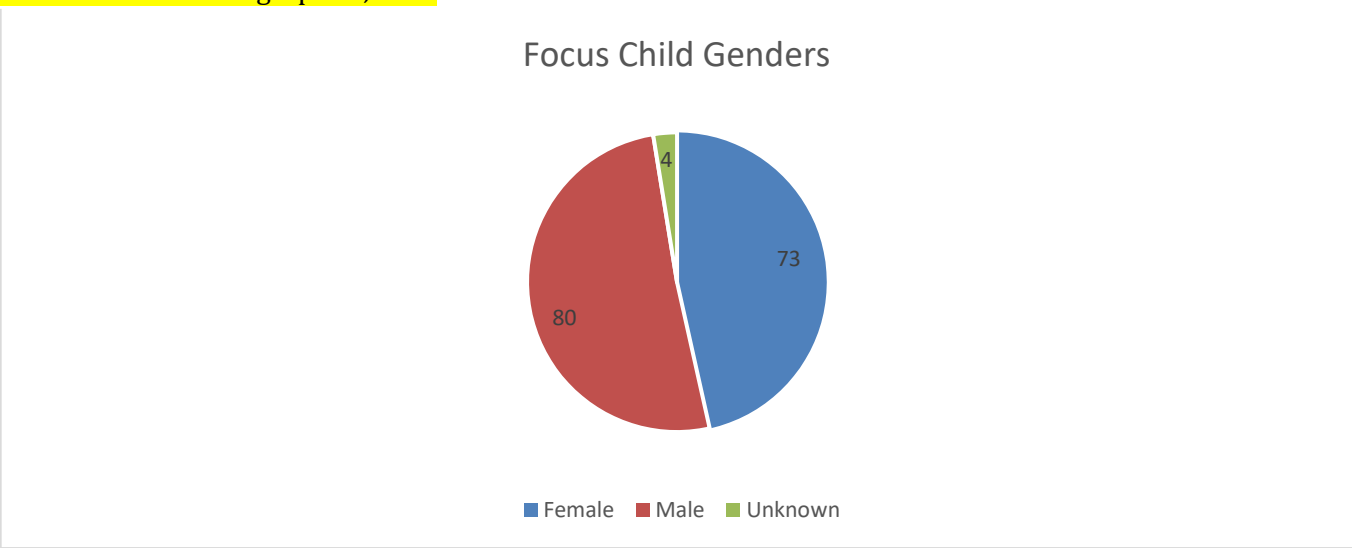
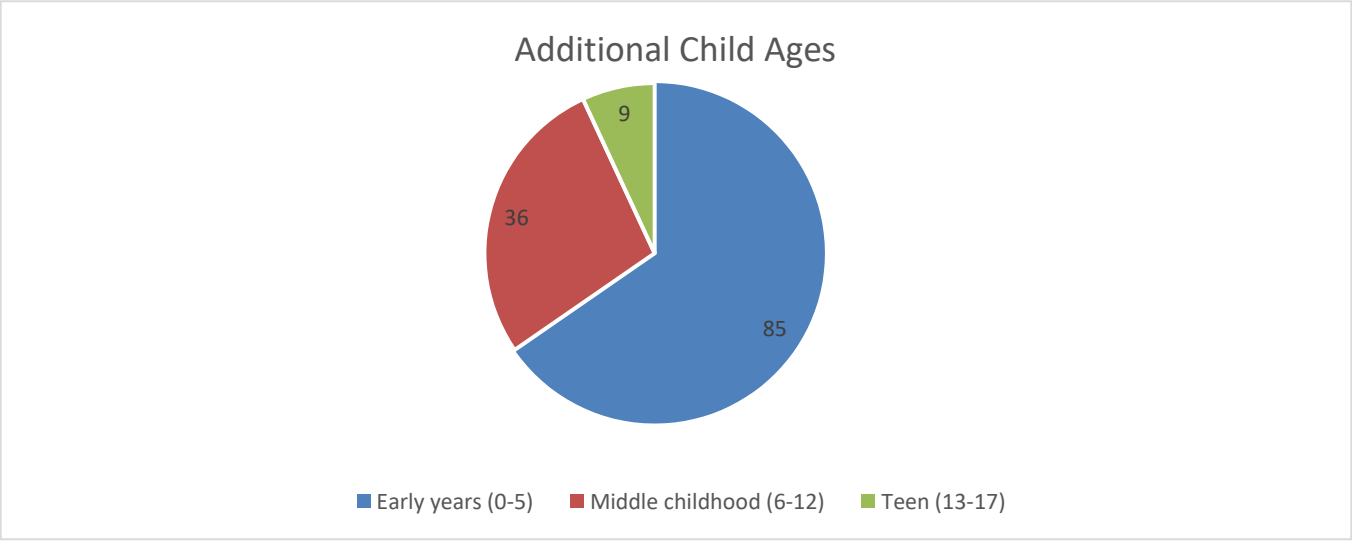
First 5 Overall Demographics, cont.





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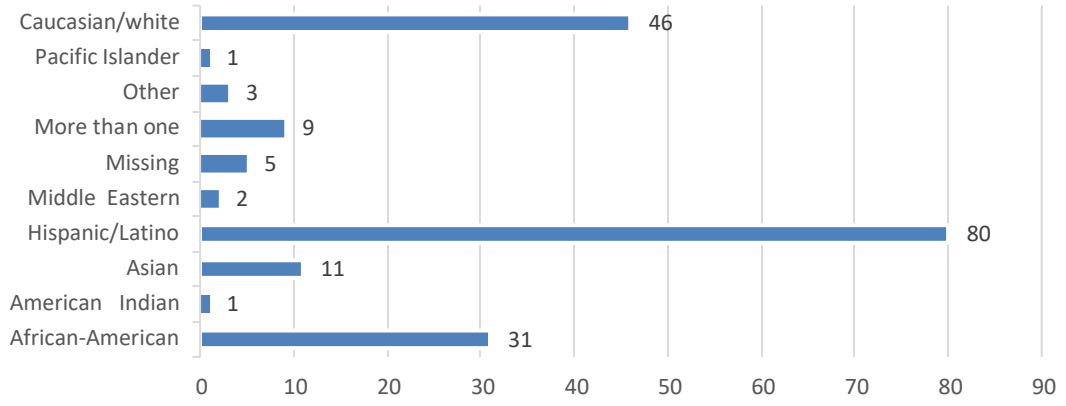
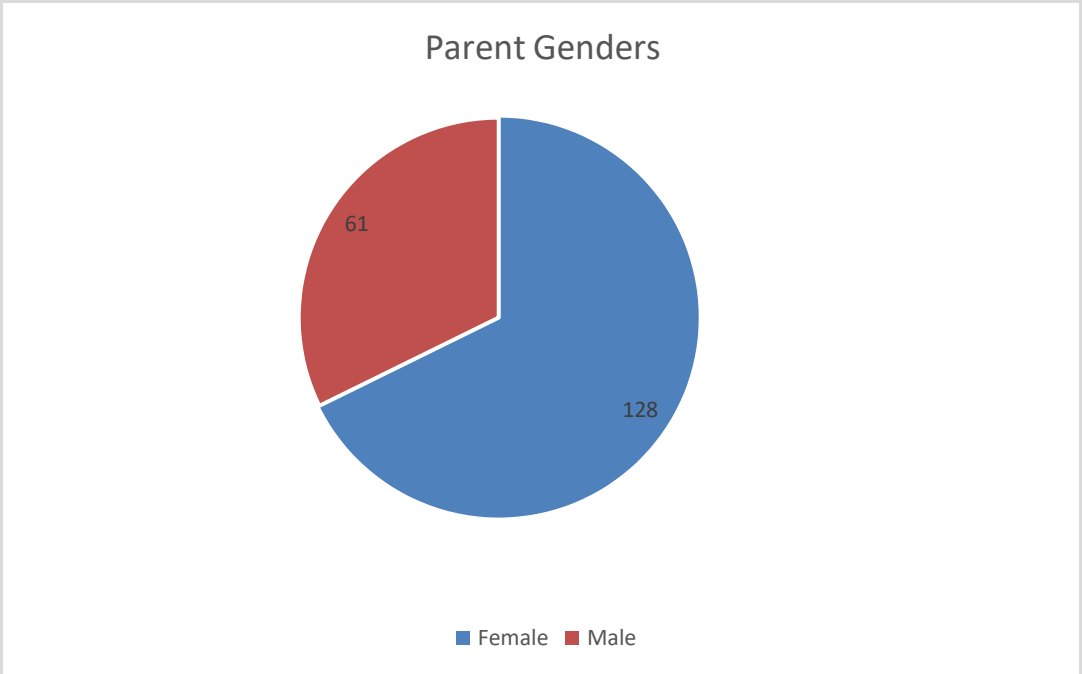
MHSA Overall Demographics





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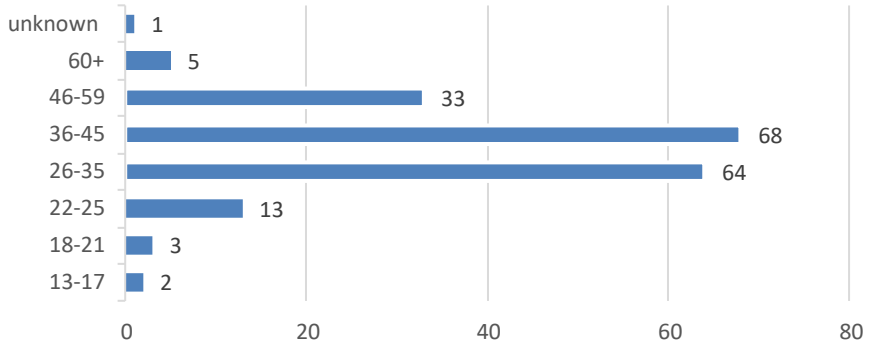
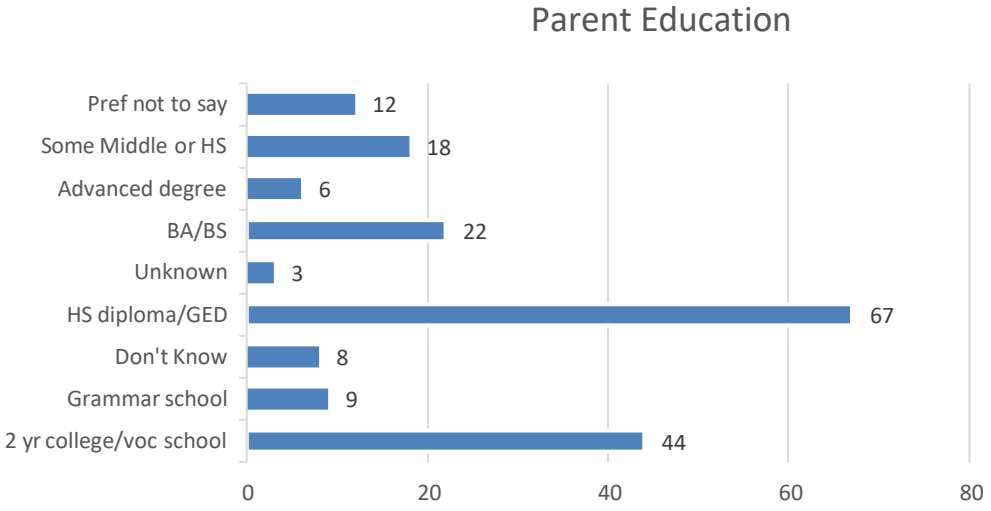
MHSA Overall Demographics, cont.





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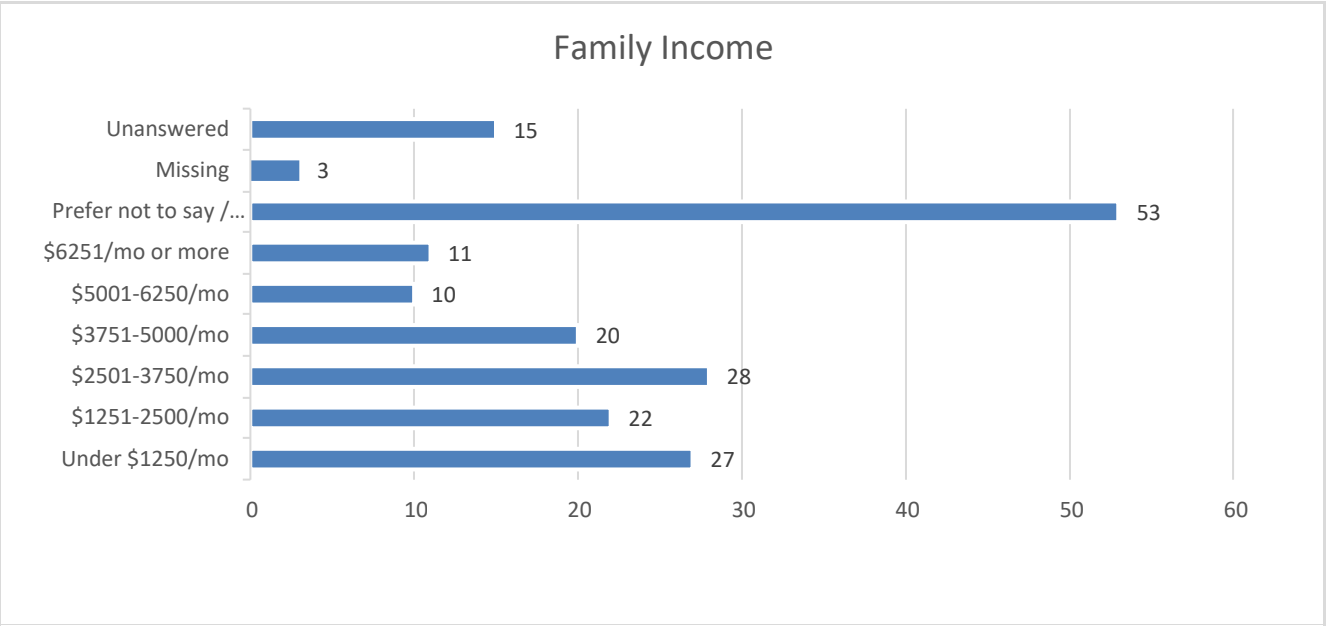

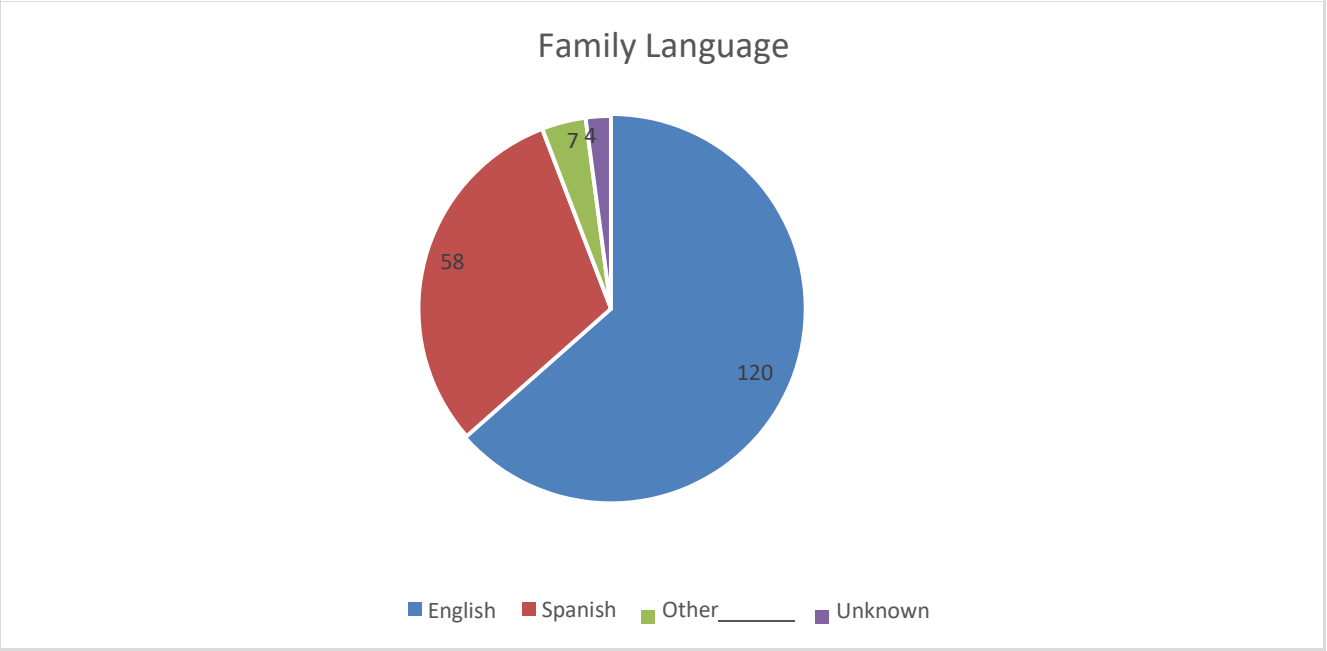

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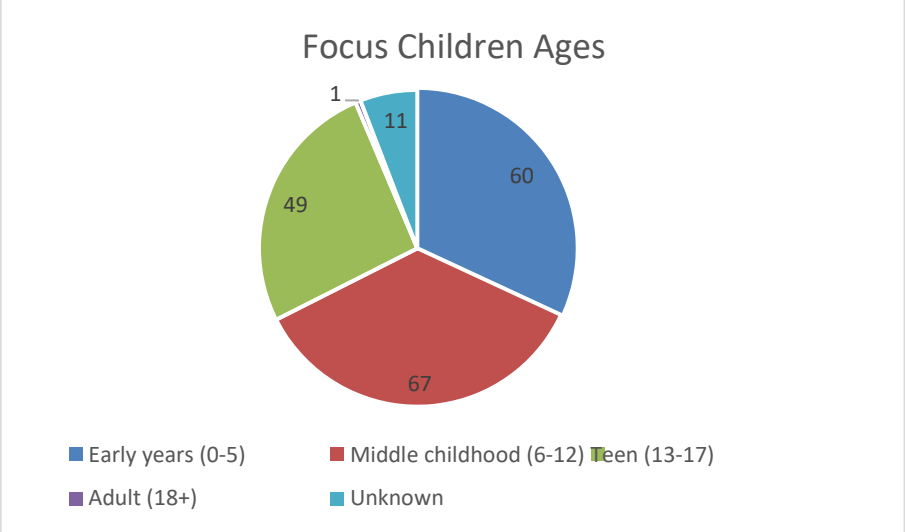

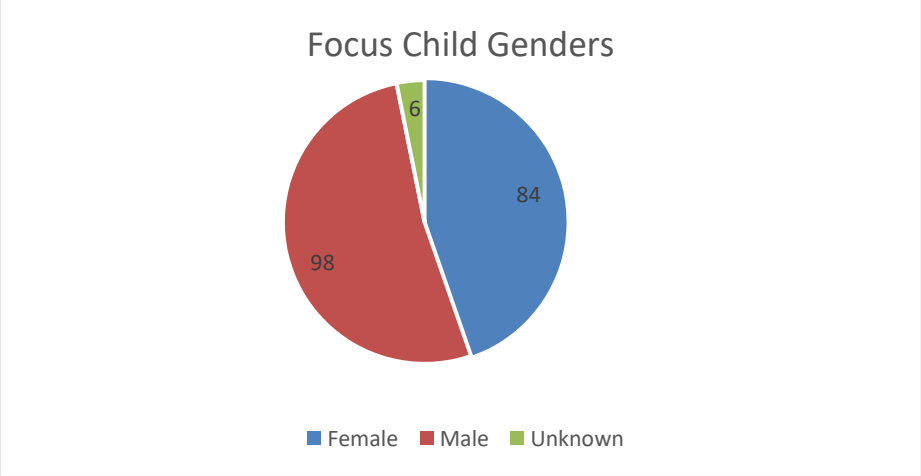

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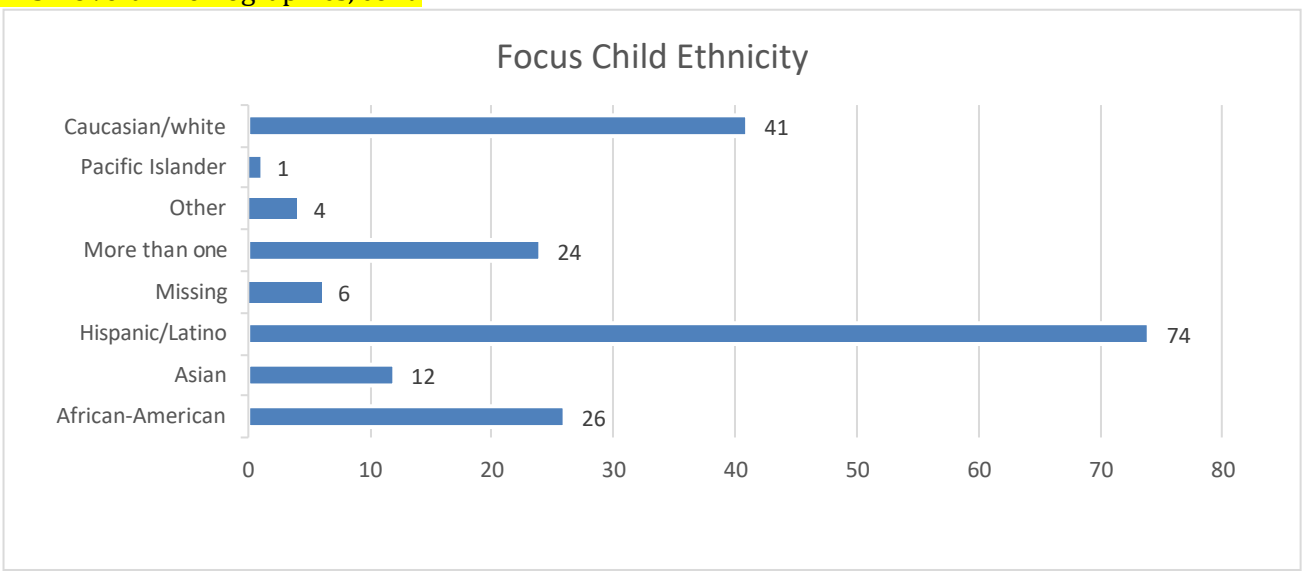
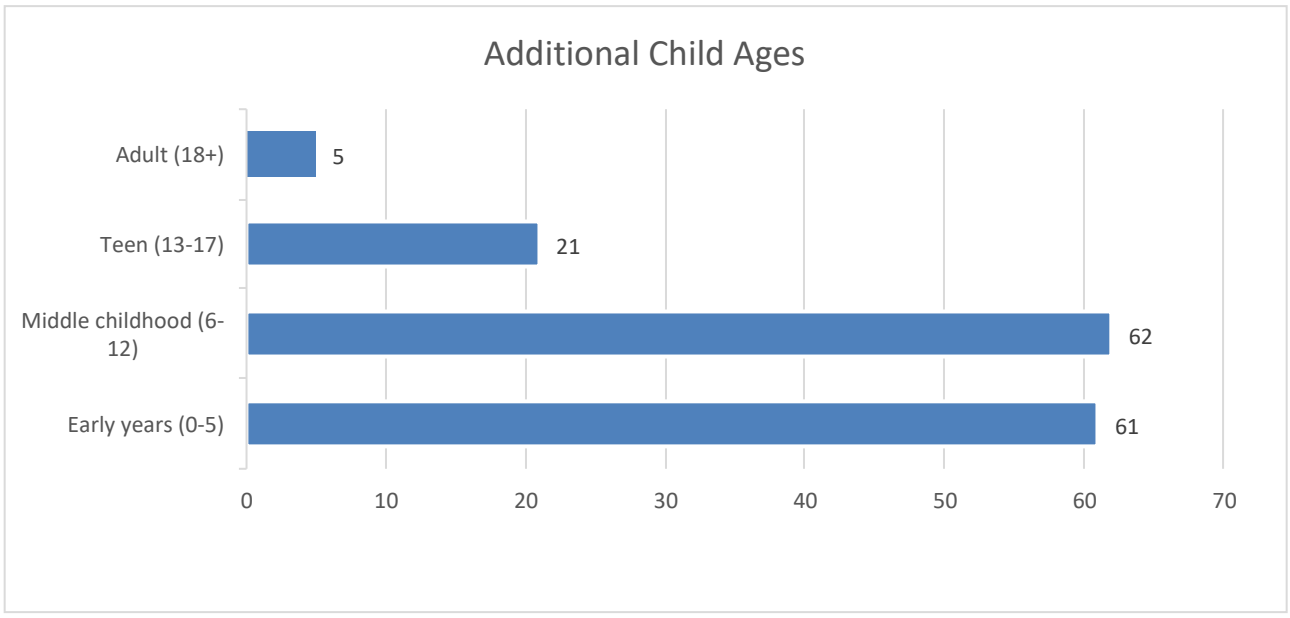
MHSA Overall Demographics, cont.





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1b) Settings of Potential Responders for the 2018-19 FY included elementary, junior and high schools, early education centers, churches, homeless shelters and community-based organizations. Below is a list of class site locations for Triple P:

MHSA Triple P Site Locations
C.O.P.E. Family Support Center – Central County
Family Justice Center – West County
Martin Luther King Jr. High School – East County
Hillview Jr. High School – East County
Cornerstone Fellowship – East County *New partner
Ranchos Medanos Jr. High School – East County
Contra Costa Juvenile Hall – Central County
Shelter Inc. – Central County

First 5 Triple P Site Locations
East County First 5 Center – East County
Martinez Early Childhood Center – Central County
Monument First 5 Center – Central County
West County First 5 Center – West County
Shelter Inc. Mountain View House – Central County
Cornerstone Fellowship – East County *New partner
C.O.P.E. Family Support Center – Central County
Delta First 5 Center – East County
Antioch First 5 Center – East County
Family Justice Center – Central County

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Methods Used to Engage Potential Responders

2) Methods Used to Reach Out and Engage Potential Responders include:

- Distribution of flyers for upcoming classes to community members and other CBOs in both electronic and hard copy
- Attended community events to provide resources (such as school resource fairs and outreach events)
- Collaboration with the Contra Costa Truancy Court, School district SARB (School Attendance Review Board) panels, Contra Costa Family Court and Children and Family Services (CFS) to refer families to parenting classes
- Collaboration with school districts and administrative staff to provide referrals to parents of students within each district
- Case Management referrals for parents working with C.O.P.E. case management staff
- Website advertising of class schedule
- Referrals from community partners such as Contra Costa Juvenile Probation, Family Justice Center, Miller Wellness Center and SHELTER Inc.
- Provided briefing/orientation meetings to community agencies interested in referring members to the Triple P program. During the 2018-19 FY, the following community partners were provided with a briefing/orientation meeting:
    - **West County Children and Family Services**
    - **Contra Costa Leadership Institute (CCLI)**
    - **Scotts Valley TANF**
    - **Acalanes Adult Education Center**
    - **Pittsburg Unified School District**
    - **Court Appointed Special Advocates (CASA)**
    - **Cornerstone Fellowship**
    - **Shelter Inc.**
    - **Lincoln Family Services**
    - **Community Violence Solutions**
    - **Rainbow Community Center**
    - **Center for Human Development**

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Strategies Utilized to Provide Access and Linkage to Treatment

3) Strategies Utilized to Provide Access and Linkage to Treatment include:

- Provide in-depth/clinical assessment of need and case management to community members in need of access to services
- Development of individual case plans (Contract for Wellness) specifically tailored to the needs of each participant
- Collaboration with mental health resources such as Contra Costa Children's Behavioral Health, Contra Costa Regional Center, Mobile Response and Lincoln Family Services
- Collaborate with County agencies to provide court-certified interpreters as needed
- Referrals to community resources such as housing, job training and placement, food banks and family law centers
- Evaluate and provide individual parent consultation for Triple P participants scoring above the clinical-cutoff range in any pre-assessment (DASS, Parenting Scale, ECBI, Conflict Behavior, Relationship Quality Index), providing resources as needed
- Train staff in available resource opportunities to strengthen the support given to each participant
- External referrals to more intensive services (such as AOD, psychiatry, medical providers) as needed
- MHSA & First 5 Resident Case Manager to provide one-on-one assistance with application process for county-related services (such as CAL Fresh, Medi-Cal, MST, MDFT)

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Strategies Utilized to Improve Timely Access to Services for Underserved Populations

4) Strategies Utilized to Improve Timely Access to Services for Underserved Populations included:
   - All First 5 funded classes are free. MHSA Classes free and sliding scale Triple P classes for low-income participants
   - Delivery of classes throughout the county at various times and convenient locations to accommodate transportation barriers (accessible via public transportation)
   - Increased capacity to offer case management services for parents and families with more intensive challenges utilizing master's level MSW interns to provide individualized support
   - Provided classes in English and Spanish and Arabic/Farsi languages in each region of the county
   - Individual assessment, consultations and referrals to county mental health as needed
   - Collaboration with school districts, social workers, other service providers and families to ensure timely access to supports and resources
   - Direct collaboration with Contra Costa County CFS Social Workers II & III to ensure participant Case Plan needs are met
   - Tailored classes that include focus topics that directly address parenting needs (ex. Family Transitions Triple P specifically addresses dysfunction in the co-parent relationship and the impact such dysfunction has on the family unit as a whole)
   - After assessing family needs, we link to other community supports such as county mental health, housing, crisis centers and other resources
   - Utilizing our Clinical Trainee Program to provide immediate services to underserved populations that have had difficulty accessing the system at large (such as Contra Costa County Mental Access Line)
   - Utilizing our Clinical Trainee Program to provide more accessibility to county systems such as Medi-Cal, CAL-Fresh and other consumer benefits

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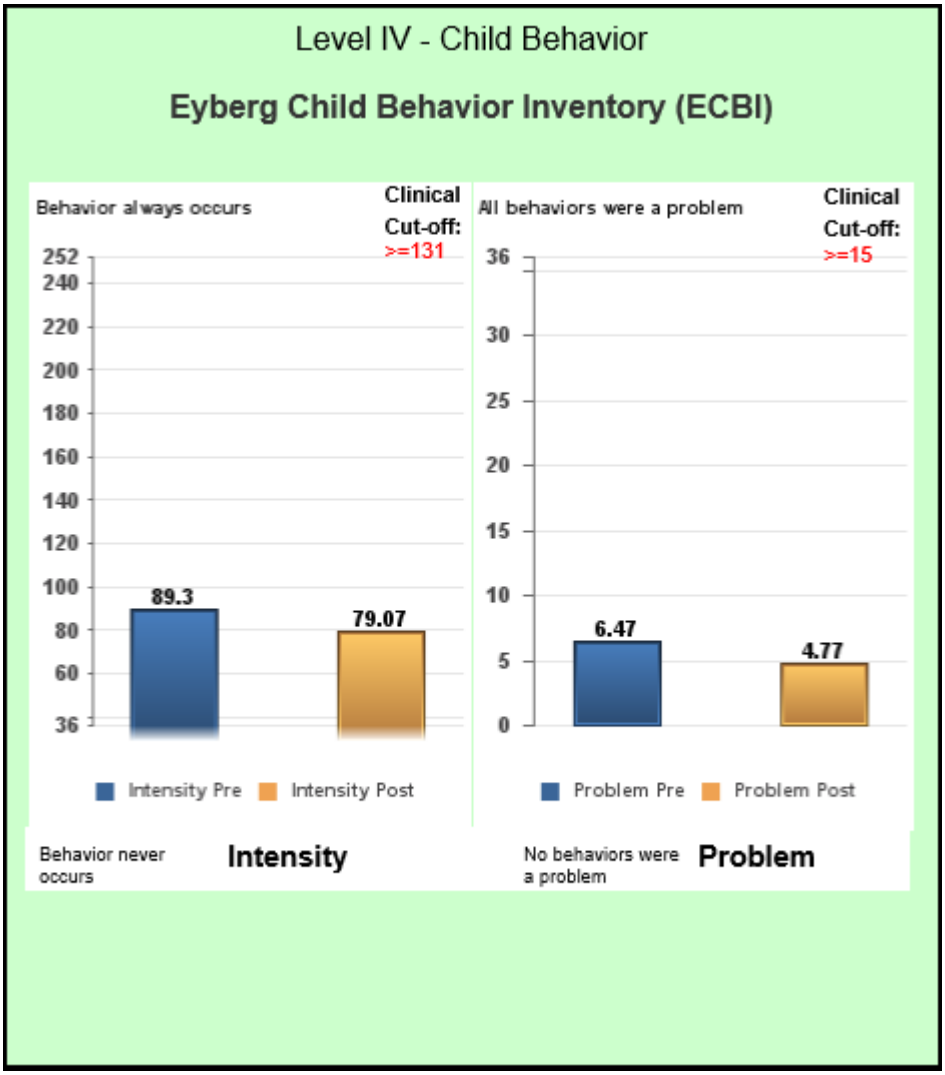
OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

MHSA Overall Clinical Outcomes

Eyberg Assessment



Intensity decreased by 11% from pre-test to post-test
Problem measure decreased by 26% f from pre-test to post-test

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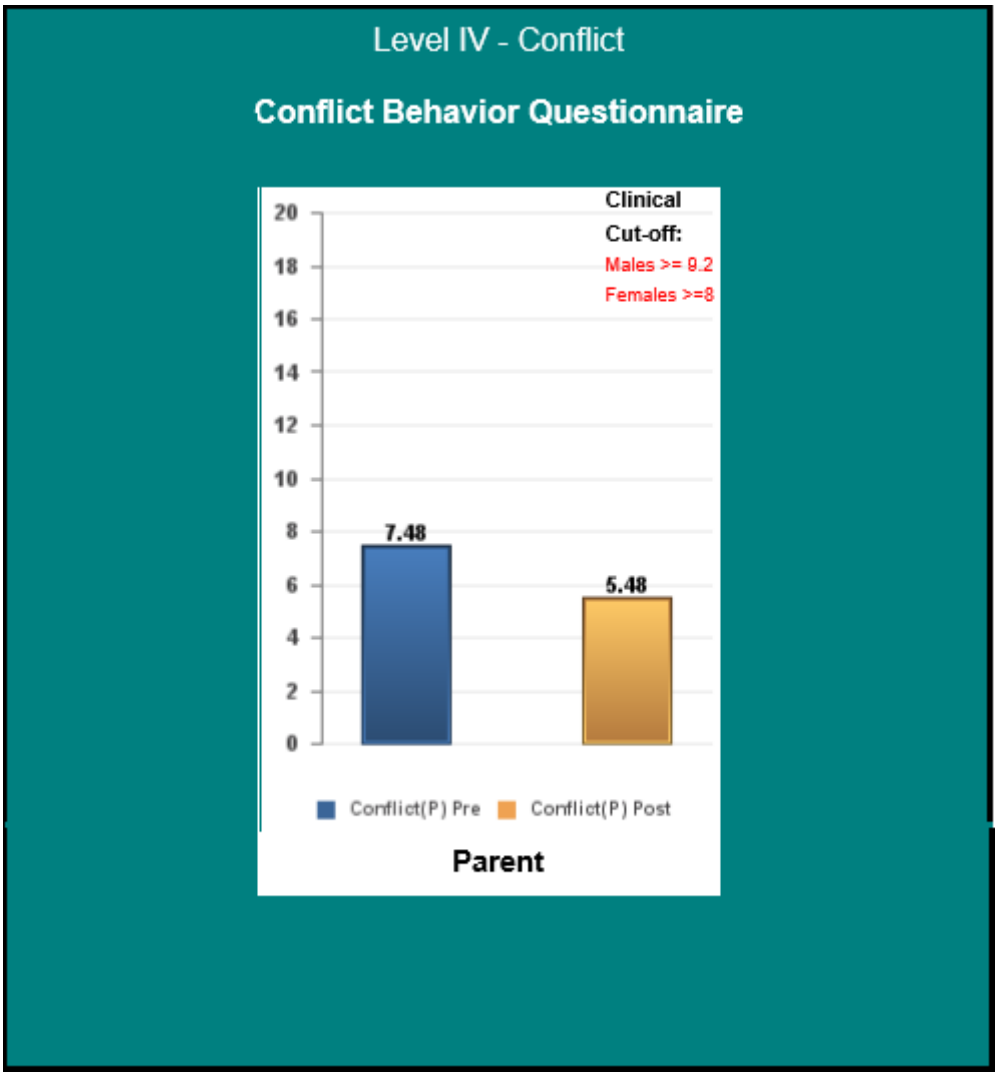
MHSA Overall Clinical Outcomes, cont.

Conflict Behavior Assessment



Conflict measure decreased by 27% from pre-test to post-test

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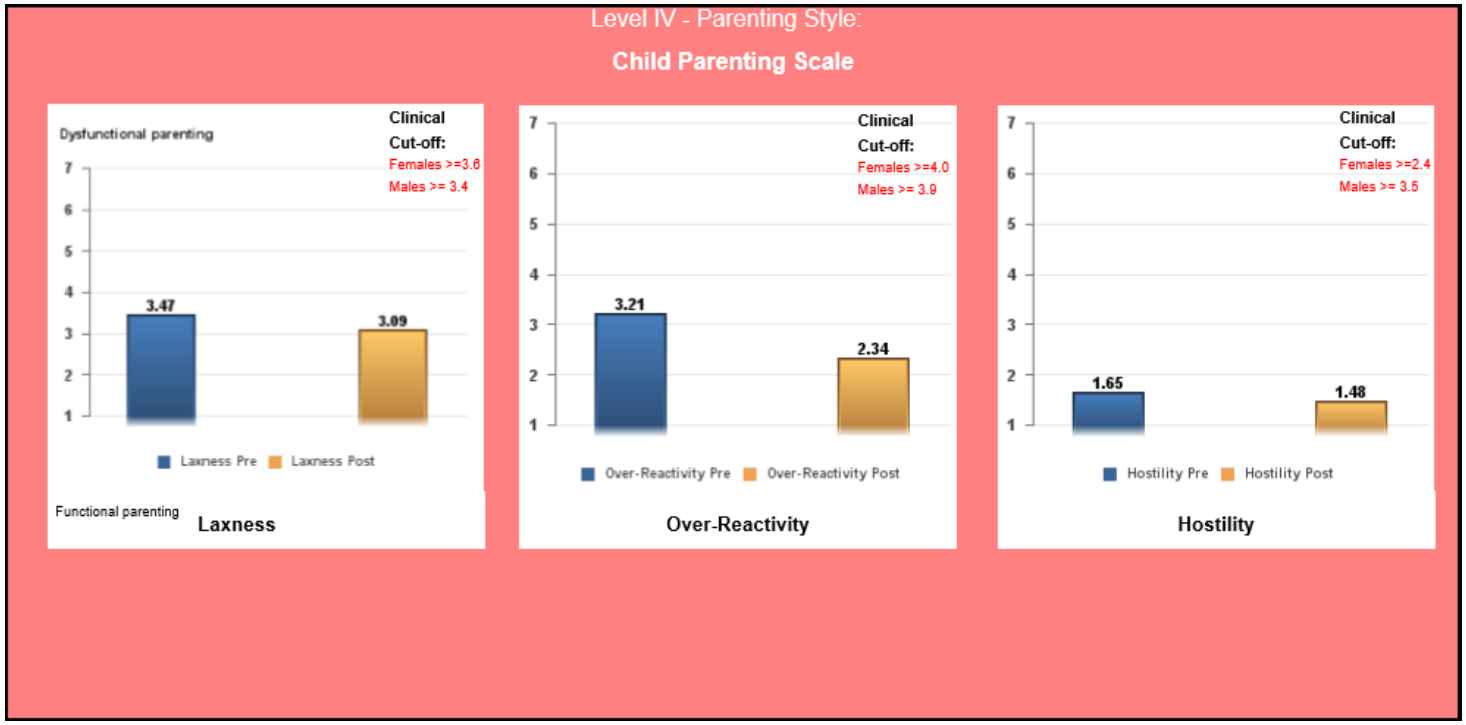
MHSA Overall Clinical Outcomes, cont.

Child Parenting Scale Assessment



Laxness measure decreased by 11% from pre-test to post-test
Over-reactivity decreased by 27% from pre-test to post-test
Hostility decreased by 10% from pre-test to post-test

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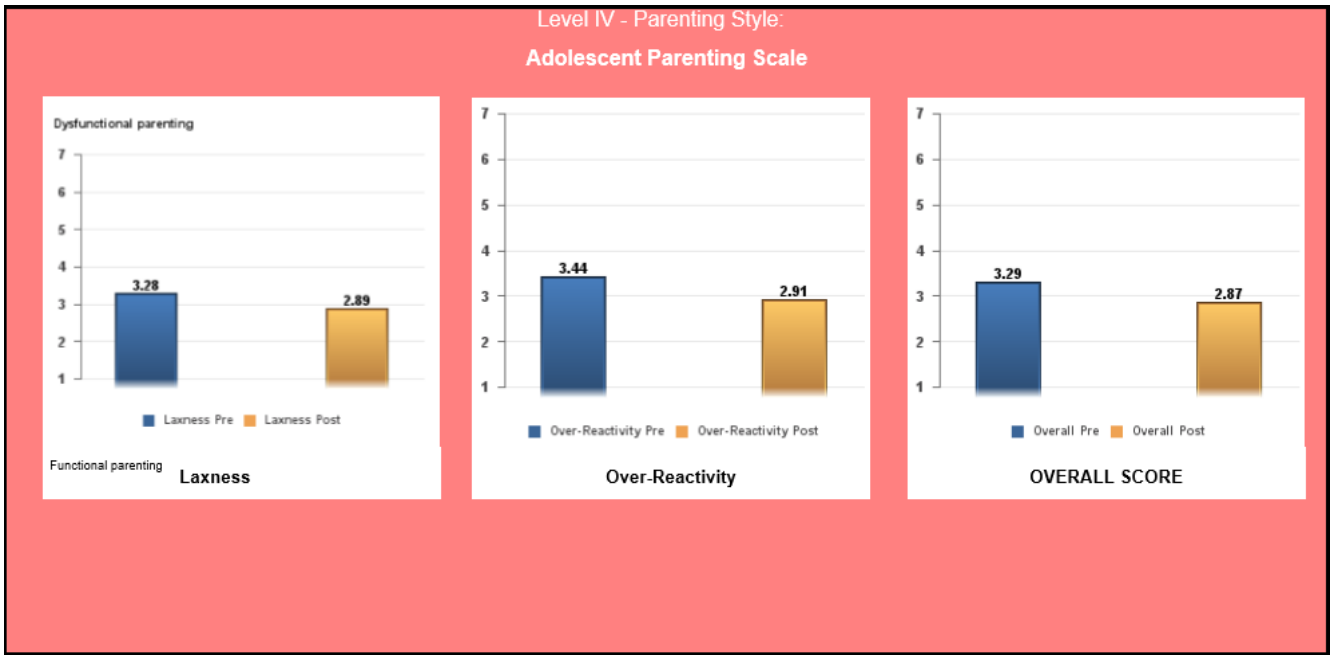
MHSA Overall Clinical Outcomes, cont.

Adolescent Parenting Scale Assessment



Laxness measure decreased by 12% from pre-test to post-test
Over-reactivity decreased by 15% from pre-test to post-test
Hostility decreased by 13% from pre-test to post-test

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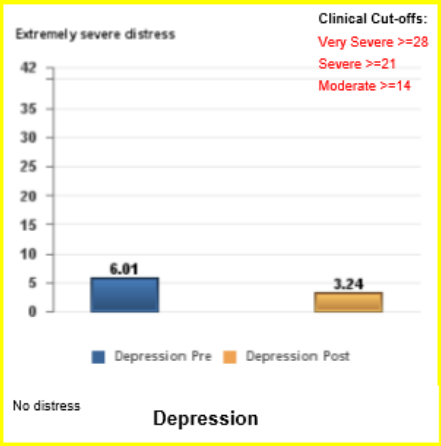
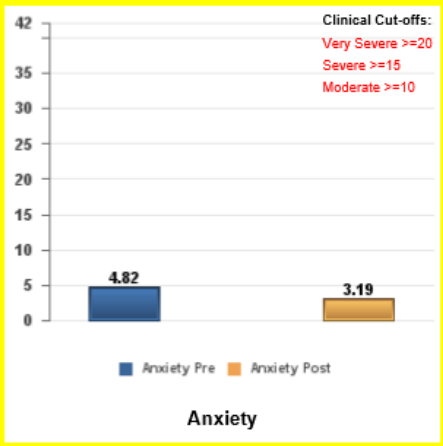
MHSA Overall Clinical Outcomes, cont.

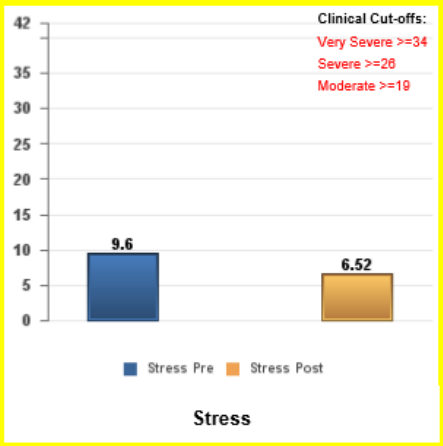
Depression, Anxiety and Stress Scale Assessment

Level IV - Parental Adjustment:

Depression Anxiety Stress Scales (DASS-Twenty-one)







Depression measure decreased by 46% from pre-test to post-test
Anxiety measure decreased by 35% from pre-test to post-test
Stress measure decreased by 32% from pre-test to post-test

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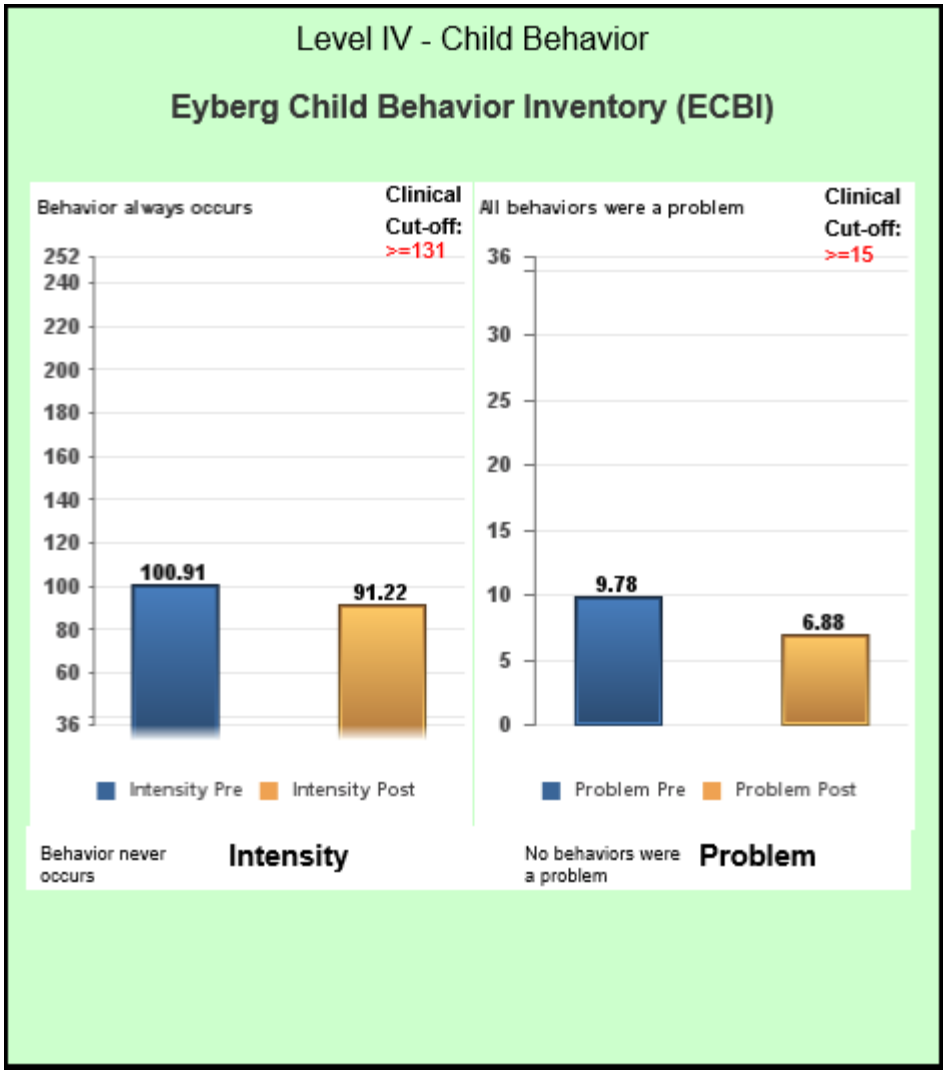
First 5 Overall Clinical Outcomes

Eyberg Assessment



Intensity decreased by 10% from pre-test to post-test
Problem measure decreased by 30% from pre-test to post-test

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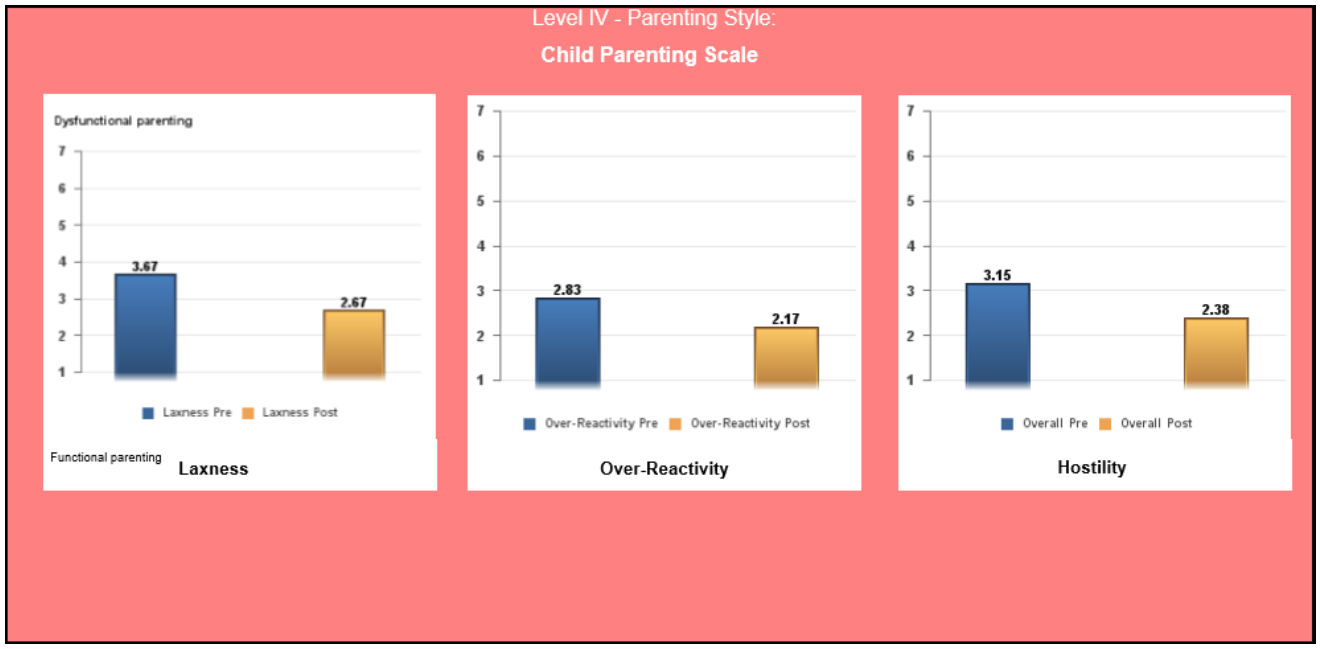
First 5 Overall Clinical Outcomes, cont.

Child Parenting Scale Assessment



Laxness measure decreased by 27% from pre-test to post-test
Over-reactivity decreased by 23% from pre-test to post-test
Hostility decreased by 24% from pre-test to post-test

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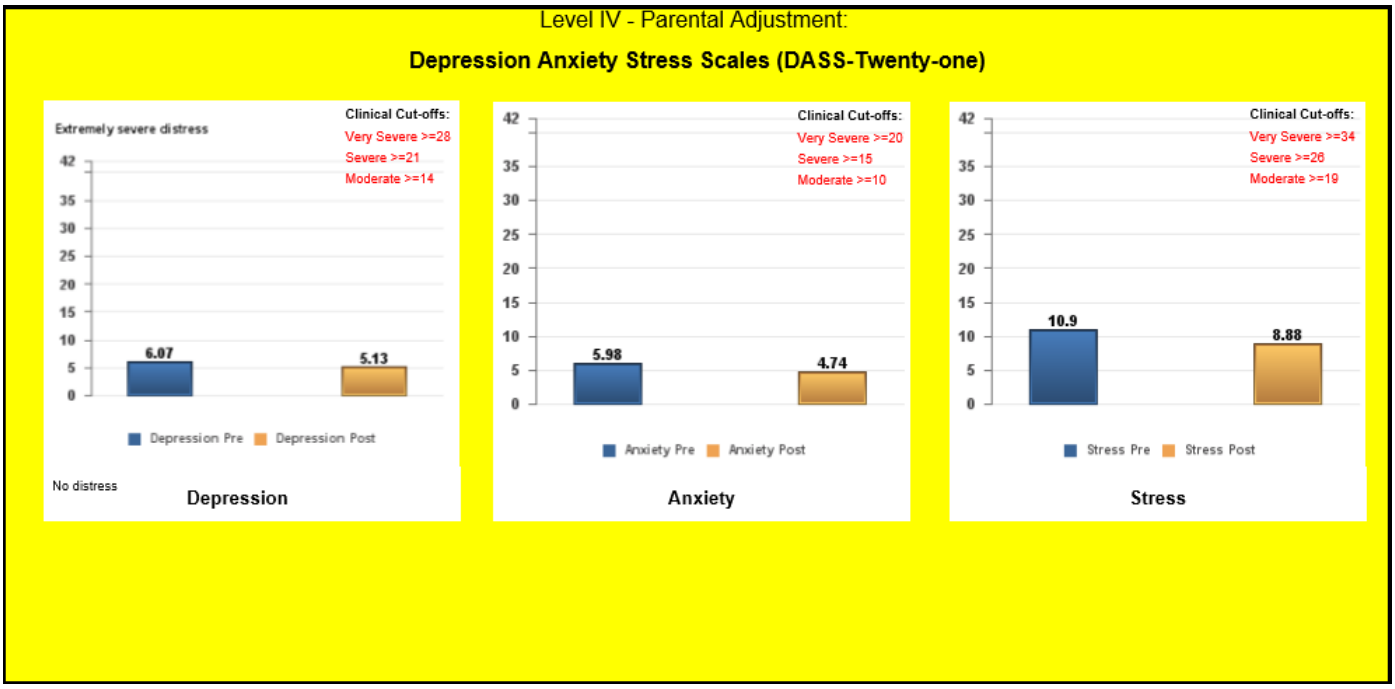
First 5 Overall Clinical Outcomes, cont.

Depression, Anxiety and Stress Scale Assessment



Depression measure decreased by 15% from pre-test to post-test
Anxiety measure decreased by 11% from pre-test to post-test
Stress measure decreased by 19% from pre-test to post-test

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DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form <u>AND</u> have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

N/A

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Values

- C.O.P.E. Family Support Center fosters a holistic approach to family wellness and recovery by providing evidence-based parenting classes along with other augmented services.
- Parents in need of further intervention are identified through their participation in Triple P parenting classes and are linked to supplementary services as needed.
- Participants may express a need for more intensive support and utilize other programs offered such as individual and family counseling, Anger Management and Truancy Intervention.
- By offering a menu of services, C.O.P.E. can provide customized support to families in need as well as identify referrals to additional resources such as county mental health, housing, food banks and family law centers.

<u>Augmented Service: Case Management</u>

Case management is provided to participating families which includes:

- Initial assessments of needs
- Parent/Family coaching
- Resource referrals
- Enrollment into appropriate C.O.P.E. programs
- Weekly check-ins from C.O.P.E. staff
- Preparation of progress reports/attendance verification

C.O.P.E. also provides a comfortable, family-oriented atmosphere for community members visiting the office for services. . In addition, C.O.P.E. employs a culturally diverse administrative staff that is representative of the community in which we serve and allows for a non-judgmental environment for all who see supportive services. C.O.P.E. has a culturally diverse Parent Education facilitation staff, both personally and professionally with sensitivity and training in the needs and characteristics of diverse populations of participants.

C.O.P.E. staff cultivate an inclusive, non-judgmental environment for participants seeking services and are trained in areas such as ACES, trauma-informed care, self-regulation techniques, conflict resolution and other methods for participant communication.

C.O.P.E. provides a culturally inclusive classroom where parents and staff recognize, appreciate and capitalize on diversity to enrich the overall learning experience. Fostering a culturally inclusive learning environment that encourages all individuals – regardless of age, gender, ethnicity, religious affiliation, socioeconomic status, sexual orientation or political beliefs – to develop respectful, effective and consistent parenting skills that nurture the uniqueness so of each family.

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

Participant Testimonials

What about this program was the most helpful?

- Learning new method to speak calmly without shouting
- It helped us to learn to educate the children and how to support them
- Helped us to better educate our children
- Learned strategies to communicate with our children without much difficulty
- I took Triple P English last year, this program is really good
- Received information on how to interact with my adolescent
- Create safe and pleasant places for rewards and contracts to spend time with her
- Helped me to understand my adolescent about his way of thinking, acting, understanding his actions. and how to apply rules and appropriate punishments
- everything
- To apply new methods to treat problems with teenagers
- How to talk with the children and give them advice
- To be able to understand my daughter's feelings
- How to understand my daughter and give more quality time and enforce rules
- Helped me to be more patient with my son, have more conversations
- Share experiences with other parents and the instructor explained very good the subject
- The different experiences shared with all the parents. the ideas shared in the videos and the examples of the teacher are excellent

- Now I have more patience now it is easier for me to talk about the problems now it is easier for me to handle the problems

What could make the Triple P classes better?

- Make the classes longer
- To have more classes to teach us how to treat our children
- Have more Triple P classes
- More time in classes
- I took class years ago, to have classes longer is better
- I think the class is very complete
- Give more exact methods and focus on how to solve problems, not so much on the problem itself
- Everything was good
- Shorter videos and more time to close
- Shorter videos and more time on tips on how to talk moderately to teenagers
- To understand how my son will react in the future helped me a lot to listen to the advice of other mothers
- Maybe a little more time of the program to understand and live more experiences
- For me it was very good class, this is my first time attending this kind of class, for me the teacher was excellent by listening to us and explained everything perfectly

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Class Pictures

Central Family Justice Center

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SHELTER Inc.

CONTRA COSTA HEALTH SERVICES

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Ranchos Medanos Jr. High School

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West Family Justice Center

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West Family Justice Center

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: CCCBH/First Hope

PEI STRATEGIES:
Please check all strategies that your program employs:

X **Provide access and linkage to mental health care**

X **Improve timely access to mental health services for underserved populations**

X **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For the past six years, First Hope has provided early identification, assessment, and intensive treatment services to youth ages 12-25, and their families, who show signs and symptoms indicating they are at Clinical High Risk (CHR) for psychosis. During this fiscal year, we expanded our program to offer Coordinated Specialty Care (CSC) services to First Episode Psychosis (FEP) young people ages 16-30, and their families, who are within 18 months of their first episode. As part of this expansion, we moved to a new location in Pleasant Hill and hired 13 additional staff, including new positions of program supervisor, a part-time RN, community support worker peer specialist, and a substance use counselor.

Key components of our program include 1) community outreach and education, 2) rapid and easy access to screening and assessment, and 3) intensive treatment services.

1) Community outreach and psychoeducation – The expansion of our First Hope services has provided an opportunity to re-engage with our various community partners and to build relationships with new collaborators. Our outreach presentations focus on the importance of early intervention, how to recognize the early warning signs of psychosis, and how to make a referral to the First Hope program. Some of the organizations we have presented to in fiscal year 2017/2018 include Seneca, Anka, the Mental Health Commission, CCCBH Central Children's Clinic, the SPIRIT program, CCCBH Financial Counselors, Putnam Clubhouse, CCCBH Psychiatrists, the Mental Health Advisory Council, CCBH Forensics Team, St. Mary's, and the Adult System of Care meeting.

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2) Screening and assessment – In order to provide a high level of responsiveness and access to immediate help, First Hope has a Clinician of the Day (COD) who takes screening calls as well as any urgent calls when the primary clinician is not available. The telephone screen helps to determine whether a more extensive SIPS assessment is indicated, whether an individual is eligible for our new FEP services (based on a combination of the potential client's self-report, a medical records review, and collateral information), or whether the caller is referred to more appropriate services. We have also established an Urgent Response Team (URT) that has some capacity to provide an urgent response to those in crisis in inpatient psychiatry or crisis residential treatment. Services are offered in any language using the language line. Services in Spanish are provided by our Spanish-speaking clinicians.

3) Intensive treatment services – Please see section below on Evidence-based or promising practices. Treatment services are offered in any language using the language line. Treatment services in Spanish are provided by our Spanish-speaking clinicians.

Functional outcomes targeted are improved functioning at school and work, improved relationships with family members, decreased need for hospitalization and PES visits, and most importantly preventing conversion to psychosis or a reoccurrence of a psychotic episode.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

We work with youth ages 12-30 who are either at Clinical High Risk (CHR) for developing psychosis, or within 18 months of their first episode of psychosis (FEP), as established by the Structured Interview for Psychosis-risk Syndromes (SIPS) assessment, the potential client's self-report, a medical records review, and/or collateral information.

The primary desired outcome for our CHR clients is to prevent conversion to psychosis in a population estimated to carry a 33% chance of conversion within two years. Secondary outcomes include reduction in crises, hospitalization, incarceration and suicide attempts or completions. We had 0 conversions from CHR to psychosis from July 2018 through June 2019. From the inception of our program in 2013, we have had 5 conversions, a conversion rate of less than 5% and a nearly 90% reduction in the predicted conversion rate if no services were provided.

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During the previous fiscal year (2017/2018), we intensified our collaboration with Juvenile Hall and started providing First Hope services to clients while they were still incarcerated, if they otherwise qualified for our program and were scheduled to be discharged from the correctional setting in the near future. This allowed us to implement intervention services even earlier than we had been able to previously. Three of our clients were re-incarcerated during the previous fiscal year (2017/2018), and one was re-incarcerated during the 2018/2019 fiscal year.

We had 3 suicide attempts and 0 suicides from July 2018 through June 2019.

Not enough time has passed since the start of our FEP services to collect needed data to assess whether the rate of PES visits and hospitalization has changed over baseline rates in our clients.

Improvement in age-appropriate functioning is also critical. Our data indicates that at the beginning of treatment the vast majority of clients were failing in school, while at discharge they were stable in school. Many who were work-eligible were now working at least part-time. We also showed a 15 point average increase in GAF for all clients, including those who did not complete the program.

We gather data on outcomes every six months of treatment and at discharge. This data is treated like all other PHI. This data is also entered into a First Hope Database that is housed on the CCC Behavioral Health server and is password protected. Only de-identified/aggregate data is shared with individuals outside of First Hope.

DEMOGRAPHIC DATA: ☐ *Not Applicable (Using County form)*
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

We use the County form to gather Demographics data for clients who engage in our assessment and treatment services. We gather different data during the outreach and screening components of our program, as described below:

Outreach: We collected different demographics for this component to target the important information needed to assess our outreach goals. The data collected include the type of service provider, the region of the county served, and the number of participants.

Screen Calls: We do not use the county demographic form in order to avoid barriers that may be encountered due to stigma or lack of a release of information. Screen calls are designed for same day conversation with one of our clinicians and in a manner that allows the caller, whether it is the client, family member, or professional, to disclose concerns without requiring background information, unless the caller is able to do so and is willing. Also, since the caller has not engaged in services and may be cautious about disclosure, we only asked pertinent questions about the client's symptoms, important history related to the symptoms, contact information, region of the county, and the referral source. The call allows the caller to inquire about First Hope services and discuss symptoms to determine if an assessment is recommended or if the client is eligible for our FEP services, and allows our clinician to offer an assessment, an intake, or a recommendation of another service. If needed, we also offer advice about how to talk to the client, son, daughter or the family about the need for early intervention.

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EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

First Hope uses the evidence-based Portland Identification and Early Referral (PIER) and Coordinated Specialty Care (CSC) models, which have been shown to be effective in preventing conversion to psychosis and the subsequent disability associated with psychotic disorders, and in ameliorating psychotic symptoms and promoting functional recovery. Both models provide comprehensive and needs-driven services utilizing the combined skills of a multidisciplinary team. Our First Hope treatment team includes a clinician, occupational therapist, educational and/or employment specialist, community support worker family partner, community support worker peer specialist, substance use counselor, RN, and psychiatrist. In addition to individual therapy, peer groups, case management, educational/employment support, psychosocial rehabilitation, and psychiatric services, clients also benefit from a heavy emphasis on family psychoeducation and engagement in Multifamily Group Treatment (MFGT).

Our clinicians are trained and certified to provide Structured Interview for Psychosis risk Syndrome (SIPS) assessments, Cognitive-Behavioral Therapy for psychosis (CBTp), and MFGT, evidence-based practices for assessing and treating CHR and FEP. Clinicians who have joined our team over the past year participated in intensive training in SIPS in February 2019 with Dr. Barbara Walsh of Yale University, one of the co-authors of the SIPS assessment, and in MFGT in May 2019 with Dr. Alex Kopelowicz of UCLA and Dr. Barbara Stuart of UCSF. Drs. Kopelowicz and Stuart will be conducting monthly supervision over the next year with audiotape review and feedback on MultiFamily Groups. All staff are expected to achieve clinical competence and certification by the end of this supervision period.

Weekly team meetings and weekly supervision meetings with First Hope's program manager and program supervisor provide opportunities to discuss services and assure fidelity to the treatment model. We also hold a weekly consultation call with Dr. Barbara Walsh, one of the co-authors of the SIPS assessment.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

First Hope practices a collaborative, strengths-based, and recovery-oriented approach that emphasizes shared decision-making as a means for addressing the unique needs, preferences, and goals of the individuals and families with whom we work. We define family broadly, that is, whoever forms the support team for the client, which may include friends, siblings, extended family, foster parents, significant others, and clergy. We

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also coordinate closely with other mental health and primary medical care service providers, to support our clients' overall mental and physical health.

Much care is taken to provide a welcoming and respectful stance and environment, from the very first contact by phone, to the individual and family's first visit to First Hope, to each and every interaction thereafter. We work closely with our families to identify and problem-solve barriers to accessing care, including childcare and transportation difficulties.

We over-screen so as not to miss any individual in need of service. Any individual who is determined not to be eligible for our program is provided with a referral to more appropriate services. For any individual/family who is found to be eligible for First Hope and accepts our services, treatment begins immediately with engagement (termed Joining sessions) with their assigned clinician.

Services are offered in any language using the language line and in Spanish by our Spanish-speaking clinicians, including a Spanish-language MFG. Our program brochures and psychoeducational materials are available in English and in Spanish.

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

Many of the individuals and families who have graduated from First Hope keep in touch with us, and several have returned as volunteers to speak with new clients and families about their experiences with First Hope. other members of the family. We also had one mother join our outreach presentation at the San Ramon Valley Mental Health Advisory Council on Feb 22, 2019. She spoke movingly about the struggles her daughter had experienced, and how much First Hope helped her daughter recover her life back.

Below is some additional feedback we have received from our clients and families:

"I have sound people who care."

"Talking one on one has been the most helpful thing. Everyone is really nice."

"I'm really happy with the First Hope group, helping my son getting much better. It's helped my son can go back to school regularly and hanging around with family."

"First Hope helped me realize my problem and talking with me to help me improve it."

"[My daughter] got the help she needed to receive home and hospital services from the school."

"The team helped solidify [my] life goals."

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"[My] family understands more."

"It's been better for me going to places with friends and family."

"I like how everyone treats me."

"I love and appreciate the staff here at First Hope. They are helpful, resourceful, caring, and genuinely good people."

"Thank you all for your true commitment to helping families and improving outcomes for young people in crisis."

"El apoyo de Colleen a sido de lo major."

"Para todo esta muy bien. Todos son muy buenos. Gracias por todo personas. Me siento yo imi niña como encasa."

"Lo que mas le ha ayudado es que lo mayoria de tiempo estan disponible"

"A saber entender lo que es siente y saber como mangejar esas situaciones."

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PEI SEMI-ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENTREPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: James Moorehouse Project (at El Cerrito High School)
Reporting Period (Select One): ■Semi-Annual Report #1 (July – Dec)
☐Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:
Please check all strategies that your program employs:

■ **Provide access and linkage to mental health care**

☐ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For 2018-2019, the JMP has a team of ten clinical interns. In the fall semester (August – December 2018) interns and staff worked at capacity across our mental/behavioral health programming—this included individual/group counseling, crisis intervention and support, youth leadership/advocacy and youth development. Our groups continue to engage a wide range of young people facing mental health and equity challenges. In the fall semester over 300 young people participated in 20 different groups and/or individual counseling. Targeted outreach and services continue to reach our English Language Learners (ELL) who receive counseling, case management, in-class support and youth development programming. In November, the JMP took 50 ELL students to the Monterey Bay Aquarium for the day. Their joy and excitement to be in community and to see the exhibits and travel outside of the East Bay, was memorable. One of our ELL students was interviewed for a national radio program, Radio Bilingue, and reported that his participation in the JMP Youth ELAC group allowed him to begin to heal from his traumatic history and his long separation from formal schooling and that he now has a family at school and identifies as a leader in his community (link available upon request). The JMP continues our partnership with Niroga to support JMP youth leaders, Culture Keepers, to lead in-class dynamic mindfulness practices in classrooms. The JMP offers ongoing coaching for participating classroom teachers to strengthen their own personal practice and their classroom leadership of dynamic mindfulness practices.

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Twenty – Forty people attend our monthly evening English Language Advisory Committee (ELAC) meetings. Families learn about navigating the school, resources in the community and how to advocate for the rights of their children. Immigrant families also receive case management support connecting them to legal, housing and other family supports in addition to counseling services for youth on-site.

There is a new principal and one new assistant principal at ECHS this year (the third in four years). While it is a challenge to begin over again with a new principal, it is a very welcome change from the previous administration. Our new principal is a strong advocate for the JMP and is enthusiastic around collaboration and shared initiatives. We are eager to capitalize on this support to grow and strengthen our work with teachers around, restorative practices, mindfulness, trauma, structural racism and other school climate initiatives.

The JMP director continues to support school communities and school linked providers to build trauma sensitive disciplinary, community building and instructional practices. She continued her work in Contra Costa and Alameda Counties as a trainer for T2 (T Squared), the Bay Area wide collaboration working to shift public systems toward trauma informed practices. She also continued to offer trainings around racial justice work with teachers and school staff through the CA School Based Health Alliance offering trainings at their annual conference in Sacramento and to school health staff in the Central Valley at a Fresno convening in the fall.

The JMP is excited to play a role in the broader movement to help schools implement more compassionate and effective practices to support trauma impacted young people to be successful in school and to integrate strategies for including racial justice in every conversation around trauma. This fall, the JMP welcomed At ECHS this work included teacher-student restorative conferences, ongoing coaching around trauma sensitive instructional strategies and the second year of a JMP led year-long professional development group with 14 ECHS teachers on race and equity. Participants co-created a safe container to deepen their self-reflection around the ways that white privilege, white supremacy and implicit bias impact their own instructional practices and drive inequitable outcomes on campus. This group will continue for a third year into 2018-2019.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

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Young people are referred for services by parent/guardians, school staff, peers and themselves.

We measure a range of indicators (see Work Plan for 2017-2018) including connection to caring adults/peers and school, and a sense of well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence). The JMP engages in ongoing formative assessments throughout the school year that include participation by JMP staff/interns, school staff and youth participants.

(From 2017-2018 Work Plan)

Outcome Statements

A) Stronger connection to caring adults/peers (build relationships with caring adult(s), peers) for participating youth.
From UCSF evaluation: 96% of participating youth reported feeling like "there is an adult at school I could turn to if I need help." 91% "I get along better with people at my school."

B) Increase in well-being (diminished perceptions of stress/anxiety, improvement in family/loved-one relationships, increased self-confidence, etc.) for participating youth.
From UCSF evaluation: 96% of participating youth "I deal with stress and anxiety better" after program participation.

C) Strengthened connection to school (more positive assessment of teacher/staff relationships, positive peer connections, ties with caring adults) for participating youth.
From UCSF evaluation: 81% of participating students reported they "skip less school/cut fewer classes after program participation.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

We have completed the County Demographic Form with the exception of the following:

Part 2: We import demographic data from PowerSchool (PS), the school district database; PS does not capture the ethnic categories listed in Part 2 of the County form.

Part 3: We capture only 6A, as reported by PS. It is not consonant with our respect for personal sovereignty to ask young people to identify their own sexual orientation, gender identity or disability status based on our need to know. Young people's identity language belongs to them; they can choose to disclose aspects of their identity in ways that feel useful and owned by them. We don't assume a right to that information.

Part 4: #8. We do not ask clients to disclose a "disability status." See Part 3 above.

Part 5: See Part 3 above.

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LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including, how the PEI program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Young people are referred to services through a "Resource Request (RR) Form" widely available on the school campus and online through the JMP website. When the JMP receives a RR form, a JMP staff/intern will meet 1:1 with the young person to determine the appropriate level of support services. This can result in participation in on-site mental health services (i.e. individual counseling or therapeutic group support), a youth development/leadership/peer support program or a referral to a community based resource. Because we are an on-site school based program, we are able to easily follow up with students to ensure that they have successfully engaged with (or formally declined) services. If there is a crisis or urgent referral, students are connected with services immediately.

The length of time between referral and entry into services is 1 – 14 days depending on the urgency of the referral and staff/intern caseloads.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

The JMP integrates an activist youth centered program with more traditional mental health and health services; we prioritize community change along with positive health outcomes for individual youth participants. Our clinical program and youth centered initiatives challenge the dominant narrative that sees youth as "at risk" or as problems to be fixed. We partner with young people to build their capacity, and connect them with opportunities for meaningful participation in the school community. Students in counseling or a therapeutic group have direct access to wider opportunities for participation in JMP programs. All of these efforts foster resilience and wellness as they engage young people and caring adults in active and robust relationships.

The range of supports and opportunities at the JMP create an energetic field that powerfully mitigates against stigma. Young people come to the JMP for a counseling appointment, to offer peer support through a youth leadership program, to participate in the ELD youth committee, Culture Keepers, Skittles (a group for queer identified youth of color) or a myriad other possibilities. The JMP is a vibrant sanctuary on campus for youth of color and young people from low-income families in a school building where social identity threat is pervasive in other spaces.

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VALUABLE PERSPECTIVES:

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

The following quotes are from spring 2018 student evaluations of JMP services and programs:

The JMP is my second family

My counselor helped me understand where my anger is coming from. I don't get into so many conflicts at home like I used to.

The mindfulness exercises that I do with my counselor have helped me a lot with my anxiety. If I feel myself getting overwhelmed, I think about my breath and do that thing with my fingers.

My favorite thing about the JMP is that they keep things confidential. It's the only place I can go where I can say what's really on my mind.

The following quotes are from spring 2019 teacher evaluations of the JMP:

The JMP is the heart and soul of our school. I don't know what we'd do if you all weren't here

I can focus on my teaching, because I know that my students are well cared for when I refer them to the JMP for support.

The Culture Keepers are a gem—please keep them coming to my classroom for presentations, student support and mindfulness! Great stuff!

The work we're doing around racism has given me a whole new way of relating to my students. I feel more awake now, better able to connect to students that before I couldn't connect with.

The JMP on campus is like a sun sending out its warm rays into every classroom. It just feels safer knowing you all are here.

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PEI ANNUAL REPORTING FORM

EARLY INTERVENTION REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: JFCS East Bay / Prevention Early Intervention

PEI STRATEGIES:
Please check all strategies that your program employs:

☒ **Provide access and linkage to mental health care**

☒ **Improve timely access to mental health services for underserved populations**

☒ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

1) We provided culturally appropriate mental health education for client groups in their native languages.
2) We served 224 individual clients – including 81 staff, 46 children, 73 parents, and 24 older adults. Our demographics are based on 133 clients, representing 46 children, 73 parents, and 14 of the older adults. Staff members who attend trainings are not included in demographics. In addition, 10 of the older adults were served in groups at Mt. Diablo Adult Day Health Center and do not provide demographic information due to HIPAA limitations, nor do they receive navigation services.
3) We completed assessment and short-term early intervention with 104 bilingual clients. This number includes 17 children (those over the age of 18), 73 parents, and 14 older adults.
4) We provided individual mental health and health navigation services to 104 clients, as above.
5) We directly provided individual therapy in Dari/Farsi for 21 clients.
6) We provided community outreach and engagement activities in all of our target populations.

1. **Cross-Cultural Mental Health Training Series.** The training series began in August 2018:
    - *August 27, 2018: Living in Fear* – The presenters provided an overview/introduction to U.S. immigration law, information about the recent orders related to immigration, and changes under the new presidential administration. The presenters also provided know-your-rights information for immigrant communities and information regarding local nonprofit organizations for immigration legal assistance. Presenters spoke about the essentials of cultural history, reasons for migration, as well as reasons for staying in the U.S. despite the constant fear of deportation. The presenter also spoke about the mental health impact of immigration enforcement policies on children, families, and communities. Presenters also

discussed the barriers and struggle of living in mixed-status families and communities and the ideas of collective healing practices and culturally appropriate ways to cope and seek support

- *October 3, 2018: Suicide Risk Assessment* – Discussed a simple and easy to use model to help increase awareness, skills, and confidence in suicide risk assessment and management for a variety of providers such as case managers, clinicians, nurses, teachers, volunteers, mentors, and support staff.
- *February 27, 2019: Mandated Reporter* – Presented in collaboration with the Child Abuse Prevention Council. The trainers spoke on California state laws related to suspected child abuse. The training covered indicators and risk factors for child abuse and the legal responsibilities of California's mandated reporters.
- *April 15, 2019: Diversity, Equity & Inclusion* – Presenters cultivated a shared anti-oppression framework and built the foundation for courageous conversations and understanding; initiated a conversation on mindfulness, capacity-building, and accountability for diversity, equity, and inclusion and recognized additional ways to know and support each other in new ways that could break old patterns.

2. JFCS East Bay held **mental health education groups** throughout the year for the Dari-, Farsi-, Arabic-, and Russian-speaking communities.

   Russian psycho-educational senior groups: took place at Mt. Diablo Adult Day Health Center in Pleasant Hill. Katya Vorobeyva, Ph.D, hosted the psycho-educational groups, which were facilitated by JFCS East Bay staff member Lila Katz:

   - *October 15, 2018: Psychoeducation* (14 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *December 3, 2018: Psychoeducation* (14 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *March 4, 2019: Psychoeducation* (10 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.
   - *June 10, 2019: Psychoeducation* (13 participants) – focus of the group was to improve mood and socialization by encouraging group participation in positive reminiscing through games and discussion.

   Afghan/Iranian parenting groups: took place in our office and community spaces. Dr. Sohi Lachini facilitated the groups:

   - *November 28, 2018: Parenting Group* (9 participants) – Discussion about parenting issues related to foods and assisting children make healthy eating choices.
   - *February 27, 2019: Parenting Group* (12 participants) – Discussion about parenting issues with children with behavioral needs.
   - *January 28, 2019: Parenting Group* (17 participants) – Discussion about parenting issues related to financial needs and early tax preparation.
   - *June 19, 2019: Parenting Group* (10 participants) – Discussion about parenting issues related to school readiness.

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Afghan/Iranian Senior groups: This year, we had decreased the number of Afghan seniors' groups to two to gradually discontinue offering the group starting in FY20. But even organizing two groups proved to be challenging because the number of Afghan/Iranian seniors who are involved with the Mount Diablo Adult Day Center has decreased significantly in recent years. Many of the seniors have passed and the few who remain active struggle with cognitive issues due to old age. We were able to facilitate one group in June 2019 with 10 participants.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***Which mental illness(es) were potentially early onset***
- ***How participant's early onset of a potentially serious mental illness was determined***
- ***List of indicators that measured reduction of prolonged suffering and other negative outcomes, and data to support overall reduction. Include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The program used the following tools to evaluate the efficiency of the program.

- Participants/clients evaluation forms for education sessions.
  - Collected after education session.
- Staff and community members' evaluation forms for education sessions.
  - Collected after training session.
- Tracking logs for:
  - Participants/clients associated with clinician and other mental health services.
  - Participants/clients associated with case managers for assessment and early intervention to community mental health services.
  - Number of participants/clients.
  - Number of participants/clients receiving navigation services.
- Pre- and post-assessments to measure progress.
  - Collected once at intake and once at exiting the program.

The indicators measured for this reporting period were:

- Ability to communicate, self-advocate, and see progress.
- Ability to apply for and receive services.
- Understanding rights.
- Access to and ability to navigate mental health system.

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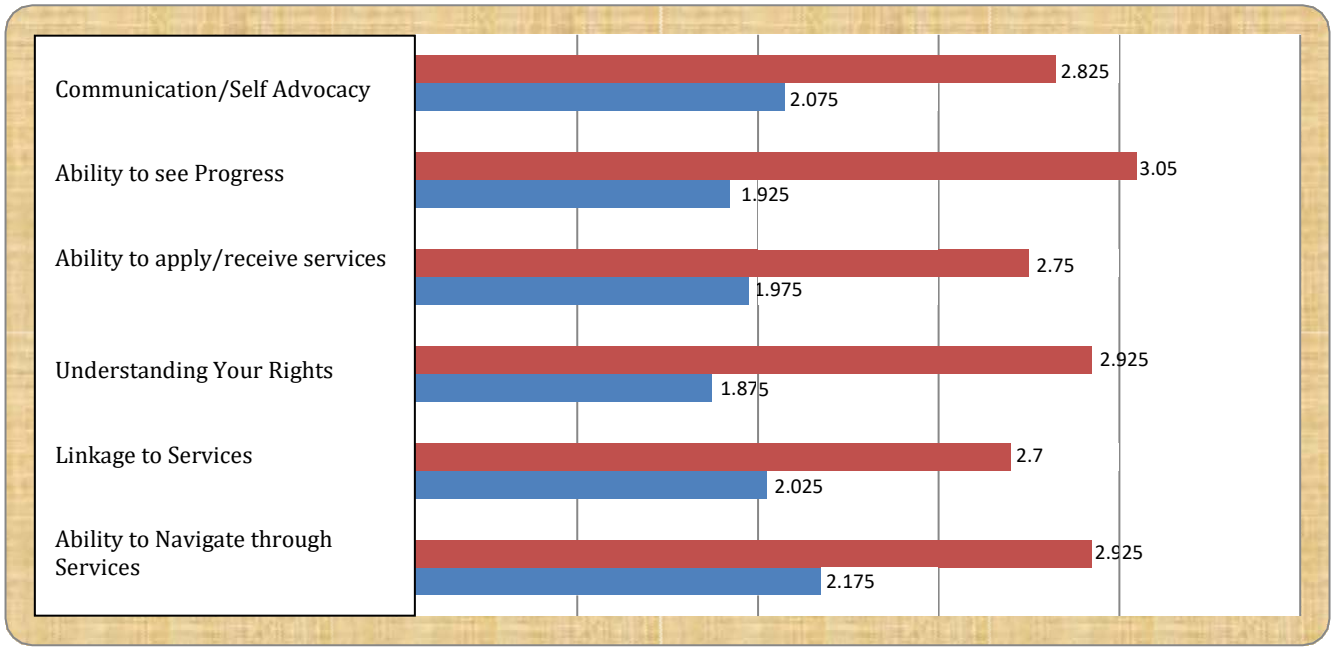
The chart below summarizes the results of client assessments as they entered and exited the program. The blue bar reflects the pre-assessments scores, done during intake. The red bar indicates post-assessments upon exiting. Assessments are on a scale of 1.0 to 4.0, with 1.0 being the lowest ranking and 4.0 the highest



The chart reflects a total of 104 individual adult participants/clients who completed the pre- and post-assessments. All participants increased in their ability to advocate for themselves, understand their rights, link themselves to mental health service, and navigate the system.

Cultural Competency: The case managers and staff are aware of, and responsive to, the cultural and demographic diversity of the population and specific client profiles. Case managers and staff understand relevant cultural information and communicate effectively, respectfully, and sensitively within the client's cultural context. During the grant period, we had Farsi-, Dari-, Arabic-, Russian-, and English-speaking staff.

Integrity & Confidentiality: JFCS East Bay's case managers and staff adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights, and act in a manner consistent with the client's best interest. Staff has up-to-date knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of client medical information issues.

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DEMOGRAPHIC DATA: ☒ *Not Applicable (Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based or promising practices are used in your program and how is fidelity to the practice ensured?

The clients served by PEI are primarily survivors of human rights abuse. They have fled war and persecution and have experienced or witnessed violence and trauma. JFCS East Bay staff worked with clients from a holistic and strength-based approach, with a focus on increasing parenting skills and knowledge of child development. In addition, our case managers help families access services to increase family stability. For families exposed to trauma, the additional stress of immigrating and starting new lives can lead to a heightened risk of child abuse and neglect. Stress can become toxic and create strain in family dynamics leading to physical conflict and abuse. By helping families navigate systems as well as attend to their mental health needs, PEI works to effectively support these extremely vulnerable and at-risk families.

Psychotherapy, including family therapy, is provided to newcomer families in Farsi and Dari. These services are inspired by evidence-based modalities such as trauma affect regulation, child-parent psychotherapy, and attachment therapy with a focus on trauma treatment. Therapy services are modified to make the treatment culturally appropriate for our clientele.

This year, case managers were trained in Mental Health First Aid and worked on identifying clients who may need further intervention, and then facilitated connections to internal mental health services and/or to partner organizations. We believe in collaborating and building partnerships to increase access to mental health services.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

JFCS East Bay's commitment and dedication to our clients greatly contributed to our success. "Welcoming the stranger" and serving vulnerable people are at the core of our mission. Having linguistically and culturally competent staff enables us to build rapport with clients, helping us better understand and respond to their needs. At JFCS East Bay, we honor our clients' strengths and resiliency and empower them by providing opportunities to identify their needs. Goals and the services provided are evaluated regularly with the client/family to ensure that they have the primary decision-making role. Clients receive wrap-around services at JFCS East Bay's Walnut Creek office; these services include case management, health and mental health navigation, mental health services,

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and parent education classes. We utilize personalized strategies to empower clients in participating in their own lives and taking steps toward self-sufficiency.

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

Shakiba* is a single mother in her early forties from Afghanistan. While she was pregnant, her husband left their home in Kabul one morning and never came back. She believes that he was killed in a suicide attack, but there is no way to prove it.

Shakiba is a college graduate and knows conversational English. She used to work for a U.S. agency's woman empowerment program in Afghanistan. Her daughter is now four years old and her parents have passed away. She has four siblings who have all migrated to countries in Europe. Upon coming to California, Shakiba was feeling very isolated and stressed and did not know how she would provide for her daughter. She was worried about the future and was finding being a mother and navigating a new country extremely overwhelming. This level of stress and anxiety put the family at risk of child abuse and neglect.

JFCS East Bay's volunteer program trained a group of five volunteers as her "Welcome Group," and found her housing with a host family in Lafayette. Our case manager helped her sign up for public benefits, including health insurance. The case manager also provided in-depth cultural orientation, including helping her learn the public transportation system. Shakiba was very eager to work, but her choices were limited since she didn't have enough childcare. Her Welcome Group decided to raise money and was able to fund her childcare for a few months, which eased the stress of having to find one alone. Shakiba was then able to get temporary jobs at a children's gym, as a teacher's aide, and as a babysitter. She finally moved out on her own and JFCS East Bay subsidized her rent for the first month.

Shakiba continues to receive health and mental health navigation from her case manager and is receiving individual therapy from JFCS East Bay's bilingual psychologist. To insure she can facilitate the healthy development of her daughter, she has also attended three of our parenting groups. PEI's combination of case management and mental health services has greatly contributed to the stability and safety of Shakiba's family.

* Name has been changed.

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18-19

Agency/Program Name: La Clinica de la Raza - Vias de Salud and Familias Fuertes

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

Vías de Salud (Pathways to Health) targets Latinos residing in Central and East Contra Costa County and has provided: a) 5944 depression screenings (198% of yearly target); b) 528 assessments and early intervention services provided by a Behavioral Health Specialists to identify risk of mental illness or emotional distress, or other risk factors such as social isolation (211% of yearly target); and c) 1,185 follow up support/brief treatment services to adults covering a variety of topics such as depression, anxiety, isolation, stress, communication and cultural adjustment (95% of yearly target).

Familias Fuertes (Strong Families) educates and supports 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. This year, the program has provided: 1) 955 screens for risk factors in youth ages 0-17 (127% of yearly target) ; 2) 185 Assessments (includes child functioning and parent education/support) with the a Behavioral Health Specialist were provided to parents/caretakers of children ages 0-17 (247% of yearly target); 262 follow up visits occurred with children/families to provide psycho-education/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues (87% of yearly target).

Services are provided at two primary care sites, La Clínica Monument and La Clínica Pittsburg. The service site enhances access to services because they are provided in a non-stigmatizing environment where many clients

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already come for medical services. As research shows that Latinos are more likely to seek help through primary care (Escobar, et al, 2008), the provision of screening and services in the primary care setting may identify clients who would not otherwise access services. Furthermore, up to 70% of primary care visits involve a psychosocial component (Collins, et al; 2010). Having integrated behavioral health care allows for clients to receive a more comprehensive assessment and treatment, especially those that cannot attain specialty psychological or psychiatric care.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Participants are referred to the Integrated Behavioral Health (IBH) team through either their primary medical provider or self-referral. Clients are given an annual behavioral health screen which includes screening for substance use and depression. If these screens yield a positive result, primary care providers discuss with the client and offer a referral to IBH. Additionally, primary care providers may identify behavioral health needs amongst their client population at any visit, discuss with the client and refer to IBH. Clients who self-refer to IBH contact the clinic themselves, or request referral during a primary care visit.

The indicators measured for Vias de Salud are:
A. 3,000 Depression Screenings will be completed annually by clients of La Clínica primary care.
B. 250 assessments and early intervention services will be provided by a Behavioral Health Specialists within the FY 18-19
C. 1,250 support/brief treatment services will be provided by a Behavioral Health Specialists within FY 18-19

The data for A-C are collected at the appointment and captured in La Clínica's Practice Management Computer system and data reports (NextGen or SSRS)

The indicators measured for Familias Fuertes are:

Familias Fuertes program, Project #6:
A. 750 Behavioral Screenings of clients aged 0 – 17 will be completed during the 12-month period by parents (of children 0-12) and adolescents (age 12-17)
B. A total of 75 assessments or visits (including child functioning and parent education/support will be provided for FY 18-19
C. 300 follow-up individual/family visits with Integrated Behavioral Health Clinicians to provide children/caretakers will participate in follow up individual/family education/brief treatment sessions with a Behavioral Health Clinician to provide children/families with psycho-education/brief treatment regarding behavioral health issues including parent education, psycho-social stressors/risk factors and behavioral health issues.

La Clínica strives to reflect cultural competency in the assessment, treatment and evaluation of the program. La

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Clínica utilizes screening and assessment tools that are evidenced-based and have been normed for and researched utilizing a similar client population. Linguistic competence, and cultural competence and humility, are central factors to the new staff hiring process and at the core of La Clínica's program design, the approaches used, and the values demonstrated by all of the staff. An embedded value is to honor participants' traditions and culture and speak the language the participant is most comfortable in. Throughout the initial and continuing training for all IBH staff, cultural and linguistic accessibility and competence is a core element to all topics. Culturally based methods including "dichos" (proverbs) and "Pláticas" or individual/family meetings are used to engage participants and employ culturally familiar stories and discussions with Latino clients. Furthermore, mental health terms are interchanged with language that is less stigmatizing and more comfortable. For example with Latino clients, sadness (tristeza) is a topic used to engage community members, rather than approaching discussions with mental health language terms such as "depression". At the same time, La Clínica strives to understand our unique client population and evaluate data while taking into consideration our unique client population. All of behavioral health providers are bilingual (English/Spanish) and most are bi-cultural. When appropriate, La Clínica utilizes translation services for all other languages.

La Clínica complies with HIPAA regulations and guidelines for all client health information and do not release any client health information to entities outside of the health center.

The average length of time between the report of symptom onset and entry into treatment for Vias de Salud and Familias Fuertes is 244.6 weeks (almost 5 years). This was determined by reviewing a random sample of new appointments for 24 clients and looking at the chart notes which document how long the presenting problem has occurred.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Data for gender identity, ethnicity and disability will only be collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment.
The Familias Fuertes program serves children and data on veteran status and military status will not be tracked.

For clients under the age of 18, La Clínica collects sexual orientation if it is directly connected to the reason for referral or treatment plan. Given that La Clínica is providing brief treatment, La Clínica wants assessments to be as targeted as possible. La Clínica also wants to be sensitive to the reality that our adolescent population is in the process of forming their identity and sexual preferences and do not think would be appropriate to ask sexual orientation in our entire adolescent client population.

For the Familias Fuertes program, data for gender identity, ethnicity and disability is only collected by clients seen by a behavioral health provider. Other demographic data is already collected and a standard part of the data collection process for all clients during registration for medical care. It would be burdensome and could harm the client relationship to try to collect this data as part of the screening process during a medical appointment.

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LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants are referred to behavioral health services through their primary care provider or self-referral. Participants are scheduled into our Integrated Behavioral Health Clinicians' (IBHC) schedules directly from their medical appointment. For more urgent need, clients are scheduled for a same-day or 'warm hand-off' appointment with the IBHC. La Clínica encourages all medical providers to discuss the behavioral health referral before it is scheduled to ensure that participant is both interested and motivated to attend the appointment. If the client does not show to the IBHC appointment, the IBHC will call the client to attempt to reschedule the appointment, which may include clarification of purpose of appointment. If the behavioral health clinician assesses participant to need a higher level of care than our program model, La Clínica will work to link the participant to the appropriate services. La Clínica continues to meet with and support the participant until they are linked and follow up with the recommended service.

For clients in the Vias de Salud and Familias Fuertes program, the average length of time between referral and treatment is 20.8 days. This is measured from date of referral from their primary care provider (or self-referral) to the date of the appointment. Please note the next available appointment may be sooner but may not fit in with the client's needs so the appointment is scheduled later.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

La Clínica strives to offer quality, consistent behavioral health services to the client population. By locating behavioral health clinicians within primary care facilities, La Clínica provides direct, often same-day behavioral health care to those who need services. Often clients are identified as needing behavioral health support in an early stage, before they have developed severe symptoms. In these cases, services promote client wellness and provide coping skills that prevent the need of a higher level of behavioral health care. For clients with more severe symptoms, La Clínica able to assess them in a timely manner and determine what course of treatment would be most appropriate. La Clínica clinicians work in a team-based approach along with our medical providers to offer holistic care that addresses the intersection between physical and mental health. This team approach is both effective and proves to have the best outcomes for La Clínica's client population. Many of the clients who access behavioral health care at La Clínica would not otherwise have access to behavioral health for a variety of reasons including: transportation difficulties, stigma associated with behavioral health access, and

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inability to navigate the larger behavioral health system due to language barriers and system complexity. La Clínica makes every effort to provide services equally to all clients who are open to receiving care. Staff use non-stigmatizing language by interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. La Clínica emphasizes the improvement in well-being, recognizing disequilibrium, and providing tools and resources for establishing emotional well-being, physical health, and supportive, healthy relationships in one's life. La Clínica also helps normalize mental health issues by pointing out the prevalence of mental health challenges, the availability of a range of treatment services, and the efficacy of support and treatment to help reduce stigma.

VALUABLE PERSPECTIVES:

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

Client story #1:
Behavioral Health Clinician began working with a 20 year old female client in May of this year. She presented with moderately-severe depression symptoms and severe anxiety symptoms due to the stress of dealing with a sister with opiate addiction for the past three years. At her initial visit, she described feeling "out of control" with her emotions as a result of the instability and chaos her sister caused her family. Behavioral Health Clinician has worked on the reactivation of behavioral strategies (exercising, spending time with supportive people in her life) and developing mindfulness skills. Currently, they are midway through the course of treatment and client has shown a reduction of symptoms (at last visit reported mild depression symptoms and moderate anxiety symptoms). Despite the continued uncertainty of her family situation, this client has expressed benefit from increased awareness and validation of her own emotions through mindfulness exercises/skills, she stated at last visit that by doing mindfulness exercises, she was able to get in touch with her own emotions without feeling out of control, which led her to acknowledge her own strengths and options for taking care of herself while being a source of support for family members.

Client Story #2:
Female client was referred by her primary care physician for severe depression symptoms that included sadness, passive suicidal ideation, problems with sleep, excess worry, anxious, headaches, nightmares, fatigue, and anhedonia. Client had recently arrived to the US from Mexico and was having difficulties adjusting to a new environment, culture and language. There were other significant stressors that worsened client symptoms such as a recent divorce, her living situation: lived in an old commercial building with no bathroom and kitchen and unstable relationship with her new partner. Client attended IBH sessions for several months, in counseling she developed coping skills and learned strategies to improve her partner relationship. With a strength-based approach in therapy client improved her symptoms, developed self-confidence, started doing community work, and attended ESL classes. With the support of our IBH case manager, client applied for a scholarship that was granted to obtain her certification in a trade school. Client ended IBH services and once in a while stops by to update us with her progress.

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PEI ANNUAL REPORTING FORM

ACCESS & LINKAGE TO TREATMENT REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Lao Family Community Development, Inc. (LFCD)
Health and Well-Being for Asian Families

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **Provide access and linkage to mental health care**

☑ **Improve timely access to mental health services for underserved populations**

☐ **Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

The Lao Family Community Development's (LFCD) Health and Well-Being Program for CCC Asian Families (HWB) continued to focus on delivering PEI services to 125 unique clients targeting South Asian and South East Asian immigrant/refugee/asylee residents living in Contra Costa County. This report covers services provided between July 2018 to June 2019. We served 125 participants from both communities representing a diverse group (Nepali, Tibetan, Bhutanese, Laotian, and Mien) Majority (70%) of the clients were aged 26-59; seniors over 60+ years was approximately 26%; and young adults ages 16 to 25 were (4%). For FY 2018 – 2019, a total of 125 participants were enrolled (104% of enrollment goal for this fiscal year).

We provided navigation and timely access to internal and external services including linkages to mental health and other service providers such as: *a) Partnerships for Trauma Recovery in Berkeley, a community based organization offering linguistically accessible mental health care and clinical services; b) Contra Costa Regional Hospital in Martinez, West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, California's Employment Development Department, Kaiser Permanente in Richmond, RotaCare Bay Area Richmond Clinic, and Highland Hospital in Oakland, all public health facilities for physical health services and severe mental health access; c) La Clinica Fruitvale Free Clinic in Oakland for free physical medical and mental health service, d) Bay Area Legal Aid in Oakland and Richmond, for related services in family violence, restraining orders, and other civil legal assistance, e) linkages to access the American Bar*

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Association for pro-bono and consultation in legal services (free or low cost consultation), and f) Jewish Family Services – East Bay for naturalization and citizenship services to address our clients' issues affecting their mental health and recovery needs.

For timely access, we escorted high barrier clients such as seniors with visual and physical disabilities; monolingual language barriers, and those with few other options for transportation to 1) mental/physical health evaluations and appointments at to Contra Costa Regional Hospital in Martinez, West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Partnerships for Trauma Recovery in Berkeley, Kaiser Permanente in Richmond, RotaCare Bay Area Richmond Clinic, Highland Hospital in Oakland, and La Clinica Fruitvale Free Clinic in Oakland; 2) the USCIS office in San Francisco for immigration assistance; 3) Jewish Family and Community Services – East Bay for onsite legal assistance with naturalization and immigration services 4) Federal SSA offices in Richmond or Oakland for SSI benefits or Temporary Protected Status. These access and linkage services were provided for clients by providers located in both inside and outside CCC county in line with participants' individual service plans.

Enhanced services included: 1) assisting individuals to build connections and links in their cultural communities; 2) strengthening family relationships and communication within their families; 3) reducing stigmas associated with seeking mental health support through education and awareness; and 4) helping individuals learn how to navigate the public and community mental health and well-being systems and in some cases private providers.
The following were activities during the program year:

1. Strengthening Families Program (SFP) Educational Workshops:

LFCD held a total of 18 SFP workshops during the program year. (2 workshops per month from August 2018 to April 2019). We focused on graduation and closing out of cases in June 2019. We continued to conduct SFP workshops for the two population groups separately to accommodate their specific needs. SFP workshops for SA and SEA populations varied from 4-5 hours per month. Weekly 1-2 hour SFP sessions were delivered on an as-need basis. SFP workshops and sessions were delivered in a variety of locations and timeframes. Locations included participants' homes, community parks, community buildings and at LFCD's community-based facilities during the weekday evenings, days and weekends as needed.
For our South Asian population, a 5-hour SFP workshop session was preferred due to personal, work, and school schedules. The top 5 most significant challenges identified by the South Asian population were: 1) parent relationship conflicts 2) mental and health insurance access, 3) behavioral health in areas of alcohol and drug abuse and its relationship to well-being, 4) healthy communication conflict resolution skills within the family, 4) wellbeing and resilience in the areas of immigration status such as Temporary Protected Status (TPS), green cards and citizenship, 5) need for jobs-employment-financial stress. These topics were incorporated into the SFP workshops including having guest trainers and additional ones were provided as requested.

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The Southeast Asian population preferred monthly 5-hour workshops in addition to weekly sessions as needed to allow clients to make up missed workshops. The top 5 most significant challenges identified by the SEA population were: 1) mental health/SSI related assistance, 2) affordable housing assistance, 3) health insurance/mental health access, 4) citizenship and employment, 5) parenting and reducing family conflicts.

Program format for both populations included integration of these identified challenges into each SFP workshop module using discussion and group peer counseling and individual case management and counseling. Linkages and connections to resources were provided to participants in line with their individual goals. Timely access and referral are part of the case management protocol and participants were provided services through internal programs and CBO providers in the community. This timely and relevant menu of linkages are critical in providing positive reputation for successful outreach, engagement and retention of participants, and SFP workshop completion and individual service plan achievement. Program feedback from SFP workshops and/sessions indicated that program participants continue to prefer the following:

- Outdoor settings for peer/individual activities-physical health and mental health benefits including the use of the Health and Well-Being Community Garden at the San Pablo. NOTE: LFCD plans to complete the expansion of the Community Garden to the Community Building located across the street from our San Pablo office.
- Strong preference for community and spiritual related events for building social connections
- Preference for interactive socialization time with other participants and outside groups
- Live music/dancing as therapy to help reduce stress, reduce pain, depression, anxiety
- Interactive activities in workshops/social gatherings

2. Enrollment and Participants Individual and Family Goals

By June 30, 2019, a total of 125 program participants were enrolled for FY 2018/2019. Of the 125 participants, 26 participants (21%) were from East/Central Contra Costa County. Each intake enrollments took 1.5 to 2 hours to complete. Participants developed individual and/or family written goals working closely with case managers. Exits and entrance are on a rolling basis.

Participant goals examples include:

a) To access and obtain treatment for mental healthcare and evaluation for severe mental health issues, PTSD, etc.
b) To access SSI benefits for elderly participants with visual impairment and other disabilities
c) To access health and mental health services through Covered California exchanges or other low-cost health insurance options including County Basic Care, Medical, Medicare, CalFresh and other free services.

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d) To obtain/increase access to preventative health care including annual physical examinations
e) To access permanent affordable housing (public housing, section 8, foreclosure assistance, etc.)
f) To reduce anxiety and depression related to citizenship, naturalization, unemployment and under employment.
g) To reduce stress related to financial hardships and lack of money for basic needs (mental health stress and well-being related illnesses)
h) To develop and maintain healthier lifestyle behaviors
i) To improve their relationships with immediate family members/children/grandchildren
j) To be more engaged and civic oriented within their community
k) To increase integration into US society through citizenship access

Outreaching strategies continue to include word-of-mouth referral from alums, current participants and South Asian/Southeast Asian community members. LFCD has a strong and established reputation among the communities of the targeted population.

Alums are important for outreach, promotion and referrals through their networks to build awareness of the services available and to reduce stigma around mental health. Case managers must still continue to actively do direct outreach at local ethnic events such as community New Year celebrations (e.g. Mien, Khmu, and Nepalese) and social faith-based events. Case managers also conducted outreach at ethnic grocery stores, ethnic community leadership meetings, and other ethnic community gatherings. Outreaching at these events allowed case managers to continue to build awareness of the program services; personally engage and build collaboration and rapport with ethnic group leaders; and to outreach to new community members. The HWB outreach strategy ensured that program staff continue to connect with hard-to-reach populations.

Case managers continued to leverage partner relationships with local service providers for needed service to address needs in the individual service plans. Community building with CBOs and stakeholders has allowed the HWB program to expand deliverable services. An example of this is an MOU signed with Jewish Family Services to provide on-site legal assistance with immigration and citizenship issues at the LFCD San Pablo office once a month. Referral relationships have been valuable in recruiting and retaining program participants by allowing participants to become more aware of different community, public and private resources available to them within Contra Costa County.

3. Thematic Peer Support Groups

The HWB program participated in 8 thematic peer support groups during this reporting period. These events allowed individuals to 1) make connections in the community, 2) become more aware of available public/private services including mental health assistance and how to navigate these systems, 3) communicate with family members across generations and 4) increase timely access to services by making a personal connection with HWB staff. The following

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is a brief summary and highlights of each event.

- September 23, 2018 - A Meet and Greet Event was attended by 44 clients with food provided. A program introduction was provided by LFCD CEO Kathy Chao Rothberg that encouraged participants to take advantage and become engaged in the HWB program. Certified Zumba dance instructor led the group in Zumba activities and ethnic food was provided. Topics presented including Covered California, Census 2020 and community participation. Participants were encouraged to assist each other to reduce stress and isolation. Former clients shared their inspirational success stories including a recent college graduate who has a disability and is continuing her path to self-sufficiency.

- October 28, 2018 - A Halloween BBQ was held at Wildcat Regional Park in Richmond, CA with 21 Southeast Asian attendees participating in Halloween activities such as learning the way Halloween is celebrated in different cultures. Participants introduced themselves and their families in a meet and greet session. A "walk and talk" session followed lunch with participants taking advantage of the local hiking trails.

- October 28, 2018 - A Senior Clients Appreciation event was held in Rodeo, CA with 45 Nepali participants including 12 new participants. Senior clients blessed younger participants. Traditional Nepali songs and chants were played, and health information was provided on Covered California including locations of free or low cost flu vaccinations.

- November 25, 2018 - A Thanksgiving Festival was held at a participant's home in Rodeo, CA with 42 people attending including 15 new clients. The participants celebrated with a traditional Thanksgiving meal plus a special cake for an established family from the program who was moving to Texas and guitar music provided by community members. The HWB Case Manager presented information on Covered California and highlighted mental health access through this program.

- December 16, 2018 - The HWB Christmas Event and Toy Giveaway was held at the Community Building in San Pablo with 71 clients and family members attending in total with 27 of them regarded as new participants. The purpose of the event was to bring clients together to reduce isolation and meet new families. A Covered California representative provided information and answered questions concerning insurance after the meal. The City of San Pablo in partnership with LFCD provided some of the toys provided to the children in attendance.

- April 28, 2019 - A Lao New Year event was held at a community member's residence in San Pablo with 25 family and friends in attendance. The focus of the event was to learn about Lao traditions and culture. Younger attendees participated in a traditional ceremony where they asked for forgiveness and blessings of their elders. The group also participated in a group walk in the surrounding neighborhood as a means to make connections and reduce isolation/fear.

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- April 20, 2019 - A Nepali, Burmese and Lao New Year Celebration was held at a client's residence in Rodeo, CA with 45 clients attending. Activates included tug of war, cultural dances, and yoga from a local yoga guru before the meal. HWB Case Manager provided a presentation to emphasize the need to take time for your own health and well-being including flu vaccinations.

- June 29, 2019 - A Graduation Event from the of the HWB program was held at the Community Building in San Pablo for 51 clients and their family members. Important information was provided about the continued support provided by the program. Certificate of Completions for SFP workshops were presented to graduates of the HWB Program in FY 2018/2019. Ms. Anupama Chapagai of Bay Area Legal Aid presented information on workplace safety and chemical hazards (lead, asbestos, etc.) that has been a concern of many clients living in older rental housing. Other representatives of Every Women Counts and Nepali Association of Northern California provided information about their organizations and service. Other information from the HWB Case Managers included mental health access and health insurance options that are free and low cost. Small group discussions focused on how to access different services and related experiences from clients.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

Participants were given a Pre and Post Lubben Social Networking Scale (LSNS-6) mental health assessment to help identify mental health needs. The LSNS-6 assessment was administered to each individual program participant at the beginning and end of their time in the program. According to program protocol, clients with initial or final scores that indicate a high level of social isolation and/or a lack of social connectivity are recommended and referred for mental health assistance.

The LSNS-6 assessment is a tool that measures social connectivity and gauges social isolation in adults by analyzing the perceived support that the participant receives from family, friends and neighbors. According to Boston College's School of Social Work, the LSNS-6 "consists of an equally weighted sum of 10 items used to measure size, closeness and frequency of contacts of a respondent's social network." This provided quantitative data that measured the effectiveness of our HWB program within the framework of establishing mental health/well-being through social interaction/community building.

A total of 125 clients completed the Pre LSNS assessment and 125 clients completed the Post LSNS assessments. The average progression was 7 with a high correlation between the

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participant's progression and level of participation in monthly social peer support groups activities and workshops.

Please refer to the table for LSNS results:

	Pre-LSNS	Post-LSNS	Progression
# of Completion:	125	125	-
Average Range:	17	24	7
(Min) Range:	9	16	5
(Max) Range:	23	30	7

In addition, case management provides a continuous contact and monitoring of clients to determine if any trauma or event has affected their mental health status. Referrals to link participants to more rigorous mental health assessments and treatment were provided on an as-needed basis.

Internal evaluation of the program includes reviewing cases to ensure strategies for communication and taking into account the cultural competency of the counselors. Cases are reviewed to ensure participants in the program receive services that are linguistically and socially appropriate. Examples of these services include communicating in their native language (Mien, Lao, Thai, Nepalese, etc.) and understanding the cultural norms in order to address health and well-being issues in an appropriate and effective manner. A thorough review of cases every 6 months ensure that the confidentiality and integrity of the participants' information is protected.

A program activity evaluation form was completed per each activity conducted (e.g. ethnic peer support gatherings and SFP workshops). In each program activity, 5 random participants were asked to complete the activity evaluation form. This process allowed a program staff or volunteer to work one-on-one with the non-English monolingual participant to complete the form. Each set of completed evaluation forms are attached to an activity reflection form for documentation purposed. The evaluation forms are reviewed by the program staff and changes were implemented according to the participants' evaluations. Comments in the evaluations included recommendations for cultural activities, outdoor events including using the recently opened Community Garden at the San Pablo office.

The last evaluation tool used was a general program evaluation form that was created by the program staff to measure the participants' comfort level, participants' engagement and the cultural competency of the program services. The tool was also used to measure the participants' knowledge of accessing services that were related to their mental health and well-being and the impact of stigma on their will to seek services after receive program services. The evaluation was completed via phone by non-program staff that spoke the same languages as the participants.

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The results stated that the 93% (116 of 125 respondents) of the participants were satisfied with the program services, and 7% (9 of 125 respondents) were somewhat satisfied with the program services. Some of the resources the participants listed on the survey were West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Community Health for Asian Americans in Richmond, California EDD in Richmond, Department of Rehabilitation in Richmond, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, La Clinica Fruitvale Free Clinic in Oakland, and East Bay Area Legal Aid in Oakland and Richmond, Law office of Laura A. Craig, Jewish Family Services – East Bay in Walnut Creek, etc.

From July 2018 to June 2019, there were 2 participants that were referred to mental health services as a result of monitoring clients' mental health status. The participants were referred to therapy related to PTSD and expressed symptoms of distress, anxiety and depression. The average length of time between report of symptom onset and entry into treatment was from 2 to 6 weeks depending on availability of services with an average time of about 4 weeks.

One of our continuing challenges is utilizing the county mental health services as it can take up to 16 weeks to get an appointment. By comparison, access to private low-cost and CBO mental health services takes an average of 4 weeks.

DEMOGRAPHIC DATA: ☑ Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including, how the PEI program follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Participants were linked to mental health services and other providers depending on their need and goals identified in the individual service plan. From July 2018 to June 2019, this PEI program referred participants to different agencies inside and outside Contra Costa County using the following step-by-step procedure:

1) We carefully, patiently and attentively listen to the participants in a safe confidential setting as they explained their needs. Through our culturally competent counselors, we begin to establish understanding and trust with the participants. The LFCD office in San Pablo was able to add a new confidential private room that is used for intake, counseling, etc.

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2) We gave support to participants while helping them develop their individual service plan with step by step goals and tasks including identifying linkage providers.

3) Then, we encouraged individual participants to access and seek service provided by others. This process can take from 4 to 8 weeks in duration.

4) Once the participant feels strongly that they can trust us with their confidential information, then we escort them (most of the time) to the provider for the warm handoff.

5) If we are not able to do this, we set up a phone conference call to provide an introduction and assure that there is a translator available when they go to their appointments. We also provide the participants with name and address to assist them. If the provider is not available, we send an email and call while the participant is there to witness this.

6) Next, we followed up with the participant and referral partner within the week. Then we stay in contact either weekly, every two weeks, 3 weeks, or monthly depending on the length of time in their treatment and in the program with more attention upfront until the treatment is complete. Average time from the referral to consultation first appointment, evaluations and then entering into the treatment at the referral partners' office is 1 to 8 weeks (depending on availability of interpreters and appointment slots at the outside partners; we have found public providers take longer than CBOs or private).

This is the list of the external services including linkages to mental health and other service providers such as:

1) West County Health Center in San Pablo, Contra Costa County Mental Health Services in San Pablo, Community Health for Asian Americans in Richmond, California EDD in Richmond, Department of Rehabilitation in Richmond, Contra Costa Regional Medical Center in Martinez, Highland Hospital in Oakland, RotaCare Bay Area Richmond Clinic, Kaiser Permanente in Richmond, La Clinica Fruitvale Free Clinic in Oakland, Trauma Recovery in Berkeley, and Regional Center of the East Bay in Concord for physical health services, severe mental health access and/or developmental disability services.

2) Dr. Lee Hee, MD, a private practice medical doctor in Oakland for affordable medical care.

3) Bay Area Legal Aid in Oakland and Richmond, East Bay Sanctuary Covenant in Berkeley, law office of Judith Lott in Oakland for related services in family violence, restraining orders, immigration assistance and other civil legal assistance and linkages to access the American Bar Association for pro-bono and consultation in legal services (free or low cost consultation) for our participants' needs affecting their mental health and recovery needs.

4) Jewish Family Services – East Bay, to assist with naturalization and immigration services on

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site at our San Pablo office at regularly scheduled intervals.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

At the end of the 12-month period, we reflect on our work and partner linkages. Our evaluation is that our program values reflect MHSA values in these areas:

1. Our written program policies and agency commitment and practice of providing a safe, trusting, and confidential setting at LFCD and elsewhere engenders feelings that there is no stigma. We patiently listen to understand. Knowing that anything shared is safe and that no one other than who they authorized will know.

2. We have a zero-tolerance policy for discrimination or prejudice on the basis of race, place of origin, gender, religion, disabilities, etc. and our practice gives participants confidence that they are not discriminated upon.

3. Our practice and demonstration of our commitment to timely access for our clients. This results in the high level of satisfaction feedback we get from our clients with service provided in terms of case management, peer support, reduction of isolation, comfort in asking for helping and talking to others about mental health and increased knowledge of services in the community. Our services are provided daytime, nighttime, weekends, and escorted assistance.

4. Our strategy to establish trust first through case management-leads to participants engaging at a higher level and higher graduation from the program and accomplishment of their goals. Our Case Managers are well-respected members of the communities that they serve which allows for an engaging relationship with participants.

5. Providing participants with timely access and warm handoffs to linkages (specific person with the linguistic and cultural competency) to the mental health PEI services and providers helps participants to begin their recovery path sooner. Several mental health providers have provided reflections about the importance of participants trusting our Case Managers that results in a better handoff to services.

Our thematic peer group activities; individual connections to the counselors, linkage providers, and each other; cultural activities, food, music and indoor/outdoor physical activities selected based on participants' wants and needs engenders resiliency and wellness. These activities help participants build their resiliency and their recovery from crisis.

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VALUABLE PERSPECTIVES:

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

During this time period, we have had several clients with mental health stress as a result of issues concerning immigration, housing, finances, physical health and death in the family. Here are a few stories related to mental health stress:

Ms. A is a 38-year-old Nepali who was referred to us by Bay Area Legal Aid in July 2018. From monitoring her situation, it became evident she was experiencing a lot of stress and anxiety due to a situation in her home country. Due to her visa requirements, she was separated from her small children and her husband who are back in Nepal. In addition, her in-laws seized her and her husband's property in Nepal which ended up in a prolonged court case. She was also diagnosed with stomach cancer and suffered from extreme anxiety. The HWB Case Manager referred her to the East Bay Trauma Center to provide immediate access to mental and physical health professionals. She is currently in therapy and takes medication to reduce her anxiety, address her stress related conditions and treat her cancer. She has benefitted from participating in the LFCD PEI program activities which has provided more connections in her cultural community to provide her support and comfort while providing access to mental and specialized medical services.

Ms. A is a 58-year-old Laotian woman who came to the US in 2001 and was sponsored by her husband. In 2014, they divorced, and she has struggled to get access to housing, health benefits, etc. For example, she has struggled since 2015 to qualify for Medical because he continues to claim her under his health insurance without her having the ability to use it. The HWB Counselor has helped her navigate the mental and physical health system to get the services she is entitled to receive. She currently receives Medical to address her high blood pressure and sleep amnesia which allows her to continue to work at her job in a local restaurant. She felt a lot of anxiety and stress about losing her job although her employer was flexible with her as she addressed her physical and mental health needs without any MediCal support. Now that her health insurance situation has stabilized, she is working fulltime and receiving medication and health support though MediCal. The HWB Case Manager helped her apply for the CCC Housing Authority Voucher as she is currently renting a room from a friend. The PEI program has provided ongoing support and engagement with other participants as she progresses towards economic and social stability.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 7/1/2018-12/31/2018**

Agency/Program Name: The Latina Center/*Primero Nuestros Ninos*

PEI STRATEGIES:
Please check all strategies that your program employs:

☐ **XX Provide access and linkage to mental health care**

☐ **XX Improve timely access to mental health services for underserved populations**

☐ **XX Use strategies that are non-stigmatizing and non-discriminatory**

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment; and 4) strategies utilized to improve timely access to services for underserved populations.

Parenting classes: During the period of July 1 to December 31, 2018, The Latina Center provided the 12-week *Primero Nuestros Ninos*/Our Children First, linguistically and culturally relevant parenting classes for parents at 1 school and at The Latina Center in West Contra Costa County. During this period, 47 parents (41 women and 6 men) enrolled. All parents belonged to low-income families. Classes were taught in:

- Lake elementary School 16
- The Latina Center 31

Thirty-six parents (77%) completed all 12 sessions and graduated from the program.

During the period of July – December 2018 we offer 1 workshop for mental health at the first five in San Pablo with 6 people attending this workshop, also 46 clients not participating in parenting classes or the workshop where referred to different services, reaching a total of 99 people attended.

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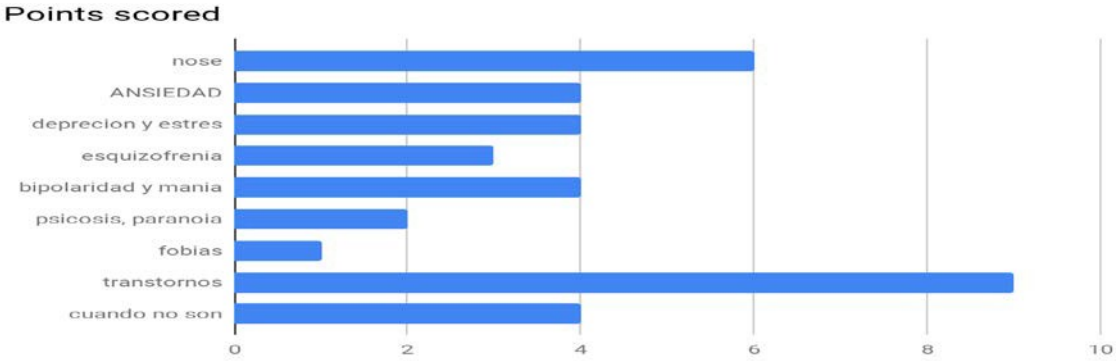
Mental Health Services: During July 1 to December 2018, 42 people participated in mental health workshops. Of these 42 people, 36 were participants and graduated from parenting classes. Pre-survey results indicate that almost 65% of survey respondents did not know what a mental illness was and did not know signs or symptoms, or where or how to seek help for themselves or a family member; most people did not think that a mental illness is a chronic disease.

Post survey results showed that 83% of participants said they could understand more about mental illness, including warning signs and symptoms and where and how to seek help.

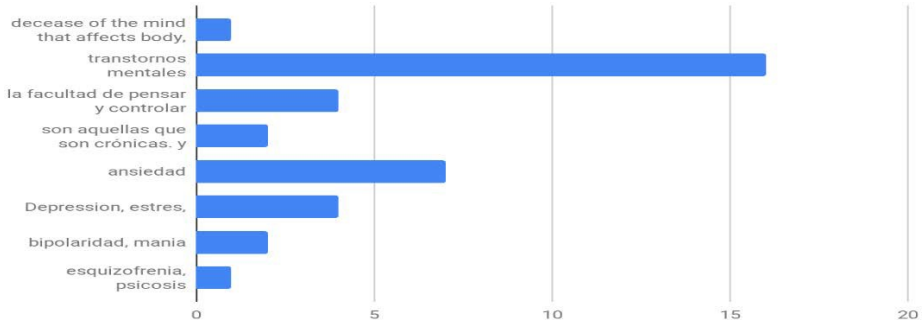
Just as we could see a difference in the percentage of responses in the pre- and post-evaluation in what it is if they have suffered from depression, anxiety and stress. In conclusion at the end of the survey we were able to obtain information that people after the workshops have a more adequate knowledge of what are a mental illness and the steps to follow.

1. What are mental illnesses?

- Pre-survey



- Post- survey



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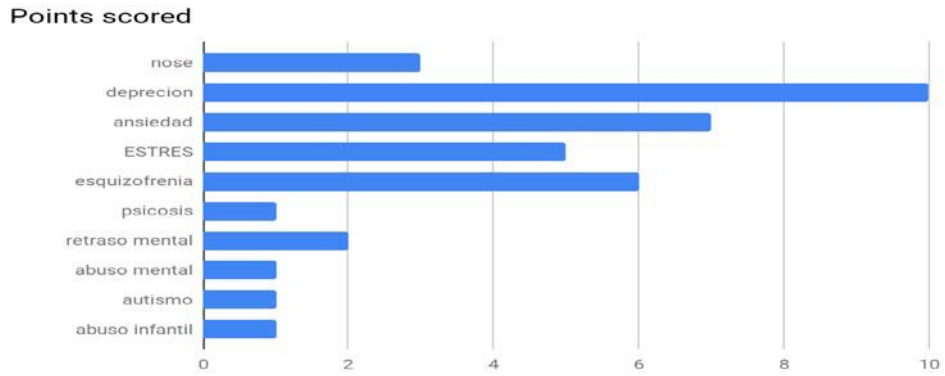
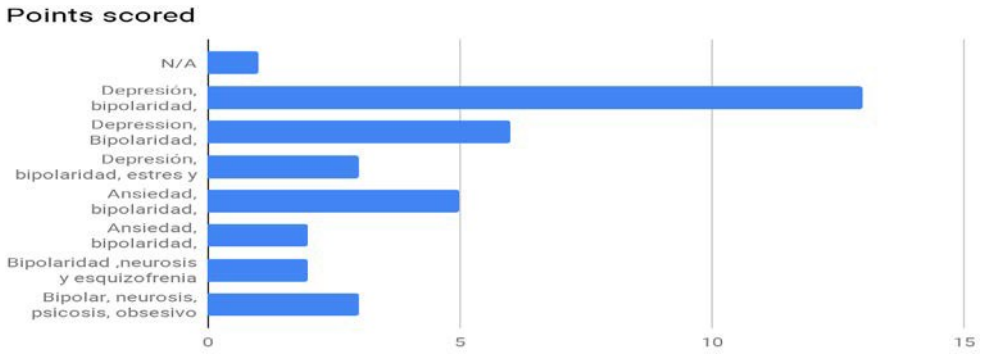
2. What kinds of mental illness do you recognize?

- Pre-survey



- Post- survey



3. Could you recognize some sign or symptom of mental disorder?

Before the workshop, only 34% of participants said that they could recognize the warning signs or symptoms of a mental disorder. However, after the workshop, 83% said that they could.

- Pre- survey

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- Post- survey

4. Do you have depression?

Before the workshop, 32% of survey respondents said that they were or that they had previously been depressed. After the workshop, 41% said that they were or had been previously depressed.

- Pre- survey

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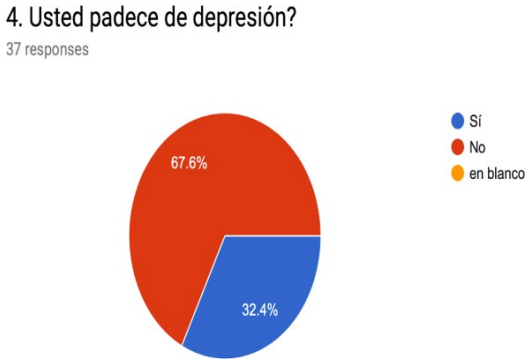

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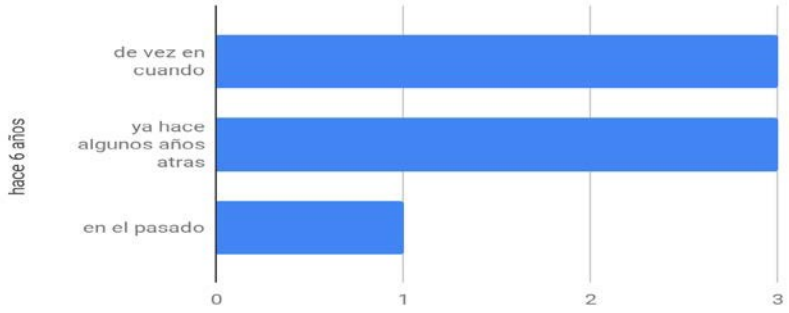
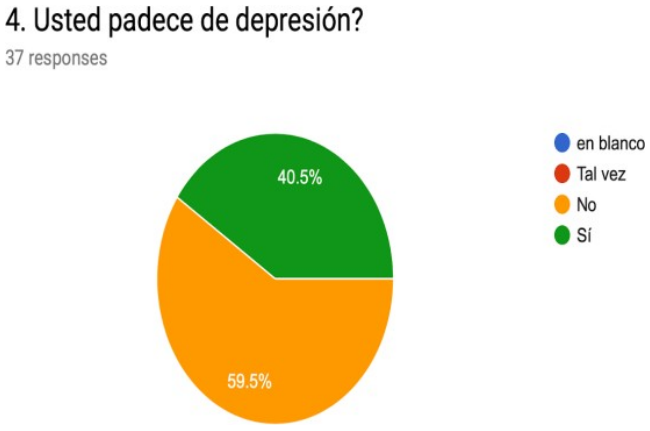


- Post- survey



When?

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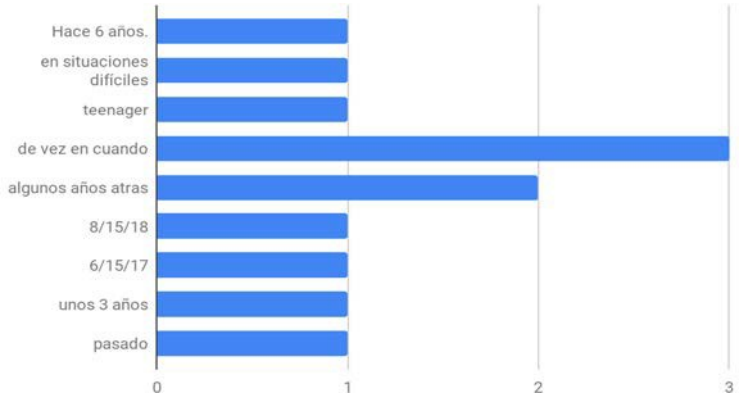
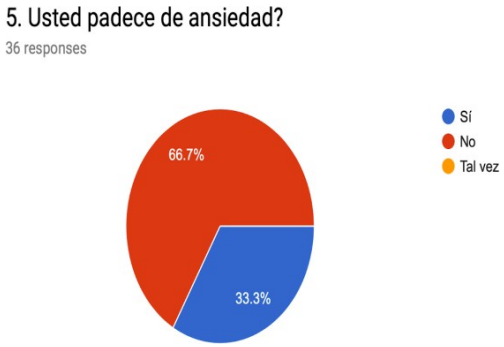


5. Do you suffer from anxiety?

- Pre- survey



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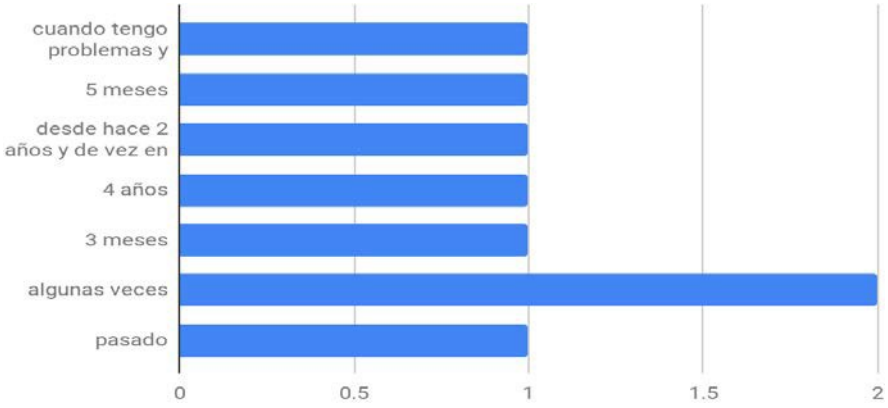

- Post- survey

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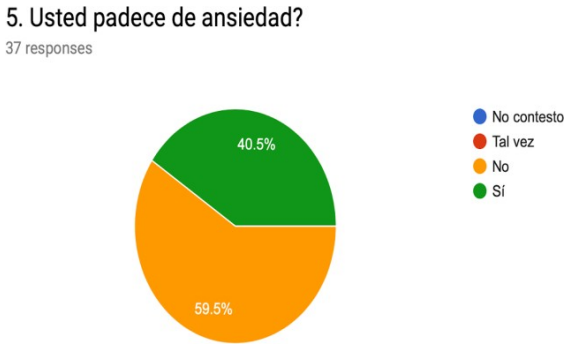
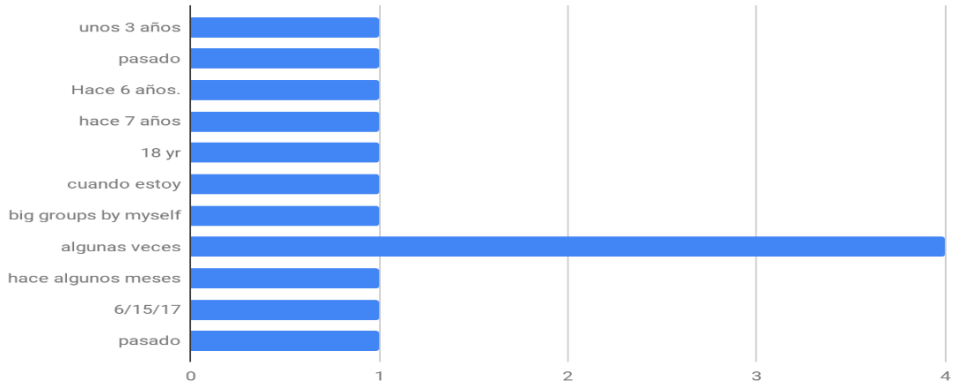


When?



6. Do you suffer from stress?

- Pre- survey

When?

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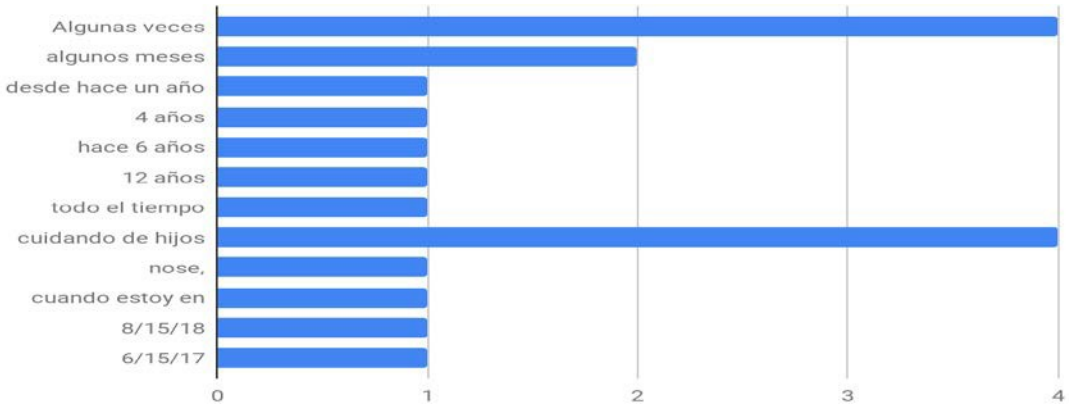
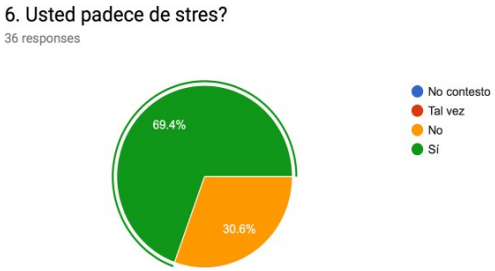


- Post- survey



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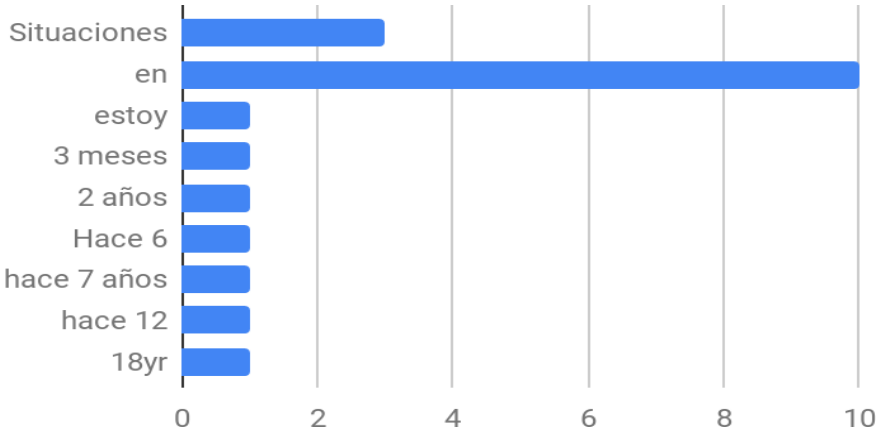

7. Some member of your family has a cognitive disability.

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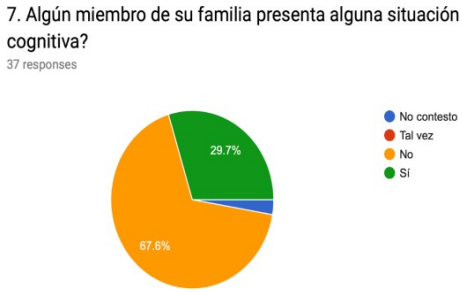
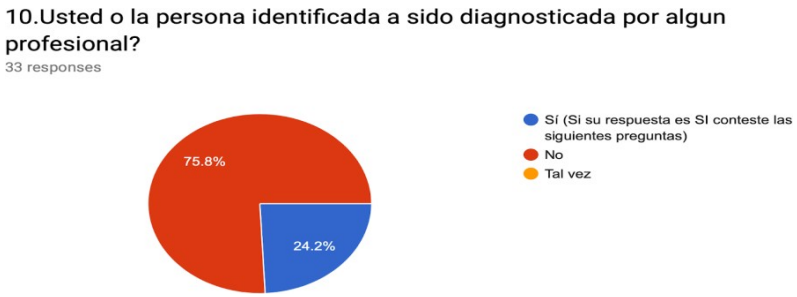
- Pre- survey

- Post- survey



10. You or the identified person has been diagnosed by a professional?

- Pre- survey



- Post- survey

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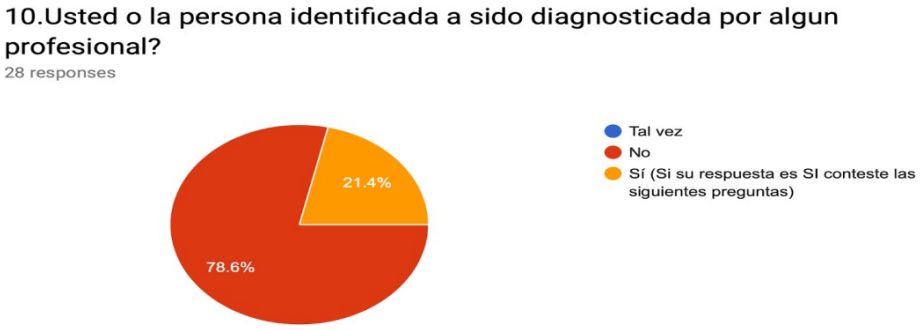
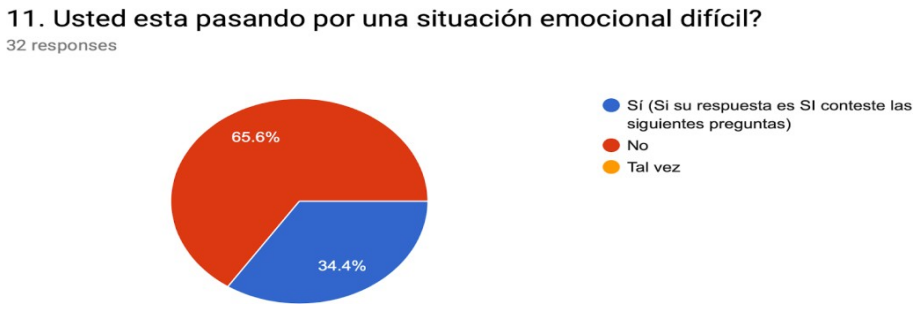


11. You are going through a difficult emotional situation?

- Pre- survey



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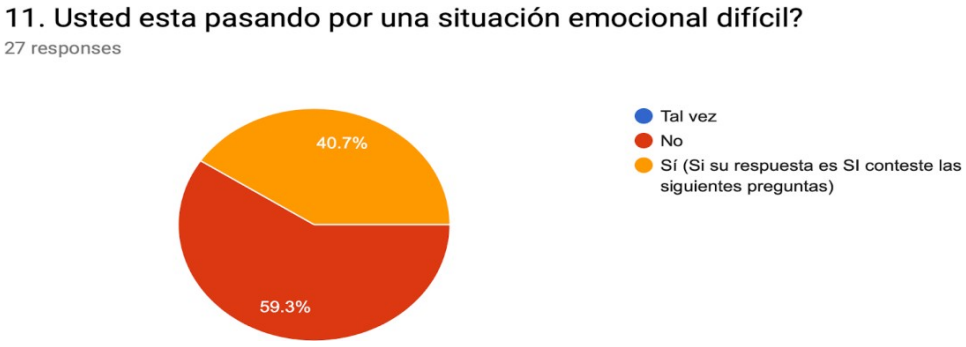

12. Would like to make an appointment with a counselor?

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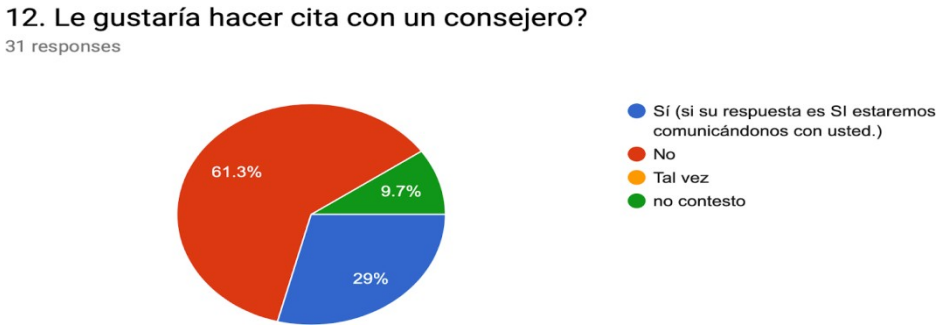

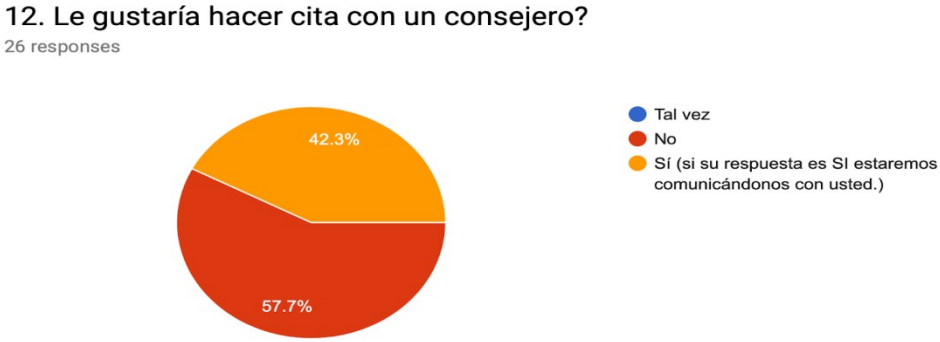

- Post- survey

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

At the beginning of the program Our Children First, we use a survey that gathered the following information from the parents:

- *41 They wanted to acquire new skills*

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- *33 wanted to improve communication with their children*
- *19 improve couples communications*
- *23 Better relationship with their families*
- *19 learn more about child development*
- *14 learn more about mental health*
- *13 have Access to community resources*

During this survey we could also identify that 44 of them were referred

- *4 Court*
- *4 CPS*
- *18 friends*
- *3 Family*
- *15 by different programs within The Latina Center*

Between the topics they would like to receive more information are the followings

- *11 Individual advise*
- *12 Treatment for depression, anxiety or others*
- *8 Schizophrenia and bipolarity*
- *5 bereavement counseling*
- *4 Domestic violence support group*
- *2 Celebrating the recovery*
- *3 Suicidal prevention*
- *4 child Abuse*
- *22 Techniques of stress reduction*
- *33 Better communication with their children*
- *23 Better communication with their partners*
- *20 Counseling for kids*
- *17 Counseling for youth*
- *2 Counseling for the elderly*
- *17 How to have a better self esteem*
- *3 Legal services*
- *2 housing assistance*
- *3 food assistance*

Some of this information was offered though

- *Individual advise, one on one counseling*
- *Information about deportation , anxiety, Schizophrenia and Bipolarity- Mental health workshop*
- *Referred to the support Group*
- *Referred to celebrating the recuperation*

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- *Techniques to reduce stress – workshop of family harmony about stress*
- *Better communication with their children and their partners thanks to the technics and tools from the STEP guide*
- *How to get a better self-esteem workshop from family harmony and support groups*
- *Giving information about juridical services, housing and food. Referred to difference services*

In this survey we could also identify that 37 participants have lived domestic violence in different phase of their life

- *29 have lived emotional and physical*
- *7 have lived physical, emotional and verbal violence*
- *1 have suffer sexual violence*

During this period we could achieve 86 people from different services being this internal and external, as stated below.

Internal and External referrals

In the following chart we identify the resources to where we have referred our clients

TLC support group for men	*	**Internal**
TLC parenting classes	*	
TLC GETA	*	
MSL	*	
Terapia Javier Northon	*	
Ono a Uno Nancy	*	
1Celebrating the recuperation	*	
Maria clubs	*	
Information on the process for vocation	*	
Lawyer TLC	*	
Support Group VD	*	

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Maria Gamboa business	*	

211	*	External
Service for alcohol and drugs	*	
David defect and character	*	
Family justice center	*	
Nutri sol	*	
Multicultural center	*	
NAMI	*	
DMV	*	
Lifelong medical center	*	
Lawyer Jonathan	*	
Centro cuscatlan	*	
Primeros 5	*	
Support group in English	*	
veteran hall	*	
Early child mental health	*	
Crisis line in Richmond	*	
First Hope	*	
Suicidal line	*	

Referrals in person:

Referrals to different agencies internal and external who came seeking help in person to the installation of THE LATINA CENTER installation of THE LATINA CENTER.

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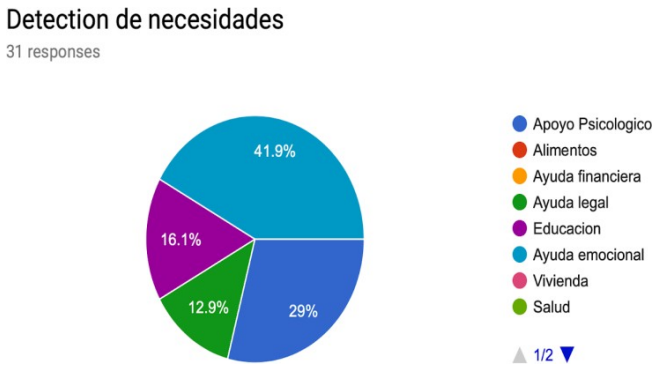
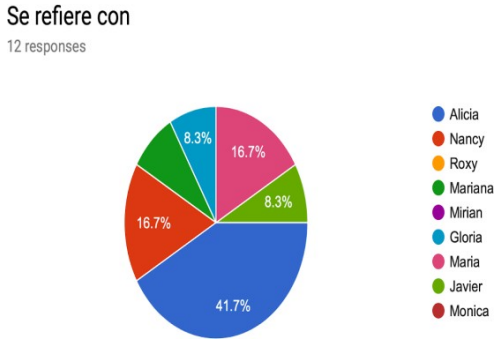
The different necessities and resources vary, even more, psychological and emotional help are the needs from which more resources are sought



Phone referrals:

Similarly, there were referrals to different internal and external agencies that sought help by telephone in THE LATINA CENTER



The different needs of resources also vary, but also the greatest resource that is sought is psychological help and the second is migratory help.

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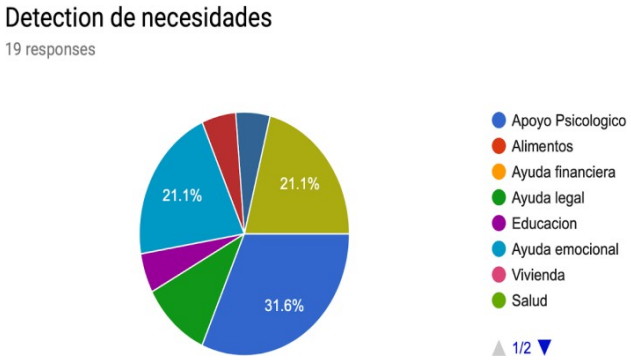

DEMOGRAPHIC DATA: ☐ **Not Applicable** ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Through the education program for parents (Our Children's First) implemented by THE LATINA CENTER that supports all people with different needs, economic or cultural background. We have been able to identify that if indeed our Latino community has a very large need for different resources of mental health, we still see the deficiency in access to these resources, there are very few resources available to our Latino community because of the cost, the language and the fact of trust between patient (culture) and the professional or the agency, in addition those that exist already have a waiting list, another reason for inaccessibility is the fact that many of our clients are undocumented immigrants and for them to seek help or have access to services means not only putting oneself in a vulnerable situation for their migratory status but also

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economically inaccessible for them since many do not have medical insurance and are low income. Regrettably, this is the biggest problem we face, and it persists year after year, which is reflected in the results of the surveys that have been prepared for the participants of the program, another of the obstacles we have faced is the mental health factor as a result of a sexual abuse, since people with such experience is very difficult to have confidence with a mental health provider, the biggest obstacle for this part of the community is the lack of resources and mental health professionals trained in this area and the few that exist (Ex: violence solution, united families) also have a waiting list.

VALUABLE PERSPECTIVES:

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

I am very grateful for the program that has been brought to us at Lake School.
The program our children has helped me to understand my children more, how to helped them, to deal with them, has given me tools to use that are beneficial for the whole family, I have also learned to know myself and discover how much I am worth , also what is the different levels of sexual abuse and what is an abuse of children, what is domestic violence and the strategies to deal with depression, stress and self-esteem, when I started the program I said I wanted to learn all things that they will help me to be a better mother; and with the help of the program I have learned a lot.

Thank you
N. Mora

I really liked the program because I learned many good and positive things for my life, it helps you to tell you about problems that you did not notice before and how to solve them, how to value yourself and be better parents, I recommend these classes because not only You meet new people but they help and de-stress you.

Thanks for your time and dedication.
Beatriz

I like the class because it help me better understand how to communicate with my kids, i liked how it says to let the kids to be part of the decisions making for the family, because we were thinking only adult could solve it, i also like how it says we have to explain why they punishment and how it has to be tie up with what they did, this class is a great benefit and will help me build a better bond with my kids. The first half translation was great but the second half i feel like i missed a lot. This was a great class.

Thank you.

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M. Bortolli

Before I came to this class, I shouted a lot to my children and I had no patience, I was always in a bad mood and on my phone, the truth is that sometimes I treated my daughter badly for no reason. This class helped me so much and it has been noticed, now I talk to my children, I stopped screaming at them and being with my genius always, now I feel with them to do homework and I talk a lot with them I feel very happy to have taken this class.

Thanks
P. Balcazar.

I thank God for giving me the opportunity to get to know the Latin center, my life changed in many ways, first by being able to see myself as a father or mother all the mistakes I had made while raising my children, I could understand how to change my attitudes and ways of be with my children, husband and other family, likewise this course changed my way of feeling about the past, I left the guilt and the condemnation that I felt inside this course made me free, thank God for the classes, teachers and the place, without this teaching I would not have achieved it alone.

Thank you very much and may God continue to use it.
S. Cifuentes

Before this program I was disoriented and I felt bad, now I feel different, in this class they helped me a lot. At first, I was angry I did not want to come, but I really liked it a lot because I learned how to talk to my children. I take many tools to go teach Mexico.
Thanks to God and Latina Center for helping me a lot, thanks to all those who helped me and supported me to be a better person.

A. Vega

The STEP classes helped me to have a better communication not only with my daughter but also with my husband, I learned not to hit or punish, instead of putting consequences, setting limits, messages in me.
From being a frustrated mother, who shouted, depressed and in a bad mood all the time, after classes I learned to smile, I learned to give a discipline without violence and to be a better mother and more communicative.
With the classes for parent educator, I learned many things about myself, for example that I love helping other parents who, like me, did not know how to react to the problems and difficulties that life presents us every day. I know that little by little I will continue to recognize my abilities and strengths as well as strengthen them.

Many thanks to all.

The STEP program helped me to have tools to help my children to be better people and to be able to cooperate, the messages in me have changed the behavior of my children to have meetings in families and say that we like it and that we do not like it, It has taught me how to talk to my children not to shout, to listen reflexively.
I give thanks to this program for giving us tools to raise healthy and happy children, who know how to give and receive love.

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Thanks to
L. Tinajero

For me it is a great experience to participate in this training to be a parent educator, my main impact is my family, now I have much more family harmony especially with my children, until today there is more cooperation, I learned to be tolerant, listen before judging or criticizing, I am excited to continue preparing parents to know this beautiful project and can have the tools that only in these classes are found.

Thank you very much

I thank God, my family and the facilitators, for allowing me to take the courses of parenting classes and mental health, for me personally it has helped me a lot, to know how to identify, solve problems also the inconveniences that arise daily at home, as in any home or family, the children have had significant change but first of all I myself have being changing and I go on the road, fighting day by day and putting into practice everything that we have been taught, such as know how to listen reflexively, make agreements, set rules, be concise and precise, the first 15 seconds are the ones that count, that you do not have to give up to the fire but be wise and get away a moment later on return and talk it over, give I messages, to know who is the owner of the problem. I invite you to continue forward giving more courses, reinforcing the previous ones, since it is very important for other parents to have better families, healthy children living in harmony in a healthy home.

Thanks 1000 thanks
M. Sanches

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PEI ANNUAL REPORTING FORM

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: FY 2018-19

Agency/Program Name: **LifeLong Medical Care**

Reporting Period (Select One): ☐Semi-Annual Report #1 (July – Dec)
X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

*Please check **all** strategies that your program employs:*

X☐ Provide access and linkage to mental health care

X☐ Improve timely access to mental health services for underserved populations

X☐ Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:

Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

LifeLong Medical Care's SNAP program creates safe and accessible places for underserved populations to experience community, enjoy meaningful activities, learn new skills, and obtain referrals for needed resources. Program goals include: 1) Increase morale, self-esteem, self-efficacy and sense of purpose; 2) Increase meaningful social engagement and participation in pleasant activities; and 3) Provide referrals to other mental health and support services as appropriate.

SNAP is based on research linking social engagement, a sense of personal control and mastery, access to lifelong learning opportunities, and sustained creative activity with mental and physical well-being in older adults. Social isolation has been linked with negative outcomes, including depressive symptoms, reductions in coping skills, and cognitive decline, while strong social connections and person-centered learning opportunities, tailored to each elder's needs and interests, contribute to improvements in morale, mood, and overall physical and mental health. Research shows that negative outcomes are exacerbated by poverty: about 9% of seniors living in poverty experience depression, more than double the rate of depression among community-dwelling older adults in general (Gum, Arean, & Bostrom, 2007).

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LifeLong's experience working with older adults in West County mirrors these research findings. Seniors facing isolation, depression, and other stressors, benefit from opportunities for lifelong learning, social engagement, and creative activity. Seniors who work with LifeLong's case manager receive needed resources as well as emotional support around grief and loss, family stress, and other challenging issues. Participants have told us that they value SNAP because of the connections they make with others, satisfaction of engaging in positive activities, and practical help obtaining needed supplies and resources.

SNAP ensures timely access by providing services in the community rooms at Nevin Plaza, Friendship Manor, and Harbour View (senior and/or low-income housing sites in Richmond where many program participants reside), and in partnership with the Native American Wellness Center, located across the street from Nevin Plaza. Offering services in convenient and familiar environments encourages participation while also improving the dynamic in public housing buildings by introducing positive activities and reducing disruptive behaviors.

In addition to offering services in highly accessible community locations, SNAP uses programmatic strategies to promote access, including hiring staff who reflect the race/ethnicity of populations served; creating safe and inviting spaces that welcome participants of all different abilities, needs and interests; providing case management to identify and address mental health and other support service needs; and reaching out regularly to encourage participation.

Services Provided:
During FY18-19, SNAP provided social activities and case management as described below:

Social Activities:
This program year, SNAP maintained activity programs once per week at Nevin Plaza, Friendship Manor, and Harbour View. Monthly groups at the Native American Wellness Center (NAWC) provided opportunities for cross-cultural experiences, making excellent use of the NAWC's unique social atmosphere. These social programs created opportunities for building residents to relax and enjoy themselves, support each other through inter-personal connection, try new experiences, and learn and practice new skills -- all of which reduced social isolation and supported long-term mental health, well-being, and quality of life.

Each SNAP location has its own "social personality," and staff employ different approaches to engage residents at each building. At Nevin Plaza, participants especially enjoy BINGO, Uno, Scrabble, and casual movement exercise groups. On-site, one-time activities tend to hold the most community involvement, rather than ongoing projects or excursions. With varied literacy and education levels among Nevin participants, they support each other with mutual encouragement, patience and a unique sense of camaraderie. Friendship Manor residents are an especially relaxed, socially involved group. They enjoy music and conversation, and often sing together. There is a great deal of playful humor alive when the Friendship Manor community is present. Friendship Manor residents are able

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to participate in outings and longer-term projects, such as going out to the movies or learning songs to perform together. Harbour View is more of an intellectual scene: residents enjoy long-term projects like Spanish language classes and arts & crafts projects. Solid relationships have developed within the Native American Wellness Center group. They especially enjoyed Tai Chi exercise and nutrition in-services. All sites enjoyed and welcomed guest speakers and performers.

Some of the highlights of this year include:

- A three-month nutrition series around healthy eating habits.
- An ongoing craft project where residents are making dolls.
- Live drumming with renowned teacher, Roberto Borrell.
- Creative movement and Salsa dancing with Luz Mena.
- Coping with loss, a group oriented around grief and loss of other community members.
- Movie groups hosted in community spaces.
- On-site memorial services organized by SNAP staff for residents who passed away.
- A conversational Spanish group with ongoing language studies curriculum.
- A "Men's Club" that encourages healthy social interaction between male-gender residents.
- Billiards, board games, Bi-lingual BINGO, and scrabble groups.
- Tai Chi classes following an evidence-based program with both physical and emotional benefits.

SNAP participants also enjoyed a variety of special events throughout the year:

Excursions: This year program participants requested popular trips from past years: a ferry ride into San Francisco with a picnic at Fisherman's Wharf (including dancing and singing on the pier!), and a movie outing to Richmond's Hilltop Cinemas. Lunch and transportation were provided for both events. In addition, throughout the year Friendship Manor residents traveled regularly to Harbor View to engage with on-site activities there.

Performances: This year, the SNAP choir got smaller as participants passed away and new participants brought different interests. The group performed twice: at Center for Elders Independence in Berkeley, and a beautiful final performance at LifeLong Medical Care's annual gala. SNAP staff will re-start the choir if participant interest re-emerges; otherwise, we are moving on to new activities based on consumer preferences.

Guest Speakers are always popular; program participants are actively interested in learning about free or low-cost community resources. This year's topics included:

- Food as Medicine
- Nutrition
- Medication Management
- Durable Medical Equipment

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- Vital Link (emergency response)
- Home Health services
- Multipurpose Senior Services (MSSP) of Contra Costa County

Case Management: SNAP provided case management to 79 consumers with a half-time social worker who is a native of Richmond who has extensive experience providing case management services for diverse elderly populations.

SNAP's case management program supports participants with individualized elder care. Frequent wellness checks, including encounters in the community, telephone calls, and home visits, maintain regular contact with clients. Services include follow-up on PHQ-2 depression screening, referrals to behavioral health and social services, and assistance in medical system navigation, including new referrals and follow-up with existing behavioral health providers.

The most common areas of case management support this year included: health insurance navigation, benefit applications (such as ParaTransit and IHSS), food assistance, small DME needs (canes, walkers, heating pads, a raised toilet seat), obtaining eyeglasses, hearing aids and dentures, and support around health issues, grief/loss, and concern about family networks and relationships. The case manager was also available to provide extra help in special situations on a case by case basis. Examples this year included visiting isolated seniors in the hospital, helping a senior find services for his adult daughter with disabilities, and helping a daughter understand and support her mother with advancing Alzheimer's Disease.

OUTCOMES AND PROGRAM EVALUATION:
Please provide quantitative and qualitative data regarding your services. • *How are participants identified as needing mental health assessment or treatment?* • *List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.* • *Average length of time between report of symptom onset and entry into treatment and the methodology used.*

How are participants identified as needing mental health assessment or treatment?

SNAP program staff provide outreach at Nevin Plaza, Friendship Manor, Harbour View, and the Native American Wellness Center each month with fliers posted in community spaces and delivered to

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residents' doors. Staff go to great lengths to explore SNAP program activities with residents on a personal level, and current program participants are known to encourage other residents to attend. It often takes up to several months before a resident decides to participate, and during that time staff continues to reach out in hopes of building community trust and support. SNAP program staff employ an inclusive "open door policy" to allow for residents to engage with staff on their own terms, in ways that feel comfortable and appropriate to them.

When a resident becomes open to participation, staff ask them to fill out an enrollment form that includes questions about mental health symptoms and whether they would like support to access services. The enrollment form also screens for depression. If the resident is unable to complete a form, then staff asks these questions verbally.

Average length of time between report of symptom onset and entry into treatment: **60 weeks**
At time of enrollment and as issues arise, SNAP staff asks participants about the duration of any mental health symptoms. Most participants refuse to disclose this information to SNAP program staff. The data we were able to capture ranged significantly, from a few months to 3 years, for an average duration of 60 weeks reported during this fiscal year.

List of indicators measured:
The SNAP program measures depression, social isolation, and program satisfaction using a two-page survey we have developed with participant input. In addition to this formal process, we also check in with participants throughout the year to identify emerging issues and to gather feedback. The small size of SNAP allows us to stay connected to participants on a regular basis.

Feedback from participants was very positive overall, with the vast majority reporting high levels of satisfaction and the belief that SNAP helps people develop friendships, feel less isolated, and improve morale. Below, survey results are matched with our contract's "measures of success":

1) *50% of participants will demonstrate self-efficacy and purpose by successfully completing at least one long-term (multi-week or multi-month) project by July 2019*.

   SNAP offered both short and long-term projects to create a variety of experiences: one-time activities designed to be fun and require no long-term commitment (such as games, sing-a-long, and Spanish Bingo), as well as longer projects requiring significant commitment and effort (such as Spanish language classes, the SNAP choir, and multi-week crafts projects). In total, 56 people completed at least one long-term project (65% of the residents who participated in more than one group activity).

2) *75% of respondents will self-report improved feelings of morale as a result of participating in SNAP by July 2019*.

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94.7% of SNAP respondents reported that they agree (50%) or strongly agree (44.7%) with the statement, "SNAP helps improve my mood." 7% responded, "I don't know."

3) *75% of respondents will self-report improved social connections and/or decreased isolation as a result of participating in SNAP by July 2019.*

97.4% of SNAP respondents reported that they agree (50%) or strongly agree (47.4%) with the statement, "SNAP helps me feel more connected to others."

4) *75% of respondents will be satisfied with the engagements and activities provided by staff, volunteers and peers by July 2019.*

97.4 % of SNAP respondents indicated that they agreed (31.6%) or strongly agreed (65.8%) with the statement "I am very satisfied with SNAP." 2.6% responded, "No Opinion."

A summary of these survey responses is provided below:

N= 38	Strongly Agree	Agree	Disagree	Strongly Disagree	No Opinion
I am very satisfied with SNAP.	65.8%	31.6%	0%	0%	2.6%
SNAP helps improve my mood.	44.7%	50%	0%	0%	2.6%
SNAP helps me feel like I can handle my problems.	34.2%	55.3%	0%	0%	10.5%
SNAP helps me feel more connected to others (less isolated).	47.4%	50%	0%	0%	0%
SNAP staff respects me and listens to my ideas.	57.9%	36.8%	0%	0%	5.3%
Case Management has improved my ability to access services	39.5%	44.7%	5.3%	0%	10.5%

DEMOGRAPHIC DATA: X Not Applicable *(Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

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We use the County form.

LINKAGE AND FOLLOW-UP:

Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please include the average length of time between referral and entry into treatment and the methodology used.

Program staff outreach monthly to residents of Nevin Plaza, Friendship Manor and Harbour View Senior Apartments, and to participants at the NAWC, taking time to contact those who express interest in services, appear to be struggling, or who are referred by other residents. In each of the SNAP sites there is community awareness: residents tend to know each other and have a good sense of who might be interested in, or benefit from, the SNAP program. SNAP program staff is also on site frequently, and are able to respond to resident cues about their interests and needs.

As part of SNAP's open-door policy, residents are encouraged to participate in the programs however they can. Residents of SNAP sites are encouraged to engage with the program at any level they would like to, allowing residents to explore by visiting, entering and leaving activities as they please, or otherwise limiting their involvement before they decide to fully engage with the community. All SNAP activities are designed to be highly accessible and welcoming for people with a variety of needs and emotional, physical and cognitive abilities.

The SNAP staff identify those who might benefit from additional mental health services through the program enrollment form, which includes the PHQ-2 patient health questionnaire. In addition, the enrollment form explores a participant's mood with the following question: *"Do you feel mental health symptoms like mood swings, being very angry or mad, sad, anxious, stressed out, isolated, unable to sleep, or something else?*" We also ask the PHQ-2 questions as part of a year-end survey. In addition to these written tools, the SNAP staff interact with program participants often and are able to identify mental health and social service needs.

The participants who describe mental health symptoms to SNAP have had prior access to therapy services about half of the time. In these cases, SNAP program staff partners with those participants around appointments and follow through with service continuation. SNAP program staff may also make referrals to additional mental health resources for more support. If a participant does not

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already work with a therapist, staff will encourage them to speak to their primary care provider, or refer them to county mental health services. SNAP program staff will also ask if participants need support around overcoming barriers to access (such as transportation), and follow up with the participant to ensure they got what they needed.

For participants who chose to pursue enrollment with formal mental health services, this year the average length of time from referral to receipt of services was ten weeks.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non-discriminatory?

SNAP promotes MHSA values to the fullest, as described below:

1) Wellness, recovery, resilience: SNAP program staff create inclusive, welcoming, and accepting environments where participants are able to support and encourage each other. Art, music, and language classes encourage participants to expand their skills and experience success with others. These activities lead to resilience and feelings of self-efficacy, all while community presence improves mood and supports personal recovery.

2) Access and linkage: SNAP programming offers highly accessible services in the buildings where our target population lives. SNAP program staff work to get to know and develop the trust of each resident, so that participants have a safe channel to disclose their needs. The SNAP case manager links participants to social services and facilitates referrals to mental health resources as needed. If the participant already sees a mental health provider, staff checks in regularly to encourage them to participate with external care providers.

3) Timely access for underserved populations: Services are provided directly in the building or local neighborhood to promote accessibility for elderly residents; culturally sensitive services are provided for this low-income and primarily African-American population.

4) Non-stigmatizing, non-discriminatory: Residents are accepted into SNAP as they are. SNAP facilitators create group environments that hold space for diverse social thought processes, energy levels, and abilities, allowing each participant's strength to surface and shine.

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Participants can come and go from groups as they need to, and it is perfectly acceptable to participate or not. Participants tend to talk freely about their mental health issues because they are comfortable with SNAP program services, they know they are not being judged.

The SNAP group is largely African-American, with an African-American facilitator and Latina teacher. The half-time case manager is an African-American woman originally from Richmond. Many of the SNAP participants are learning Spanish language songs and greetings because they want to build relationships with Spanish-speaking neighbors. The SNAP program's partnership with the NAWC is similarly based on a shared desire to deconstruct social barriers and fight the discrimination.

VALUABLE PERSPECTIVES:

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

We received lots of feedback from SNAP participants through a confidential survey administered in July 2019. Here are some of the responses we received.

SNAP has helped me by…

Being there, especially when I thought no one was there!
Get involved with other seniors
I like SNAP, it makes me happy! I like my case manager very much and I love her very much.
Having activity so I can leave my apartment and having someone to talk to.
By helping me to [interact] with other people with disabilities and age limitations – SNAP helps me remember I'm not by myself.
I am grateful that SNAP offered me the opportunity to have a social worker that helps with my concerns.
It gives me something to do when I don't have anything to do.
Keep having SNAP. We need it.
SNAP help me do a lot of good things by: laugh, cheerful and have fun with others
By taking the stress off and making me happy
Not be depressed
When I'm down and SNAP is around, I come down and join the group and I won't be thinking about what happens on that day.
Having something to do with my neighbors and others
Forget about what I am going through day by day
Getting along with others by playing games and problem-solving games
Keeping us active, and in touch with each other
It helps me feel at ease. I like to be with SNAP people.

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PEI ANNUAL REPORTING FORM

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS REPORTING FORM **FISCAL YEAR: 18-19**

Agency/Program Name: Native American Health Center

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental healthcare

X Improve timely access to mental health services for underserved populations
X Use strategies that are non-stigmatizing and non-discriminatory

---

SERVICES PROVIDED / STRATEGIES:
Please describe the services you provided in the past reporting period. Please include qualitative and quantitative data depicting: 1) the types and settings of potential responders you reached during the past reporting period; 2) methods used to reach out and engage potential responders; 3) any strategies utilized to provide access and linkage to treatment, and4) strategies utilized to improve timely access to services for underserved populations.

Through the strategy of outreach the Native American Health Center provides prevention and early intervention services to increase the recognition of early signs of mental illness, assist community members to access culturally appropriate mental health services, and host Native American cultural groups, community events, mental health and wellness workshops, and classes that increase social connectedness, cultural connection, and general awareness of community and county resources to improve member's overall well-being. From July 2018 to June 2019, NAHC provided groups and events tailored to the Contra Costa County Native community and the remaining underserved and underrepresented populations. NAHC strongly believes that culture is prevention and integrates Native American cultural practices and traditions throughout our program. In addition to this, we continue to target outside events and activities sponsored by partnering agencies within our community that may serve the Native community. Our goal last year was to further establish our presence throughout Contra Costa County and continue to provide advocacy for the needs of the community that we serve, by doing this we were able to build a strong network of support with partnering organizations within our PEI network and throughout Contra Costa County. This led to partnerships and event collaborations that have allowed us to engage an increased amount of potential responders. NAHC reached a total of 289 unduplicated members by the end of June 2019. In comparison to contract year17-

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18, we had served only 162 unduplicated members and though we had met our goals, this contract year has been a significant improvement and can be attributed to the new/ or improved methods used to engage potential responders. Our dedicated staff worked to improve our network of potential partners and increased collaborations with other organizations. Examples of collaborations include: Lifelong Medical, Building Blocks for Kids, RYSE youth center, the James Morehouse Project, Scotts Valley Tribal TANF, just to name a few. By increasing our presence in the community through outreach booths, attending community events, public hearings and town halls, and a variety of community health committees our staff was able to increase access to services for our members as well as build and arsenal of support and resources that would improve our referral processes moving forward and make warm-handoffs easier for members who may have been unsuccessful in accessing care in the past.

Peer Support for Referrals and Follow-ups:

During intake interviews (either by phone or in person) staff assess members regularly for potential needs for resources or services. Referrals by appointment are encouraged so that staff can dedicate a significant amount of time to ensure the needs of members are fulfilled as well as allowing us the opportunity to conduct wellness surveying to address any other possible concerns they may have. Staff ensures that all referrals issued to members are followed up within a 48-hour window. Referrals are issued to both continuing and new members for services that are offered inter-agency and externally. Inter-agency services include Medical, Dental, youth or transitional- age youth, and behavioral health services. In instances where we cannot provide the members with the resources they are looking for, our goal is to ensure their needs are met in other ways by providing them with information about the services we do provide and connecting them with other local organizations that may have the resources that they need. From July 2017 to June 2018 a total of 23 referrals were issued and completed by staff. Often times, these visits result in multiple referrals issued per member. For example, if a member comes to us looking to be connected with housing support, they may also need resources for food support. The following are brief examples of the referrals processed within this contract period:

Mental Health

1. Member came to us disclosing that she had become severely depressed and was experiencing suicidal thoughts due to a number of contributing factors. The following referral/ Action plan had been discussed: 1. Member was to contact Kaiser's psychiatric department to schedule an appointment with her provider to renew her medications and be connected with a new therapist. Member had also agreed to attend the upcoming Talking Circle and meet with the facilitator for a one on one. NAHC staff had committed to assisting the member with accessing dental services (that had been causing the member extreme pain), IHSS, and working with our partnering Elder Care Coordinator (from LifeLong Medical) to help seek resources that would provide attendant services for the elderly. After about a month of follow-ups the member was able to access everything she needed.

Medical/Dental/Vision

1. Referral was processed for a member who had requested to be seen for vision services by a Native specific provider. Unfortunately, there are no known facilities who provide vision care specifically for Natives. Staff attempted to connect the member with other vision care resources but were declined. The referral was closed. This instance was not the first time a request like this has been made and it does demonstrate a specific need this community has though us as an agency cannot meet it at this time.
2. Member called in seeking dental services and he disclosed that he was a Medi-Cal recipient. A referral was made to a local dentist practice in San Pablo who we were aware accepted Medi-Cal and the

member was able to get an appointment that day.

3. Member came to us seeking assistance with locating a primary care doctor and to get more information about her Medi-Care coverage. She was referred to LifeLong medical and connected with the Patient Service Advocate here in Richmond.

Transportation

Social Services

1. Medi-Cal referral issued and referral was passed on to an intake coordinator at our Oakland facility where client was able to have an in person appointment and was signed up for Medi-Cal

On-Going Prevention Groups

On-going prevention groups are a key component to reaching first responders. NAHC hosts weekly prevention groups to serve the needs, empower, uplift, motivate, and connect with potential first responders. Groups are facilitated by traditional consultants and trained NAHC staff members on site with a focus on traditional arts integrated with mental health and wellness messaging. These groups at the Native Wellness Center are a great resource and foundation for the services that take place here. They allow us to engage community members through culture and help translate mental health concepts in an informal and safe space. These different ways include:

- Exposure to and in-depth practice of Native Culture and Tradition
- Participating in and learning ceremony and etiquette
-Learning skills and various techniques associated with Native American focused crafts
-Community building and social connectedness
-Promotion of health and wellness
-Awareness and destigmatizing of mental health and behavioral health services

It is important to distinguish between the different ways people engage in our groups; our community is vastly diverse in cultural practice. This is why providing services based on the Holistic System of Care for Urban Natives is so important and useful. Being in the Bay Area, most of our clients are a long way from their homelands. Participation here in an Urban setting means that ceremonies and traditions are upheld despite our small numbers, and that makes the resiliency factor that much more important to positive mental health outcomes. Our groups are offered to all and serve a diverse group of individuals. This plays an important role in bridging the gap between people of different cultures and experiences. It allows for the opportunity for non-Natives to learn about the Native community first-hand, reduces misconceptions, corrects misrepresentations, and increases cultural humility. Our ongoing groups are Wisdom Holder's, Traditional Drum Circle and Pow Dance Practice, Beading Circle, Art for Therapy, Quarterly Basket Weaving, Quarterly Quilting, and Health and Fitness Workshop. All these groups share a common goal; to foster learning, connect members to cultural practices, provide a safe space, empower members, all while promoting healthy lifestyles, and both health and wellness education.

Wisdom Holder's Elder Support Group

This group meets on a weekly basis to provide our elders a positive outlet to communicate any issues or concerns that they may be struggling with. There are also opportunities for them to gain knowledge on issues surrounding health and nutrition, Native culture, family support and prevention in regard to depression and isolation. Monthly events are planned by the group to do outreach and interaction within the Native community. With the recent transition of facilitators, the elders support group has made

positive strides toward improvement. We have recently implemented a formal curriculum of goals we hope to accomplish with the elders. The curriculum includes three important components: Formal health and Wellness education- which includes workshops ranging from healthy food demonstration to information on "how to fall" for example. The second component is cultural education- this in particular focuses on teaching Native history, bringing awareness to issues surrounding the Native community, and providing positive entertainment that sparks awareness and constructive conversation within the group. The third component and most recent is the implementation of scheduled activities that focus on exercising the mind. Understanding that elders are commonly diagnosed with Alzheimer's and Dementia, we are more frequently scheduling activities that will help with combatting the diseases. For example, facilitating days dedicated to playing games that are proven to support brain function. In collaboration with Lifelong Medical, we partner once a month to provide our Elder's with additional support and activities they may need or want to have. Our groups combine in an effort for both programs to expand membership and build healthy relationships within the elder community. There is also a social worker with Lifelong who regular attends our elders group to provide additional support and access for wellness outside of our abilities. Throughout programming staff continually assesses attendees for way in which we may provide support or resources and the goal is to support the members to achieve independence and empower them to take control of their own well-being.
Our elders continue to express their gratitude and appreciation for this group specifically. Many of the group members have expressed their dependence on these meetings for support because they either live alone or are facing challenges. They have expressed their need for social connection as a way to combat depression and isolation. The group facilitator also ensures that their needs outside the group are addressed as well as doing regular wellness check-ups when members are not in attendance.
Elder's Fruit Day at NAHC Oakland: Combination of Elder's Support groups from Richmond and Oakland where they gather every second Wednesday of the month. This group uses a similar strategy as the Wisdom Holder's group on a larger scale, while also providing each participant with package of fresh fruit, vegetables, and other nutritious foods.

Traditional Beading Circle
This group has become well established in our Center and in the community. As the group gathers more, the beading skills improve, and they are getting to do more advanced projects. It's been amazing to see members begin the group with no skills at all, and now they are making beautiful jewelry, medicine bags, and accessories with intricate designs that incorporate many traditional techniques. Also, to see people that started with no patience and get frustrated easily, be able to sit for 2 hours in a very calm environment and focus on their beading techniques. While in transition of instructors, this group had remained a drop-in group where members are able to work individually on their own projects in a safe and welcoming space until the new instructor had begun facilitation in February of 2018. Since then she has established a specific curriculum focus on developing the coordination of members necessary to complete beadwork. She also focuses on the therapeutic aspects that beading provides to members and impact that on mental health this class promotes by providing a way in which the Native community can connect to cultural practices they're unable to learn at home. Beadwork is a common practice in the AI/AN community and the skill is typically passed down through familial interaction. For many urban Natives this tradition is not as common and by providing this class we have the opportunity to allow members to relearn lost traditions and promote cultural connectedness.

Traditional Drum Circle and Pow Wow Dance Practice
This group is offered for Men of all ages, and often combines youth and adults. The facilitator teaches various types of songs like Honor Songs, Northern and Southern Drum styles with a focus on learning the

words to the songs which are majority in the Sioux language. This group is important because it exposes members to cultural tradition and practices, promotes healing through traditions and spirituality, and provides a sense of identity and cultural connection to our Urban Native community. The facilitator has been successful in ensuring that the members not only learn songs and drum techniques, but rather they understand the stories and reasons behind specific traditional practices. This speaks to the high importance of the Oral tradition within the Native community. Recently, we have added the Pow Wow dance practice aspect to the group in an effort to attract more women and families to the center because traditionally drumming is a men's practice and the center does not want to encourage disconnection and separation. Through doing this both genders are able to learn about the culture and the reason why certain practices are gender exclusive. This is part of the cultural education component of our work.

Art for Therapy

This group is offered to the community with all ages welcomed. This class was newly established in June of this year with the help of one of our volunteers, a local artist named Juan Nunez. The idea for the class came from his own education and experience. He is currently a psychology student and in thinking of how he could align his education with his interests, we worked to come up with an art class that allows the community an outlet to express their creativity, build community and social connectedness, and reduce stress. This provides members with a therapeutic alternative to traditional clinical settings where they might feel discouraged due to the negative connotations and stigma associated with accessing behavioral health services. It also allows the opportunity for staff to connect with community members and assess for potential needs of members. A few specific examples of the ways in which we've seen this class prove to be effective is the through the demographic of first responders that have attended. There has been families who attended in an effort to strengthen their relationships with their children through bonding, elderly members who suffer from dementia have been brought to participate (arts and crafts have been proven to help relieve patients from symptoms associated with dementia as well as help to calm them during extremely stressful times), and lastly members who seek to participate in paint nights in a sober environment. There has been an increased popularity of "paint nights" due to the recent establishment of "wine and canvas" paint nights at different restaurants and social spaces. This is our alcohol-free alternative for those who seek family and recovery friendly settings. Alternatively, we offer refreshments or community dinner/potlucks where members are still able to engage with one another and learn a new skill in a safe space.

Quarterly Basket Weaving Workshop

Basket Weaving has a similar goal and curriculum as our Beading Circle. Basket Weaving is also an important part of Native history and tradition and we offer a six week course each quarter with the goal that each participant complete one basket project. All the materials are "natural" and either gathered or purchased from specialized stores. Our first workshop of the year took place in April and had a total of 8 participants.

Quarterly Quilting Workshop

The Quilting workshop was also newly established this year and similarly to the basket weaving workshop and lasted for six weeks. Programming was scheduled on Saturdays to address the need for "after-work" hour's programs. The goal of this class was to teach the basic techniques needed for quilting as well as allow community members to work on their own personal projects who may not own the tools and materials necessary to complete the work. This program was significant because it allowed community members to repair quilts that had sentimental value. This led to community members sharing stories about the history of the quilts, family stories, and most importantly community connectedness.

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Health and Fitness Coaching Workshop

This workshop was created to help members address their health concerns and think of creative ways in which they may be able to address those concerns independently. The facilitation was provided by a Native volunteer who was diagnosed with diabetes and was able to change his lifestyle and eating habits. During this workshop members were able to identify reasons that have caused or prevented them from making healthy choices and begin a plan on how they will achieve their health goals in which ensured their accountability. Topics discussed included: diabetes prevention and management, health food alternatives, weight management, etc.

Events

There was a total of 26 events held this year. This includes both in-house and outreach out in the community. Two events I would like to highlight were the September-Suicide Prevention Month event where we brought in a guest speaker and held a video screening and discussion. The other event is the Annual Indigenous Peoples Walk for Sobriety. We partner with a small indigenous organization every year to bring awareness to the effects of substance abuse on our community. All other events include our annual Pow wow's, holiday celebrations, Annual Sage Wrapping ceremony, and Traditional Arts workshops.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***Include a list of indicators measured, how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Per our contract we had committed to the following measures of success:

a. Engage 150 community members through prevention service programming.
b. 65% of our members utilizing referral services will be successful in accessing (connecting with) services over a 12 month period.
c. Program staff will participate in 20 outreach events or activities throughout the course of the year.
d. 10 participants, including NAHC staff, community members, volunteers and interns, and partner agencies will be trained in Mental Health First Aid.

With the intended outcomes that:

a. Members will have increased access to prevention activities and mental health support.
b. Members will increase their engagement in NAHC mental health prevention and treatment services.
c. NAHC will engage a diverse population of first responders throughout Contra Costa County.
d. Members, Peers, and Staff will be trained in behavioral health related topics including but not limited to Mental Health First Aid.
e.

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen

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to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Please see the MHSA Aggregate Reporting Form submitted in conjunction with this report.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

NAHC Richmond staff are specifically trained in Mental Health first aid, Trauma Informed care, Suicide prevention and intervention, and are well versed in identifying outside resources useful to members. A significant portion of our work is dedicated to bridging relationships with local agencies, and ensuring referrals are made to reliable providers. NAHC's programming continues to reflect the MHSA values by providing direct linkages through our Community Health Workers, addressing social determinants of health and serving as system navigators for additional resources. In regard to behavioral health referrals specifically, NAHC Richmond partners with a number of local providers as well as NAHC's own Behavioral Health department which allows us to speak directly with staff regarding appointment scheduling and follow-ups. This reduces barriers and helps to speed up response times.

Embedded in our programming is the philosophy of culture is prevention. Providing services that reflect this philosophy is a key component in our overall mission and the driving force behind our service strategies and goals. Traditional cultural practices provide Native community members with a sense of belonging, identity, and restored pride. These elements are important because they have been historically lost throughout generations due to a number of causes. Exposing members to traditional practices has been proven to reduce stress by providing an outlet as well as played a key role in promoting healing from historical trauma (which we as a community understand causes those to suffer from mental illnesses). Participants report feeling a sense of belonging to community through our groups and events. The social connectedness and pride developed here directly supports wellness and recovery. It allows individual members to build relationships and prevent isolation. Our program builds upon the resiliency of our members to empower them toward the goal of self-sufficiency and self-efficacy.

NAHC also takes an intentional approach to integrating health messaging in our programming, health related topics such as understanding historical trauma, nutrition, diabetes prevention and management, self-care strategies, and insurance eligibility are all discussed in a group or event setting. Topics are covered sensitively and are mindful of language and presentation style. The Native Wellness Center also serves a prevention center by providing information on preventing STD's, providing free condoms on-site and in collaboration with Contra Costa Health Services, we provide free HIV/HEP-C Testing twice a month to members.

The values of NAHC strongly enforce a drug and alcohol-free policy while also encouraging healthy

lifestyle choices outside the center. We offer events focused celebrating sobriety and recovery as well as referrals to drug and alcohol counselors.

It is important to note that the community we serve suffers from historical trauma as well as continued poverty, substance abuse, mental illness, loss of identity, and distrust of our healthcare system. This is why the work that we do is so important and is specifically tailored the way in which it is. Wellness, recovery, and resilience not only reflect MHSA values but are also key values to keep in mind when serving the Native community.

Lastly, external outreach efforts are targeted toward visibility of our program and advocacy for the community. NAHC ensure our presence on various committees as well as our involvement in a number of cities, county, and overall healthcare events, meetings, and groups. By doing this we provide an outlet for our staff to advocate and provide a voice for our member population. The Native community has a history of misrepresentation and under-representation. This community has its own unique identity and rich history to be proud of and it is our intention to represent so accurately and effectively.

VALUABLE PERSPECTIVES:

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

Program participants frequently express their gratitude for the program and staff. They have stated that "without the center they would be alone and have nowhere to go where they feel welcome and safe". In one instance a member has explained how she looks forward to attending our Wednesday luncheons (Wisdom Holder's group), this group is vital to her life for three reasons: 1. It allows her a space for social connection, 2. The staff help to connect her with the resources she needs on a weekly basis, this includes assisting with scheduling medical and dental appointments, finding transportation and food resources, updating her MSSP and paratransit memberships, etc., 3. Lastly, this member also suffers from severe depression and through our Talking Circles she was able to speak out about the her feelings as well as use the tools taught by us to cope and find healthy outlets. Due to the nature of the discussions held at the Talking Circle they are specifically facilitated by Traditional Healers and Native clinicians who have experience working with our population. By doing so we have been able to connect members who are experiencing behavioral health issues sooner and more successfully. The member previously mentioned also disclosed to staff a near suicidal break that she was experiencing last September that led to an extensive follow-up and referral. This disclosure happened during an event that NAHC hosted for Suicide Prevention Awareness month. This is a prime example of why it is so important for us to continue to host events such as these, they not only bring awareness to mental health and reduce stigma but they also provide a safe space for individuals to feel comfortable disclosing their current situations where they typically are hesitant. Understanding that we serve a community that historically has a distrust for medical and behavioral health services (especially those ran by county or governmental bodies) we are serving as a starting point and making connections that foster trust. As an agency we have taken a traditional practice like Talking Circles (which in Native tradition is our way of approaching mental health and wellness) and merged them with the traditional behavioral health approach by providing access to clinicians or referrals, etc., this has proven to be more successful when trying to transition the members into care at other agencies that provide continued behavioral health services:

Passing of an elder member/ a community that has come together to support each other

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Expressions of gratitude regarding the work that we are doing and how we are preventing isolation, improvement in depression, and suicide among our members

Perspectives from community/ CAB regarding the surveys and how we can improve them and our plan on how to move forward

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PEI SEMI-ANNUAL REPORTING FORM

PREVENTION REPORTING FORM FISCAL YEAR: 2018 - 2019

Agency/Program Name: **People Who Care Children Association**
Reporting Period (Select One): □Semi-Annual Report #1 (July – Dec) X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

*Please check **all** strategies that your program employs:*

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

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

PWC's Clinical Program provides early intervention and prevention intervention utilizing psychotherapy in the following formats: groups, couples, family and individual sessions. We collaborate with other agencies, community-based organizations, and healthcare providers. Our goal is to aid our clients and their families in obtaining the resources/support they need to achieve their goals and thrive. Our groups are primarily prevention based and focus on building and strengthening interpersonal skills necessary for functioning effectively in life. These include the development of healthy coping mechanisms, self/ emotional awareness through mindfulness, anger management, conflict resolution, stress management, and effective communication skills. Other groups focus on team building, community support/peer relationships, creativity and expression, and self-identity/awareness groups. PWC gives our youth a safe and nurturing environment to explore what makes them who they are.

Our goal is to aid our clients and their families in obtaining the resources/support they need to achieve their goals and thrive. This is achieved in part by collaboration with other agencies, community-based organizations, and healthcare providers. Our groups are primarily prevention based and focus on building and strengthening interpersonal skills necessary for functioning effectively in life. These include the development of healthy coping mechanisms, self/emotional awareness through mindfulness, anger management, conflict resolution, stress management, and effective communication skills. Other groups focus on team building, community support/peer relationships, creativity and expression, and self-identity/awareness groups. PWC gives our youth a safe and nurturing environment to explore what

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makes them who they are.

B. Please include types of problems/needs addressed, any activities that address these problems/ needs, and any functional outcomes.

The needs we have seen in the population we serve include: issues with depression, anxiety, and management/regulation of intense complex emotions that are perceived as negative, challenges with resolving internal and external conflicts, struggles to identify and communicate thoughts and feelings when under pressure or dealing with hardships, conflict within the school setting and community setting with peers and family. Many of our clients struggle with their ability to identify their goals, talents, ambitions, along with a lack of understanding regarding their self-identity and how they fit into the world.

Our prevention groups help youth by encouraging and building self-awareness. This enables them to be better attuned to their mental health needs, empowers them to ask questions, identify their needs and seek support. Activities such as group, family, couples, and individual clinical sessions empower our clients by focusing on the creation, development, and maintenance of meaningful relationships to self and others. This also facilitates for the clients to finding who is their support system, or in some circumstances build/create/fortify an effective and strong support system. This gives our youth the keystone to create a stronger and more effective support system. Throughout this process, clients learn about themselves and start the development of a personal growth mindset. These prevention groups foster learning experiences that enhance the individual's self-awareness. This is a motivating factor in cultivating their desire towards caring for their mental health needs and becoming self-sufficient in managing personal/internal challenges and/or external struggles, in conjunction with acquiring the tools for coping through life's sometimes difficult and challenging experiences.

Our mental health program is continuing with the theme of self-discovery and building upon this cornerstone from the previous two years. This year, PWC has transitioned clinicians. Previously, we were using a Pre-Doctoral PsyD trainee, Miss Deborah contracted from the Hume Center and have shifted to a clinician, **Ute Baldwin,** also contracted from the Hume Center with dual credentials. Postmaster Associate Marriage & Family therapist (AMFT), and Associate Professional Clinical Counselor (APCC).

Though there is some overlap between regarding focus, such as both assess and treat clients with a range of problems, but the difference become apparent regarding the clinical focus thus resulting in PWC's orientation to have shifted, due to the differences in our clinician's scope of practice. This transition enabled our program to move from an individual-focused therapy to a more interpersonal relationships-based. Interpersonal relationships are examined for the purpose of achieving more adequate, satisfying interactions therapy, thus concentrating on how our behaviors, thoughts and feelings impact our interactions and their outcomes with others. Our mental health program component continues to provide clients with many opportunities to learn and develop their skills in three crucial areas of strategizing and developing appropriate coping skills to manage, tolerate, understand challenging emotions they experience within themselves and encounter in other individuals and situations, along with continuing to build and enhance communication skills to further develop/maintain and strengthen necessary

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interpersonal relationships with their families, peers, and community members. Thus, helping youth discover ways in which they can learn to manage negative emotions such as anger and hurt that they can respond in a reasonable manner rather than being overtaken by their initial gut reaction, and to find a positive and resolution to whatever conflict they may be experiencing. These concepts provide our clients with learning opportunities. They learn how to resolve issues to create the minimum of negative consequences and hopefully the best outcome for them that is possible.

Our program recognizes the need within the population and community that we serve a trend when specifically focusing on clients' relationship with themselves, their peers, family and community in conjunction with how cultural/subcultures influence how we are perceived by others, and how we deal internally with the concept of self. This ultimately can affect the individuals' emotional wellbeing and mental health. To address this need, we have focused on providing a safe space where clients can discuss and present their emotions to gain understanding how to identify what they are feeling, why the maybe feeling this way, and learn the tools and skill sets to regulate and manage their emotions. This has been especially important in helping to create the awareness needed to understand self/identity. Also, this facilitates client exploration into the depths of who they are and what makes them individuals that are worthwhile and unique. In providing this space, our clients are able to explore what makes them similar and different from others without the stigma of us vs. their mentality of seeking only those who are like them. This assisted in fostering stronger connections within the community and support for those who have been struggling to learn to accept themselves, as well as others who are different from themselves. They are able to discuss and explore a complete range of complex feelings along with thoughts that are specific to themselves and to others as they continue through their adolescent stage of development. PWC seeks to encourage, empower and enable our clients to learn about an important component culture and subcultures contribute and how it culture, and how this interconnects with whom they are. Our clients , where they have been, how it impacts them. These levels and layers of culture influence our values, beliefs and shape our norms. Culture influences the manner we learn, live, and behave to a large degree. In essence, it influences/shapes who we are as individuals, families, and as a community. A lack of cultural awareness by others also creates obstacles and in the case barriers and discrimination our clients may face along the way. By providing a space for them to develop a deeper understanding of the origins in which their emotions/ thoughts are shaped and how that influences their self-concept, identity and in turn creates our clients' reality. Our clients are learning: they are capable and competent in their ability able to manage, control and tolerate any challenges or obstacles they may experience over the course of their lives. Therefore, our goal is to create a mental health program that not only fosters clients' knowledge of themselves and others but also encourages ongoing\continued skill set development. This empowers our clients to strive towards their goals, personal growth and continues self-improvement. This builds a stronger individual, which leads to more resilient families and more cohesive communities. Addressing these needs through groups, individual, and family sessions our youth have demonstrated an increased ability to ask questions, seek support, discuss and explore their internal and external conflicts through communicating with the staff and an increase in their level of

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trust in the staff to help support them through their own challenges. There has also been an improvement in the clients' ability to work together and voice their opinions in ways that are appropriate, productive and helpful to themselves, their peers families, and community.

OUTCOMES & MEASURES OF SUCCESS:

A. Please provide quantitative and qualitative data regarding your services. (See Goals - Appendix)

B. Which mental illnesses were potentially early onset?

Mental illnesses that were detected early by this therapist included: Eating Disorders (Bulimia Nervosa, Bing-Eating Disorder, and Anorexia) in both male and female clients. Anxiety, Depression, Bipolar, Addiction, Conduct Disorder, Reactive Attachment Disorder, and in young adults Borderline Personality Disorder, Intermittent Explosive Disorder, and Antisocial Personality Disorder.

C. How participants' early onset of potentially serious mental illness was determined?

Participants' early onset of a serious mental illness was determined utilizing a combination of our referral process and clinician assessment. These are crucial in providing services, assessing needs, and mental health screening. The Triage Referral Model is utilized to assess and later reassess appropriate levels of treatment and support needed by the client. As a reassessment tool the referral form provides the clinician with additional information that can warrant additional mental health services and/or provides evidence that the client's needs are at a higher level therefore requiring a change in the mental health services being provided. It contains a list of symptoms that the individual identifies and includes a portion for the time and severity of those symptoms as reported by the individual.

PWC's use of a triage model allows us to maintain an open streamline to our mental health services. First, our peer counselor, Gerardo, has a close relationship with clients and their families. He is the person who provides all the initial paperwork for those individuals entering the PWC program. He is Spanish speaking and can create a relationship with the incoming clients and their families by building rapport. Gerardo inquiries about the clients' needs and the needs of the family which allows for him to make an internal referral if needed which is required for any potential mental health services. The next person in line is our mental health resource specialist, Miss Pope, she meets all clients and their families who sign up at PWC, sharing and discussing any possible community resources that may be available to the client and their family. This allows for her to build the necessary relationships needed to discover what each individual client needs are and what their family needs may be as well. When she is able to discover what those needs are, she finds the resources and/ or fills out another internal referral to get the client to the next level of our mental health services. This is determining whether to provide in-house individual and/or group prevention services or provide individual and group therapy and whether to incorporate family therapy into the treatment plan according to their needs level. The clinician then meets with the client to further assess based on their clinical needs and the services provided. Our internal referral system has been a vital part of making our triage model flow smoothly and eliminate as many barriers as possible from mental health services.

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Our peer counselor, Gerardo, then collects as much information as possible from the client and family to get the referral filled out and passed along to our mental health resource specialist, Miss Pope. After reviewing the referral, Miss Pope assesses what resources the client and or their family may need and also collects more information necessary for us to determine the level of care necessary. Once she has done so, she passes the referral along to our clinician to further assess the needs of the client so we will provide them the level of care required for their specific needs. Where clients present symptoms that are indicators of possibly early onset of mental illness such as isolation, social withdrawal, sadness for an extended period, continuous anger or anxiety, along with chronic issues that cause distress, those individuals are flagged for a higher level of care. Once initial referral is made, and signs of early onset are determined. our clinician meets with the client and family to further assess, and if possible, provide individual and/or family therapy services. If the clinician deems a more in-depth assessment is required, and or a higher level of care is warranted the client(s)/family are referred to an outside agency to receive the level of care they need. Besides this referral process, the clinician conducts an assessment on each youth within the program and determines each youth and places that individual in a prevention group, or if they would benefit from a more supportive/intensive therapeutic support in-house program. These dual assessments together aid in the determining if an outside referral should be initiated or if PWC's in-house services are appropriate, the client may be placed into the following pathway which may include: a prevention or therapeutic model, or a combination of both models is the most appropriate level of in-house support PWC can provide to our youth and their families.

D. List indicators that measured reduction of prolonged suffering and other negative outcomes and data to support reduction.

Indicators that measured reduction of client's suffering are parental and client weekly self-reports of feeling happier, and resolution/decrease in presenting problem. Another indicator in addition, clinical behavioral observations are noted by this clinician. For example, this therapist will ask the client a qualitative question, such as "How are you doing this week?" The client is then asked to rank their answer on a scale of intensity from (1 being the lowest to 10 the highest intensity). In conjunction to these aforementioned, this therapist asked the client customer satisfaction questions. These are utilized by this clinician as a balance measure, not a driver for outcomes.

E. Include how often data was collected and analyzed as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served

This clinician utilizes a combination of quantitative and qualitative measures to evaluate effectiveness of individual treatment\prevention sessions. This information is collected at each individual client session, generally on a weekly basis. The data collected is in the form of the client's self-reporting of symptoms, progress, and satisfaction with the session. This is then recorded in a rating/scaling format at ea. individual sessions. This information is noted in the client's progress note, which is stored at an off-site facility in compliance with HIPPA standards.

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DEMOGRAPHIC DATA:

PWC has and continues to utilize the County Demographics Form: However., as previously reported specific demographic domain (i.e., Veterans Status) are not collected due to family dynamics and clients that we serve. ***(See Appendix for additional information)***

EVIDENCE-BASED OR PROMISING PRACTICES:

A. What evidenced-based or promising practices are used in your program?

The evidence-based programs selected to meet the goals, objectives, and performance indicators are presented within our clinical success program. These evidence-based models include promising practices and exemplary programs from the Office of Juvenile Justice and Delinquency Preventions (OJJDP). Specifically, the utilization of a program model with effective proven systems that have shown to work for our at-risk and high-risk clients. This model complements our ongoing strategies and fits well into the underlying program foundation. Thus, the goal within the PWC program is much more than just prevention. Its goal is to foster confidence, character, and competence at school, work and in life, and develop unity with positive peers, family and their community. Specifically, PWC's aim is to empower our clients with the education and training needed to help them make a successful-transition from their current educational status and career paths into a well-adjusted and productive adulthood.

The clinical success program is conducted on site and within the community. Over the past few years and community-based program services, PWC evidence-based practices centered on PWC's knowledge of the community and the clients they serve. These practices or build on success of its community-based programs, and the clients come to improve care processes as well as successful client outcomes. Evidence-based practices are also utilized by this therapist in sessions with our clients. Cognitive-Behavioral Therapy and Dialectical Behavior Therapy are the theoretical realms from which therapy treatment and prevention sessions in groups, family, couples, or individual sessions is conducted. When meeting with individuals, families, or in a group setting, all the information that is discussed and explored during those sessions is data that is utilized for measuring the progress of the people involved, it is also utilized to create goals of continuation of progress, treatment planning, development of focused material to address the individual's needs for continuation of services.

B. And how is fidelity to practice ensured?

The evidence-based practices utilized by this therapist also include Cognitive-Behavioral Therapy and Dialectical Behavior Therapy when working in therapy treatment or prevention sessions in groups, family, couples, or individual sessions. Both PWC and this therapist value and utilized consultation that includes performance feedback is conducted weekly with the team. This serves as oversight with

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adherence and competence to the program. A number of different tools as well as strategies were used in our outreach efforts as well to welcome and identify individuals who would benefit from our program.

VALUES:

A. Reflections on your Work:

1. How does your work reflect MHSA values of wellness, recovery, and resilience?

2. Provide access and linkage to mental health care, Improve timely access to services for underserved populations, Use strategies that are non-stigmatizing and non-discriminatory?

Systemic links to the education system and schools re a particular problem for our clients living in low-income, undeserved communities in Pittsburg, and around the Bay Point communities doe to its overall disengaged and uninterested outcomes for youth facing life struggles.

PWC Clinical Success Program serves as an educational liaison to the school system to help our clients stay engaged and connected to continuation schools. As such, access to community resources is critical for every school. Schools are a primary place for prevention and intervention to occur. Clients who may need additional services are more likely to receive it if teacher and school administrators are aware of the warning signs and have the capacity to link clients to appropriate resources. With the impressive array of excellent innovation programing in the district, there are obvious disconnections in the services continuum relative to the accessible intensive services for the highest at-risk population, I.e., gang involved, drug/alcohol users, and sexual exploited clients. Through partnership, we help to accelerate schools' work to focus on implementing intensive prevention and intervention to serve our high-risk clients. With a practical, affordable model out program encourages our client to become an active contributing member of society. The goals are: (1) individual and family prevention therapy. PWC provides a minimum of four groups per week, one group on both Monday and Tuesdays, along with two groups on Wednesdays, with the addition of providing individual therapy, family therapy and case consultation. 2) Staff peer groups and Peer consultation, a staff support process, facilitated by the Hume Center provides clinical tool and support for working without clients. The peer consultation process emphasizes trust and curious exploration as its primary mechanism f approaching problematic behaviors and maladaptive patterns. Because of the explorative nature that this process engenders, staff and service providers are challenged to abandon preconceived conclusions and assumptions about the client in an effort to understand the root of their suffering from the client's perspective. Doing so allows staff and service providers to approach the clients from non-stigmatizing, non-discriminatory perspective that affects both clinical and managerial functioning on a program level.

PWC's program provides access and linkage to mental health care and improves timely access to services for the undeserved population we served by using strategies that are non-stigmatizing and non-discriminatory. First, based on the clients PWC serves, presentations regarding PWC's goal of empowering at risk youth, resiliency, recovery, and mental wellbeing are addressed to the Martinez, Pittsburgh, Ridgedale, and Brentwood, which are classified as Golden Gate Community School.

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PWC also speaks at Hispanic clubs such as such as Puente and the Latino Unidos, which are clubs located at Pittsburg High School. We continue to reach out to other agencies that can serve our clients' medical and higher level levels of mental health services when needed. La Clinica is one of those agencies we refer frequently. PWC continues to provide community service opportunities at Multi-Cultural, Civic and Community events such as the Cesar Chavez events, community festivals, and local events like the Crab feeds at local Religious centers in Pittsburg, where the population largely Spanish-speaking Youth and their families. This information is shared in Spanish and by our Bi-lingual staff members to ensure the information is shared a language that the population we serve can easily understand. To further de-stigmatize and breakaway barriers to healthcare, PWC offers home visits as a way to provide a space for the client and their family to share in the comfort of their own home. These home visits provide the services in for clients and their families so they can feel emotionally supported and understood in a manner that the stigma is removed/diminished, and they can accept mental health services.

Timely access to mental health services is very important in the treatment and prognosis for the client. PWC's use of a triage model allows us to maintain an open streamline to our mental health services assessment, ensures the most appropriate level of care, whether that is providing in-house services for prevention or therapy groups/individual/family sessions, or providing referrals to outside mental health services in the community. This process also enables PWC to continue breaking down stigmas and barriers of mental health. How we accomplish this is first with our peer counselor, Gerardo. He has a close relationship with clients and their families, as he is the person who provides all the initial paperwork for those individuals entering the PWC program. Gerardo is Spanish speaking and can create a relationship with the incoming clients and their families by building rapport, inquiring about the clients' needs and those of the family as well. This allows for him to make an internal referral if needed, which is required for any potential mental health services. The next person in line is our mental health resource specialist, Miss Pope, she meets all clients and their families who sign up at PWC. Miss Pope shares and discusses possible community resources that may be available to the client and their family. This allows for her to build the necessary relationships needed to discover what each individual client needs are, and what their family needs may be as well. When Miss Pope is able to discover what those needs are, she finds the resources and/ or fills out another internal referral to get the client to the next level of our mental health services. This is determining whether to provide in-house individual and/or group prevention services or provide individual and group therapy and whether to incorporate family therapy into the treatment plan according to their needs level. The clinician then meets with the client to further assess based on their clinical needs and the services provided. Our internal referral system has been a vital part of making our triage model flow smoothly and eliminate as many barriers as possible from mental health services.

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REFLECTION ON YOUR WORK:

A. Valuable Perspectives:

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

On three occasions this year, this process was paramount in aiding the PWC team in determining the level of care appropriate for our clients and their families. For some individuals that face issues of anxiety, depression and/or symptoms of isolation and continued conflict with family were observed and addressed through our assessments of clients through our referral system. When individuals exhibit these types of symptoms, our staff reach out to the individual to seek understanding, provide support, and we can make a referral.

The three instances in which this triage approach was paramount in determining the care level. The first occasion concerned a client who has a dual diagnosis: substance abuse, Bipolar II disorder with psychotic features, this individual was non-medication compliant, had an extensive Hx. of hospitalizations for suicidality, and substance abuse. This adolescent needed more supportive and intensive psychiatric services than PWC could provide, and as a team we made the determination that a referral to county mental health services was the correct pathway to follow. PWC made the following recommendation to the client and her family: she should remain with her primary psychiatric care providers for treatment and seek additional mental health services in the form of therapy with a licensed therapist through county. PWC also encouraged the client to continue partaking in youth activities at PWC. As a team, we felt this has enabled her to be in a structured and safe social environment that promotes and teaches healthy coping mechanisms.

The second occasion where the PWC triage and support services were instrumental in a successful outcome involved a young adult. Through his teen years, he was a client of PWC and when he became an adult, he had left our organization. This client had been affiliated with gang members and then later became estranged from his family. This client later was involved in criminal activity and had been on the run from an outstanding no bail arrest warrant for the last two years. He came in to PWC to speak with Miss Pope. The client and Miss Pope had a good established rapport. He could trust her and shared with Miss Pope what had transpired, along with his dilemma. Miss Pope referred the client to this therapist. Because of the previous rapport and trust this client had established with Miss Pope in conjunction with the privilege of therapist and client confidentiality this client could share his whole story. He could openly discuss his concerns, fears, and hope. After this initial meeting with the client, the PWC triage team (Miss Pope, Peer Counselor—Gerardo, and this therapist, we discussed how we could best support this client in making a decision that would have a profound effect on his life.

Later that week, this therapist and Gerardo meet with the client and openly discuss his options. We addressed the client's fears and worst-case Scenario We, as a team feared because the warrant for this client's arrest was for a past crime that involved a firearm. There is always a chance that something might go horrible wrong depending on the unknown variables of any scenario that might

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ensue. What if he were with any friends or relatives and was stopped by law enforcement for some unrelated reason, they learn that he has a warrant for his arrest, and if one of his friends ran, or resist detainment? We discussed some potential negative outcomes. This therapist, Miss Pope and Gerardo also explored with him the "what if" he processed coped with his fears of incarceration and could turn his life around. "What if you could educate yourself with a trade, earn a decent living wage, and make a difference by being a role model to other young people?
The client decided to surrender to law enforcement. Before he turned himself in, Miss Pope linked this client with Rubicon Programs. This organization provides people with knowledge, resources, and support to break the cycle of poverty. They commit to each program participants for up to three years to help them build a foundation for future success. Gerardo provided moral support and accompanied the client to the Office of the Sheriff Contra Costa County. PWC supported this client through the entire decision-making process, so he could make the decision that in the long-run benefited himself, his family, and the community.

The third case involved a fourteen-year-old Hispanic male. His mother came in asking for help with severe behavioral problems being exhibited by the client (her son). The mother shared with Miss Pope that the client was expelled from school because he brought a knife to school and stabbed a student. The client's mother described events where the client was displaying patterns of episodic excessive anger in response to specific or situational themes. The client's mother is a single parent and does not receive support or has had contact with the client's father since his birth. Mom works long hours and is not receiving any government assistance. She and the client are sharing a residence with multiple family members (uncles, aunts and cousins) who are known to this therapist as gang members.
The relationship between the client and his mother has recently been strained, and she at the initial assessment session with this therapist the following: drastic behavioral changes in her son since the stabbing incident and school expulsion, He also has a repeated history of engaging in passive-aggressive behaviors (e.g., forgetting, pretending not to listen, procrastinating) to frustrate or annoy others, and his academic achievement declined.

Upon this therapist's assessment the client showed the following: cognitive biases associated with anger (e.g. demanding expectations of others, overly generalized labeling of the targets of anger, in response to perceived "slights"). The client described experiencing direct or indirect evidence of physiological arousal related to anger, while displaying body language that suggests anger, including tense muscles, glaring looks, clenched jaw, or refusal to make eye contact. The client demonstrated an angry overreaction to perceived disapproval and criticism. He rationalizes and blames others for his aggressive and abusive behaviors. The client excessively swears when efforts to meet desires are frustrated and when limits are placed on his behavior. He is involved in frequent physical fights with peers. The client consistently fails to accept responsibility for anger control problems by a repeated pattern of blaming other for anger control problems. He also has a repeated history of engaging in passive-aggressive behaviors (e.g., forgetting, pretending not to listen, procrastinating) to frustrate or annoy others and is

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rather proud of this accomplishment. It was determined this client would benefit most by: (1) Providing individual therapy (2) also placing the client in a skill set group where the focus is on building distress tolerance levels and coping mechanisms. (3) Providing support to the client's mother by de-stigmatizing and by normalizing the difficulties with acculturation that many families experience, this removed the stigma that there is something mentally wrong with the child/family, and (3) Providing support in the form of psychoeducation with parenting skills, combined with family therapy. This therapist and Miss Pope have frequently coordinated and collaborated with the client's school therapist to ensure that skill sets, and therapy efforts are not in theoretical conflict therapeutically, and that we are supporting the client and his family. This adolescent can now identify and understand the emotional mechanisms driving their behaviors and impulsivity and can now regulate/control his responses. After approximately 6 months of sessions, Mom is now able to establish and maintain consistent boundaries with the client. She also has learned positive parenting skills that have empowered her in her role as a parent and improved her relationship dramatically with her son. This client has reduced, and some instances the negative behaviors/responses are now extinct. The client is attending classes regularly and made the dean's list at his school. The client mostly completes his chores and is following mom's direction. He is now on a PRN therapy schedule and frequently stops in to talk when something is troubling him or when he wants to share about his accomplishments. The client apparently feels safe and secure at PWC. He interacts with his peers while at PWC. This client has done so well that he is allowed to attend Pittsburg High School this fall semester.

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Appendix

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The PWC Clinical Success After-School Program strives to provide positive outcomes for children and youth by increasing protective factors such as providing structural opportunities and caring relationships with mentors to support education and economic success of at-risk youth, and thereby promote lasting healthy development.

The underlying purpose of the evaluation check/study is to help discern if program elements and activities are resulting in important and meaningful outcomes for targeted youth. The main focus of this study is to track the progress of the objectives that were set for the program at the beginning of the year in accordance with funder expectations as aligned with actual program activities.

Participant surveys

1. A participant pre-/post-test was developed previously in a collaborative effort between PWC program staff and the external evaluators (Hatchuel Tabernik & Associates, & Michael Kee & Associates Architect). This test is designed to measure Entrepreneurial and Environmental knowledge prior to and following exposure to the 8-week Solar and Environmental Training course.

2. A participant pre-/post - survey for this year was replicated as previously approved by Mental Health Administration staff from Contra Costa Health Services. This survey was designed to measure the following: resiliency; community support; recidivism; and program satisfaction.

The pre-survey is designed to be taken at program intake, and the post-survey is to be taken at the end of the 12-week program. As shown in Table 1, the participants were divided into cohorts based on when they started the PWC After-School Program.

It is important to note that many students chose to re-enroll in multiple courses upon completion. To that end, we recorded these students' tests and noted the methodology used for the analysis.

Table 1. Participant Survey Administration (July 1st, 2018 – June 30th, 2019)

Quarters	Participants N	Cohort	Period	Pre-Surveys	Post Surveys
Quarter 0	67	0	July - September	39	29
Quarter 1	47	1	October - December	39	29
Quarter 2	23	2	January - March	35	20
Quarter 3	70	3	April - June	24	19

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School Day Attendance Data from Pittsburg Unified School District (PUSD)

This data is acquired through connections made at PUSD and staff from the schools that our participants attend. Permission was secured from parents/guardians, and every effort was made to collect student records for as many participants as possible. Due to the high-risk nature of our student population, longitudinal attendance records were at times a challenge to collect. For example, a number of students referred to the program were not enrolled in public school due to mental health issues in families that PWC serves, as school attendance is not a top priority within the dysfunctional family unit. This makes it difficult to obtain adequate information in a timely manner for participants for the duration of their involvement in the PWC program (usually lasting 12 weeks).

Through networking efforts with PWC, and the PUSD Director of Student Services, Pittsburg Unified School District (PUSD) staff did provide attendance records for a majority of the Cohort participants attending public schools. Some of the students served by the PWC program are high-risk youth who did not regularly attend school, transferred through multiple schools and districts, participated in alternative school/independent study programs, had issues related to truancy and/or are on record as having dropped out of school. Despite these challenges, school day attendance data was available for **87** participants of which a total of **67** students was referred to the program through the Student Attendance Review Board (SARB) due to attendance and behavior issues.

Probation Data from the Contra Costa County Juvenile Services Department

Data on recidivism is acquired from the Contra Costa County Juvenile Services Division's Director of Field Services. The Director was provided with a list of program participants, and asked to designate which students, if any, had re-offended during the time period for which they were in the PWC program. Due to the sensitive nature of the information, the Director provided aggregated information only; student names were not identified. The Probation Department provided PWC with reporting information for **13** students (6 Cohort 0, 4 Cohort 1, 1 Cohort 2, and 2 Cohort 3).

EVALUATION FINDINGS:

In this year of implementation, PWC continues to make notable progress in assisting at-risk youth to strive for a higher quality of life by providing them with a safe and supportive environment through which they can get vocational training, mentoring, counseling, and peer group support. Clients are encouraged to stay in school, develop goals for their future and lead a purposeful healthy life. The aim of the Solar and Environmental Training Class was to provide youth with environmental education, "green job" training, and opportunities to develop leadership and entrepreneurial skills related to a new "green" economy. Through our dedicated staff, and technology-advances, our success is well documented. The

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following pages summarizes the progress of the program this year as related to its tangible goals and targets.

Outreach and Participation

The target number of unduplicated participants that PWC was prepared to serve in this reporting year was ***200.*** The actual number of unduplicated participants was ***207.*** (See Table 2.)

Table 2. Program Participation by Quarter (July 1st, 2018 – June 30th, 2019)

	July-Sept	Oct-Dec	Jan-March	Apr-June	Total Served
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
# Students (Duplicated) Served Each Quarter	118	160	120	127	525
# New Students Served Each Quarter	67	47	23	70	207

Through careful planning and networking efforts the recruitment process was again an integral part of PWC implementation this year. In August 2018 within the start of the 2018-2019 school year, PWC employed an aggressive recruitment plan that involved the PUSD Director of Student Services, and Probation procedures for referrals to the PWC program during the upcoming school year. PWC also made site visits and presentations to the staff and administrators at Black Diamond and Golden Gate Community Day continuation schools, which resulted in schedules for PWC's staff to meet with the student body to introduce the PWC program, and answer questions. During the months leading up to the start of the program in ***October,*** teachers were supportive in encouraging students to participate in the after-school program.

Once school began, PWC employed their biggest recruitment strategies, the end of the first quarter saw a dramatic upswing of new participants. The first cohort (Cohort 1) began during the first quarter in ***October 2018. A total of 67 students were*** registered for the program, an indicator that recruitment efforts were a success.

Interestingly, the PWC program served the newest students in the first, second, and fourth quarters. This is attributed to the positive pro-social growth of the students wanting to remain in the program, and encouraging peers to be a part of something positive. The third quarter had the lowest number of new participants, as school was back in session, and students transitioning into winter break. A frequent occurrence that was experienced this year was that students had a tendency to remain involved with the program across multiple quarters. Therefore, participants served ***(32%)*** were engaged in program activities for at least two quarters.

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The evaluation for our program consisted with the goal and objective identified are directly linked to the activities and proposed process and outcome measure. Overall, the purpose of this evaluation is to examine specific program activities and service, identify what's working well or not, and enhance our ability to better meet the identified needs and gaps. Working with program manager, the office manager primarily manages the systematic data collection (e.g. pre-and-post clients' surveys, program application, school attendance, and probation data), analyze information, and provide data for the biannual progress reports, ensuring that all the objectives are reached. Additionally, the office manager works closely with the program manager to provide up-to-date data requested by the PEI management team. Our evaluation assesses both clients and environmental level changes (e.g. school-level, systems).

PWC clients consist primarily of Spanish speaking youth and families, who are isolated and social economically segregated from the dominate culture. PWC employee culturally proficient leaders, who must display personal values and behaviors that enable them to engage in effective interactions among students, educators, and the community we serve. Both the peer counselor and the office manager are Spanish speaking Hispanics employed by PWC. Documents combined with PWC's program packet have been translated and revised into Spanish for the support of PWC clients' families. Our data collecting methods help in regard to maintaining clients' confidentiality. Client's confidential personal data are assured by following strict guidelines for collecting and managing client's information. Clinical data are being filed away at the Hume Center while clients' program information is locked in the PWC office in double-locked file cabinets away from reach of our clients.

Participant Demographics:

This year the majority of program participant (n= 207) fell within the 13-17 age range (169), 18-21 age range (29), and 6-12 age range (9). The distribution of gender was 133 male and 74 female. Sexual orientation distribution of program participants was 0 bisexual, 194 heterosexual, 0 lesbian, and 9 declined to state.

The majority of youth participants (76%) were high school aged (9^{th} to 12^{th} grade). The most participants from any one grade level were in the 12^{th} grade.

Of the **207** participants, almost all resided in the city of Pittsburg. One hundred eighty nine (189) participants resided in Pittsburg, three (3) resided in Bay Point, one (1) in Brentwood, one (1) in Oakley, and twelve (12) resided in Antioch. The predominant language of program participants was English (48%). The remaining 52% of participants identified as being primarily English/Spanish speaking.

As there is a large proportion of Spanish speakers in the PWC program, it comes of no surprise, that an examination of the ethnic distribution of PWC participants shows that the majority of all program participants were Hispanic/Latino (73%). The second most represented ethnic group was African American (16%). These two ethnic groups account for 89% of program participants.

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In summary, in this program year:

1. **The majority of the** participants in the program were between the ages of 13 and 17 **(82%)**.
2. **Most** of the participants came from the traditional school system - high schools **(51%).** The second most represented participants (29%) came from alternative school placement.
3. **The majority** of the participants were Latino **(73%).** The next most predominant ethnic groups were African American **(16%)** and **(5%)** White. Asian and "Other" ethnicities represented a smaller part of the participant population **(6% combined)**. This ethnic distribution is similar to that which is found among the students served by the Pittsburg Unified School District as a whole.
4. The above demographic data indicates that the PWC Program is serving the high-risk youth population that it has always intended to serve.

Goal 1: Enhance the Quality of and Access to Resources

Objective 1.1: **65%** of the total number of green jobs program participants will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and "green economy" according to program curricula for the duration of their program participation.

Result: Of the 8 students hired in Cohort 1 as Green Technicians for the Environmental Studies/ Entrepreneurial course who completed pre and post Knowledge Surveys, 5 participants (95%) demonstrated an increase in knowledge between pre and post survey administrations.

In Cohort 3, for the start of the new Green Technicians for the Environmental Studies/Entrepreneurial, 9 students who were hired and completed pre and post Knowledge Surveys, 7 participants (90%) demonstrated an increase in knowledge between pre and post survey administrations.

An average score between Cohort 1 (95%) and Cohort 3 (90%) resulted in a score of **92.5%.** Indicating that the participants demonstrated an increase in knowledge between pre and post survey administrations. This far exceeds the target objective that **65%** of participants would demonstrate an increase in knowledge.

Between July 2018 and June 2019, PWC enrolled a total of 207 youth participants in their after school program. The Green Jobs Training Program was offered twice this year between July 2018 and June of 2019. Although a number of clients repeated the class multiple times, it is important to note that the class reached a total of 21 (7 duplicated) and (14 unduplicated) clients that applied for the program with a total of 17 participants who completed the class. Students who are struggling with self-esteem in their academic careers, completing this program is evident of pride in their accomplishment.

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Students completed a pre-test and a post-test at the beginning and end of each cohort. For students who were in multiple Cohorts, we used the first cohort pre-test(s) and the final cohort post-test(s). The scores of all other students were taken from the beginning and end of their respective cohorts.

Tests consisted of a total of 17 questions (7 true/false and 10 multiple choice) related to the environment and the future of green job industries. Each answer received a score of 1 if it was answered correctly or 0 if it was answered incorrectly. Totals of all 17 questions were tallied on the pre and post-test of each student and analyzed for any increase or decrease in their scores between the two test administrations. Results are shown in Table 5. Of the students who completed pre and post-tests, all demonstrated improvement **(90%).**

Additionally, when asked to rate their level of knowledge about "green industries" using a 5 point scale (1 being "very low" and 5 being "very high"), the average rating of respondents who answered this question (n= 9) was 3 on the pre-test, and 3.6 on the post-test after the 12-week course. Results by cohort and as a whole are presented in Table 5.

Table 5. Participant Demonstration of Improved Knowledge and Skills

	N	Pre-Mean Score	Post-Mean Score	Change in Mean Test Score
Total # items correct on Knowledge test (Max= 17)	17	30.0	32.3	2.3
Average rating of knowledge about green industries (Max= 5)	17	5.8	7.1	1.3

Goal 2: Develop a safer environment for at-risk youth who are chronically truant or on probation.

Objective 2.1: **65%** of the 200 youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.)

Result: Of the **207** students enrolled in the after school program who answered all of the resiliency questions on pre-and-post Student Surveys, **77%** demonstrated improved resiliency. This exceeds the target objective that **65%** of participants would demonstrate improved resiliency.

A total of 92 students completed both a pre-and-post Student Surveys. For students who were in multiple Cohorts, we used their first cohort pre-surveys, and the final cohort post-surveys. The results of all other students were analyzed from surveys taken at the beginning and end of their respective cohorts. A total of

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7 questions on the survey directly addressed Youth Resiliency factors. Students were asked about satisfaction with life, stress, levels, future lives. The most positive answers were scored the highest, and the most negative were scored the lowest, utilizing a 1 to 6 point scale per item (depending on the number of answer options) A maximum score of 32 was attainable. Of the **207** student respondents, 92 answered all of the resiliency questions (enabling us to tally a score for them in this area). Overall **82%** demonstrated improved (n= 92), and **18%** showed a decrease in resiliency on the post survey (n= 92).

It is important to note of the 92 students that answered the resiliency questions, 33 participated in multiple Cohorts, of which answers were unchanged from their first cohort surveys and the final cohort post-surveys. The results of each unchanged answer analyzed utilizing the 1 to 6 point scale per item, positive and negative answers were combined in the categories of increased and decreased outcomes.

Responses of "Extremely and Moderately Satisfied" or "Very Little Stress and Some Stress" or "The future looks very bright and The future looks somewhat bright" were considered to be positive.

Objective 2.2: **75%** of the 200 youth program participants will not re-offend for the duration of their program participation.

Result: Of the **13** probation students enrolled in the after school program, **(100%)** did not re-offend during their participation in the PWC After-School Program.

As described in the Methods, the Contra Costa County Juvenile Services Division Director of Field Services was asked to report the number of students on the lists who committed an offense and the number of students who "re-offended" or went to juvenile hall. Of the 13 student names submitted there was 0 new offense, and no new admission to Juvenile Hall. Overall ***(100%)*** of the program participates did not "re-offend."

Objective 2.3: **70%** of 200 youth participants will report that they have a caring relationship with an adult in the community or at school during their program participation.

Result: Of the 207 students enrolled in the after school program who answered all of the survey questions about caring adults on their 12-week post Student Surveys, **(77%)** indicated that they had caring relationships with adults in their lives. This meets the target objective that **70%** of participants would have a caring relationship with an adult in the community or at school during their program participation.

Among the 7 youth resiliency questions were items specifically related to the role of caring adults in the lives of these youth. Four of the questions in particular were related to caring relationships with adults. Students were presented with the following 4-point scale to answer each question (1=Not at all true, 2=A little true, 3=Pretty much true, 4=Very much true).

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To see if students reported that there was a caring adult in their lives, we examined their responses to these 4 questions on their 12-week post Student Surveys. The 12-week post surveys would best capture their feelings after having been served by the PWC program. Responses of "Pretty much true" or "Very much true" were considered to be positive. Results are presented in Table 6.

Table 6. Demonstration of Participant Relationships with Caring Adults

	% of positive responses
	Overall (n=92)
tells me when I do a good job	75%
I trust and could talk to	65%
believes that I will be a success	95%
notices when I am upset about something	74%
Average of all 4 questions	77%

A total of 92 students responded to all 4 questions on the 12-week post survey. Overall, the majority of students did self-report that they had caring relationships with adults in their lives. It is interesting to note that students who participated in more than one cohort had the most positive responses on their surveys. This data could indicate that students who have the most exposure to the program seem to feel more of a connection to the adults in the program.

In addition to the above questions about adult relationships, on the 12-week post survey students were also asked what they liked about PWC.

Students frequently cited the community events and activities, but many respondents also noted the open, familial environment. Some examples are listed below:

"I like how we help people and work hard."

"I like being able to meet new people and experience things that will further my career."

"More jobs."

"The thing that I like best is that I can talk and trust PWC people."

"The way they help me and our community."

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Goal 3: Create a culture of career success among at-risk youth.

Objective 3.1: There will be a **60%** increase in school day attendance among 200 youth participants for the duration of their program participation.

Results: Of the students enrolled in the after school program with attendance data available for their respective cohort periods, **87%** improved or maintained perfect attendance. This exceeds the target objective that there would be a **60%** increase in student's attendance.

Attendance data was collected for the entire 12-week period that each cohort was in session. Student level data was compared between the first week of participation and the last week of participation in each cohort. Attendance was considered to be "perfect" if there was no indication of absence, truancy, tardiness, etc. In order to be considered "perfect" a student had to attend every full period of class for the entire week.

Of the 207 students served attendance data was available for 87 students (not including those who participated in the program for less than 10 days, outreach students, and those attending adult education and/or graduated), 67 were referred through the Pittsburg Student Attendance Review Board (SARB) for attendance and behavior issues. Of the 67 students with attendance data available for their respective cohort periods, **87%** improved or maintained perfect attendance between the beginning and ending weeks of their cohorts.

Objective 3.2: There will be a **60%** decrease in the number of school tardiness among the 200 youth participants for their program participation.

Results: Of the students enrolled in the after school program with attendance data available for their respective cohort periods, **81%** decreased or maintained a rate of 0 tardiness. This exceeds the target objective that **60%** of participants would decrease tardiness.

Of the 207 students served attendance data was available for 87 students (not including those who participated in the program for less than 10 days, outreach students, and those attending adult education and/or graduated), 67 were referred through the Pittsburg Student Attendance Review Board (SARB) for attendance and behavior issues. Of the 67 students with attendance data available for their respective cohort periods, **81%** decreased tardiness between the beginning and ending weeks of their cohorts.

Summary of Findings

Of the six program objectives, all six were fully achieved (increased knowledge, improved resiliency factors, low rates of re-offense, increased school day attendance and decrease tardiness, caring relationships with adults). (See Table 9 and Figure 3)

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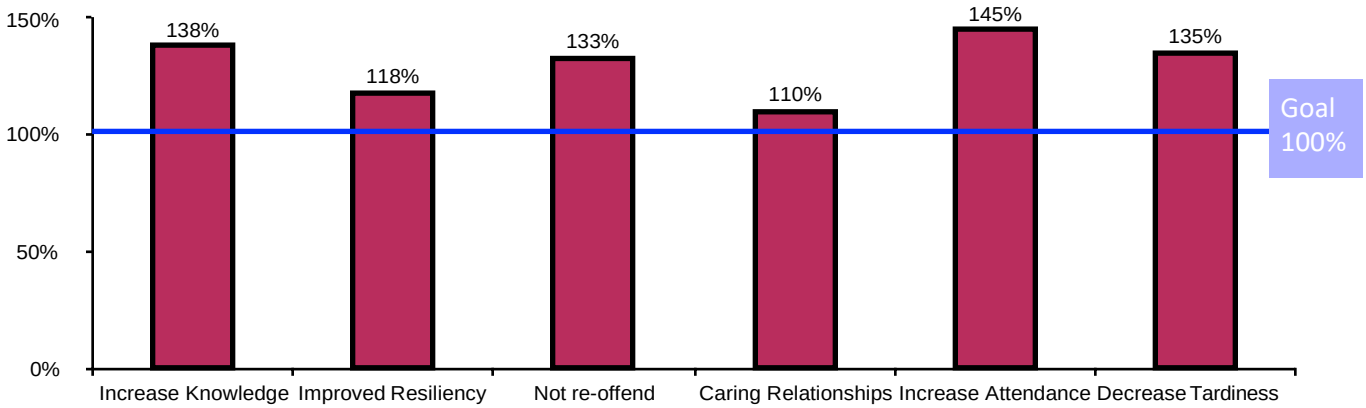
Table 9. Actual Outcomes as Compared to Target: Fiscal Year 2018-2019

Outcome Measure	Target	Actual	Percent
65% *of the total number of* **green jobs program** *participants* will increase their knowledge and skills related to entrepreneurship, alternative energy resources and technologies, and "green economy" according to program curricula for the duration of their program participation.	65%	90%	138%
65% of the youth program participants will show improved youth resiliency factors (i.e., self-esteem, relationship, and engagement.)	65%	77%	118%
75% of the youth program participants will not re-offend for the duration of their program participation.	75%	100%	133%
70% of youth participants will report that they have a caring relationship with an adult in the community or at school during their program participation.	70%	77%	110%
There will be a **60%** increase in school day attendance among youth participants for the duration of their program participation.	60%	87%	145%
There will be a **60%** decrease in the number of school tardiness among the youth participants for their program participation.	60%	81%	135%

Figure 3. Measures of Success Progress Toward Target – Fourth Quarter Report: (July 1st, 2018 – June 30th, 2019)



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Overall, PWC has fully met their targets in regard to the resiliency items in the surveys. One of the biggest tributes to the program is that there are youth who continue to choose PWC to complete their community services hours, despite the ability to complete their hours with other programs, churches or in another city. Another positive is due to PWCs' success, the program has been asked to participate in more new activities in Pittsburg, including volunteering with the Pittsburg Police Department in a human trafficking presentation.

This year PWC After-School Green Jobs Youth Training Program has been a huge success. At this time, we believe we have created a formula for success alongside with learning that will serve our community and our cohorts well, and increase understanding of climate change, renewable energy and conservation. More importantly, we believe we have created a program that helps youth learn real life skills such as cooperation, patience, and caring. Our students realize the program's success is based on their performance on the projects that we set before them. They have responded extremely well and care about the most important goal of all – to believe, achieve, and succeed.

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PREVENTION
END-OF-YEAR REPORTING

FISCAL YEAR: 2018-2019

Reporting Period: Please Select One
☐ Semi-Annual Report #1 (July – Dec)
☐ Semi-Annual Report #2 (Jan – June)

Agency/Program: **The Contra Costa Clubhouses, Inc. DBA Putnam Clubhouse**

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

For Project A, during the contract year of this report (2018/2019), 322 unduplicated members (target: 300) spent 54,386 hours engaged in Clubhouse programming activities (target: 40,000 hours). 86 newly enrolled Clubhouse members (target: 70) participated in at least one Clubhouse activity; 28 of these new members were young adults aged 18 to 25 years (target: 12 young adults). In addition, at least 46 activities (target: 40) were held specifically for the young adult age group.

Table 1: Clubhouse Membership Activity

	Target Goal	Actual	% of Target
Number of unduplicated members served	300	322	107
Number of Hours spent in Clubhouse programming	40,000	54,386	136
Number of new members participating in at least one Clubhouse activity	70	86	123
Number of young adults (age 18-25 yrs.) participating in at least one Clubhouse Activity	12	28	233
Number of activities specifically for young adults (age 18-25 yrs.)	40	46	115

Other services:

Members helped prepare and eat 9,935 meals at the Clubhouse (target: 9,000). Although a target had not been set for rides, 1,229 rides were provided to members to and from Clubhouse activities, job interviews, medical appointments, and more. During the contract year 103 in-home outreach visits (no target set) were provided by members and staff to members and potential members and numerous outreach calls were made to members on a daily basis

Additionally, under Project B, 165 postings (target 124) were made on the Career Corner Blog and four career workshops were held (target 4). The workshops included "Holiday Blues" on December 14, 2018 (21 attendees), "Cultural Responsiveness" on April 18, 2019 (34 attendees), a "Boundaries Workshop" on May 23, 2019 (53 attendees), and a "Resource Fair" on June 3, 2019 (130 attendees).

Table 2: Other services provided to Clubhouse Members

	Target Goal	Actual	% Target
Number of Meals prepared and eaten at Clubhouse	9,000	9,935	110
Number of Rides to and from Clubhouse Activities	No target set	1,229	N/A
In-home outreach visits	No target set	103	N/A
Number of Blog Postings	124	165	133
Number of Career Workshops	4	4	100

For Project C, the SPIRIT graduation was successfully coordinated by the Clubhouse and attended by 321 people on 7/30/18. The holiday party on 12/20/18 had 377 people in attendance with the collaboration of multiple agencies along with the OCE. The annual Community Picnic was held on 6/7/19 with 315 in attendance. By all accounts, the three events were highly successful.

The final portion of Project C requires the Clubhouse to recruit, coordinate, and supervise volunteer consumers to assist the County with the Adult Consumer Perception Surveys (MHSIP) administration at Contra Costa County mental health clinics twice a year. The first of the two annual MHSIP weeks took place November 12-16, 2018 and the second took place May 13-17, 2019 with the Clubhouse completing all contractual duties.

Under Project D, the Clubhouse assisted County Mental Health in implementing the Portland Identification and Early Referral (PIER) program for individuals at risk of psychosis, First Hope, by providing logistical and operational support as per contract.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.

Project A data is collected upon initial membership in the Clubhouse and then daily through a combination of self-completed forms, surveys and sign-on logs, and phone calls. None of the program outcome data is confidential and it recorded in the program database. Any confidential information provided on intake forms is securely kept in the locked office of the Director of Putnam Clubhouse. Data from annual self-reported member surveys, including the hospitalization survey is collected on Survey Monkey instruments and analyzed by Hatchuel Tabernik and Associates, an external evaluation firm.

In June 2019, members and their family members (called caregivers in this report) were encouraged to complete the annual Clubhouse survey via Survey Monkey, an online survey site. The number of members and caregivers completing the survey was 125 (the target was 120), of whom 31 were caregivers and 94 members. Among members in the survey, 2% were aged 18-21, 6% were 22-25, 18.6% were 26-35, 18.6% were 36-45, 36% were 46-59, and 18.6% were 60 years or older. The age distribution is representative of the age range of Clubhouse members overall.

Because not all respondents answered each item, all survey data reported below reflects the responses of those completing each individual survey item. The survey percentages referenced in this report consist of those who 'Agree' or 'Strongly Agree' with the given statement. Those who responded 'Don't know' or 'No opinion' were not included in the analysis.

Caregiver Respite

The data in this report represents only those caregivers completing the survey who reside in Contra Costa County (N=28). Of the 28 Contra Costa County caregivers who responded to the survey, 75.0% were parents or guardians of a Clubhouse member, 10.7% were siblings, 10.7% were the child of the Clubhouse member, and 3.6% were grandparents.

As in previous years, caregivers who participated in this year's survey reported the highest level of satisfaction with Clubhouse activities and programs that their family member attended (100% satisfied), as well as with the Clubhouse activities/programs that they themselves participated in (97% satisfied). In both areas the target of 75% was exceeded. A large proportion of caregivers (86%) also reported that Clubhouse activities and programs provided them with respite care. Such respite is intended to reduce their stress and also lead to more independence for the Clubhouse members, reflected in the data with 80% of the members agreeing or strongly agreeing that in the last year, their independence had increased. An even higher proportion of the caregivers (89%) also perceived that their family member had become more independent in the last year (target 75%).

Table 3: Caregiver Respite

		GOAL	ACTUAL
Measures of Success	N	%	%
% caregivers reporting Clubhouse activities provided them with respite care	24	75	96
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which their family member participated	26	75	100
% caregivers reporting high level of satisfaction with Clubhouse activities and programs in which they participated	27	75	96
% caregivers reporting an increase in member's independence	25	75	84
% members reporting an increase in independence	93	75	77

Below are some responses from the caregiver survey to the question of what was liked best about the Clubhouse:

"A place that is safe and welcoming for my loved one and keeps him in a committed active member level that he really enjoys." (caregiver)

"It gives [my family member] the option of being included in social activities, making friends, and participating in special and sporting events." (caregiver)

"My son has grown emotionally, socially and mentally as a result of all of the clubhouse activities. He has now moved from transitional employment to part time independent employment." (caregiver)

"Supportive staff, knowledge about reaching mentally ill adults in a positive way. Important service to the underserved mentally ill adults in our community." (caregiver)

"The fact that it is there gives families an option family member participation in programs." (caregiver)

"The fact that the Clubhouse is here. I wish my loved one was stable enough to attend regularly." (caregiver)

"The friendly open and accepting atmosphere. The vast number of choices for participation." (caregiver)

Member and Caregiver Well-Being

Several survey items addressed improvements to the well-being of the caregivers and the members in terms of emotional, physical, and mental health. When combining responses to self-perceived improvement of their own mental, physical and emotional well-being, 96% of caregivers agreed or strongly agreed their health (emotional, physical, mental well-being) had improved. When asked the same questions about the well-being of their family member, 89% also agreed or strongly agreed that their family members overall health had improved.

The member ratings for their own improvements in these categories averaged 90%, greater than the goal of 75%. The combined family members rated improvement and the member's self-ratings for improvement in these areas in these areas averaged 92%. Additionally, 85% of the members reported that they had more interactions with peers during the year (75% target).

Table 4: Member and Caregiver Well-Being

		GOAL	ACTUAL
Measures of Success	N	%	%
% caregivers reporting increase in their own health (mental, physical, emotional well-being)	25	75	96
% members reporting increase in their own health (mental, physical, emotional well-being)	93	75	90
% members & caregivers combined reporting increase in their health (mental, physical, emotional well-being)	118	75	92
% members reporting an increase in peer interactions	93	75	85

Other comments made on the surveys by members and caregivers include the following:

"Having such a great place to go during the week is vital to my overall well-being." (member)

"They do a good job. Putnam has saved my son giving him guidance and support in his illnesses worst days." (caregiver)

"You helped me quit smoking!! Thank you." (member)

"It is a comfortable place for my son to go and socialize. He feels 'safe' when he is there, and he has a 'purpose.'" (caregiver)

"It's a community that I belong to, a support system." (member)

"It is a safe and supportive community for people with insight into their mental illness." (caregiver)

"The clubhouse gives me a place to be, gives me the opportunity to be heard and also grow. I don't feel like a burden by being here and I'm always greeted by friendly faces." (member)

"The attitude of the staff members, and how it transfers over to the CH members. This is a very healthy program." (caregiver)

"It is so helpful for me to come to the clubhouse. It has kept me out of the hospital." (member)

Hospitalizations

For the ninth year in a row, members were asked to report on their hospitalizations and out-of-home placements (residential treatment) for the three years prior to joining the Clubhouse and for three years since joining the Clubhouse. Data was collected from a total of 67 active members in June 2019. If data had already been collected for the member in the previous year (June 2018) then this data was entered, and information was garnered for the previous reporting year only (since July 1, 2018). Data was not collected from those who had been Clubhouse members for more than four years since the date of their joining, since the period of observation is a six-year span from three years prior to membership to three years post-joining the Clubhouse.

Information on hospitalization was gathered in terms of "episodes" with an episode defined as each time a member was hospitalized or placed in a residential treatment program (NOT including board and cares or other long-term group living situations that are simply where the member lives but don't involve receiving treatment at his or her place of residence). Data was also collected on total number of days hospitalized or in residential care.

Of the 67 members, three were not included in the analysis: one because they showed that they had been hospitalized for an extended time prior to Clubhouse (an extended period comprises at least 1 episode of 800 plus days) and zero episodes/days after; and two because they did not enter anything beyond their demographic information. The final number of members included in the analysis was 64.

The number of hospital days prior to Clubhouse membership for those 64 members included in the analysis ranged from 0 to 228 days, with a mean of 15 days. Post Clubhouse membership, the number of days hospitalized ranged from 0 to 60 days with a mean of 2 days of hospitalization. In terms of episodes of hospitalization prior to Clubhouse membership, the Clubhouse members experienced zero to 9 episodes of hospitalization (a mean of 1.18 episodes). After Clubhouse membership, members experienced on average .10 episodes of hospitalization (range 0 to 1). In terms of change of episodes, 94% of those providing data showed a decrease in hospitalizations or maintained zero hospitalizations, 2% showed no change, and 4% showed an increase in hospitalization episodes from before to after Clubhouse membership.

Table 5: Percentage of # of episode changes before and after Clubhouse Membership

Episode Change (prior & after Clubhouse membership)	N	%
Decrease or maintained 0 prior and after	44	94
No change (1 prior and 1 after)	1	2
Increase	2	4
TOTAL	47	

In terms of number of days (total) that Clubhouse members were hospitalized or in out-of-home placements, paired T-tests were used to look at change in days before Clubhouse membership and

after Clubhouse membership. Findings showed a significant decrease in average number of hospitalization days from 15.34 days (range 0 to 228 days) before Clubhouse membership to 2.02 days (range 0-60 days) after Clubhouse membership ($t=2.817$, $df=61$, $p<.01$).

Hospitalizations were assessed in terms of change in number of episodes and days of hospitalization prior to and since Clubhouse membership, both of which decreased from before to after membership. In conclusion, the program achieved its goal (100%) of reducing hospitalizations in Clubhouse members.

Members were split into three groups according to their number of years as a Clubhouse member (less than 1 year (n=21), 1 to less than 2 years (n=11), and 2 to 3 years, but less than 4 years (n=14) (see Table 6). Although there appears to be a decrease in the proportion of those who showed a decrease or no change in episodes of hospitalization from those who have been Clubhouse members for 1-2 years (100%) to those who have been Club members from 2-3 years but less than 4 (86%), the proportion of those who show a decrease or no change in episodes still remains highest independent of how many years of clubhouse membership.

Table 6: Percentage of # of episode changes before and after Clubhouse Membership

	Years of Membership					
	Less than 1 year		1 to less than 2 years		2-3 years but less than 4 years	
Episode Change (prior and after Clubhouse membership)	N	%	N	%	N	%
Decrease or maintained 0 prior and after	21	95.5	11	100	12	86
No change (1 prior and 1 after)	0	0	0	0	1	7
Increase	1	4.5	0	0	1	7
TOTAL	22		11		14	

When looking at actual number of Hospitalization episodes Before and After Clubhouse membership, although there is a decline in number of episodes independent of how many years of clubhouse membership. This difference was statistically significant for those who had been Clubhouse members for less than one year and those who had been members for 1-2 years. Although there was a decline in episodes for those who had been members longer at Clubhouse (2-3 years but less than 4 years), this was not statistically significant.

Table 7a: Change in number of episodes from before (Prior) to After (Post) Club Membership.

	Years of Membership					
	Less than 1 year		1-2 years		2-3 years but less than 4 years	
Episodes Hospitalization Prior Membership	23	1.30	11	0.45	14	1.64
Episodes Hospitalization After Membership		0.09**		0.09*		0.14

*p<.05;**p<.01;***p<.001

Paired t-tests were also used to look at number of hospitalization days prior to Clubhouse membership compared to number days after clubhouse membership for each membership category (<1 year, 1 to < 2 years, 2-3+ years) (see Table 7b). Although members showed a decrease in number of hospitalization days from prior to post membership for all categories of clubhouse membership (< 1 yr, 1-2 yrs and 2 to <4 years), only those who had been Clubhouse members for less than 1 year demonstrated a statistically significant decrease.

Table 7b: Change in number of days from before (Prior) to After (Post) Club Membership.

	Years of Membership					
	Less than 1 year		1-2 years		2-3 years but less than 4 years	
Days Hospitalization Prior Membership	29	10.31	13	4.08	20	29.95
Days Hospitalization After Membership		0.97***		0.31		4.65

*p<.05;**p<.01;***p<.001

Overall, using the self-report data of Clubhouse members, it would seem that members of Putnam Clubhouse show a decrease in hospitalization in terms of episodes and total days from before to after Clubhouse membership.

Career Development Unit

During the 2018-2019 contract year the Clubhouse made career support services available to all members including the 90 members working in paid employment and the 48 members who attended school during this period. The Clubhouse provided support to all members who worked and attended school during the contract year including the 43 who began jobs during the year and the 21 who returned to school. Of the members completing the member survey who used career services, 88% said they were satisfied or very satisfied with the services related to employment or education (target 75%).

During the contract year Clubhouse members completed personal career plans (17 had employment goals and 16 had education goals). 100% of members who indicated employment as a goal in their career plan successfully completed their goal (target: 80%) and were referred to employers, applied for jobs, and/or has a job interview within three months of indicating goal. In addition, 100% of the members who indicated education in their career plan as a goal (return to school/finish degree/enroll in a certificate program) were referred to appropriate education resources within 14 days (target: 80%)

Table 8: Career/ Educational Development of Clubhouse Members

		GOAL	ACTUAL
Measures of Success:	N	%	%
% members satisfied/very satisfied with services related to employment/education (of those using Career Unit services)	60	75	88
% members referred to appropriate education resources within 14 days (of those indicating education as goal)		80	100
% members referred to appropriate employment resources, applied for a job, or had a job interview within three months (of those indicating employment as goal)		80	100

Importance of Clubhouse programs to Members and Caregivers

Clubhouse Members and Caregivers were asked to indicate how satisfied they were with the different programs and activities provided by Clubhouse during the 2018-2019 contract year.

Table 7 shows the percentage of members and caregivers were satisfied or very satisfied with the program. Those who did not participate in the program or whose family member did not participate did not respond to the survey item. As can be seen from the responses in Table 9, members and caregivers alike were satisfied or highly satisfied with Clubhouse programs, with a satisfaction rate of over 90% for the majority of programs and activities, bar the Rides program (for both caregiver and member) and Career services for the members. Members were most satisfied with the Holiday and Healthy Living Programs whereas Caregivers were most satisfied with the Weekend Activities and Wednesday Night Expressive Arts Programs.

Table 9**: Member and Caregiver Satisfaction with Program Activities** that Member or Caregiver's Member Participated in **(% Satisfied/ Very Satisfied)**

Clubhouse Programs/Activities	Member	Caregiver
	% Satisfied/Very satisfied (N)	% Satisfied/Very satisfied (N)
Meals	97 (86)	96 (23)
Holiday programs	96 (70)	96 (23)
Friday Night Socials/TGIF Fridays	94 (67)	100 (22)
Work-Ordered Day (Monday – Friday daytime activities	92 (85)	96 (24)
Wednesday Nights Expressive Arts Program (music and/or art)	91 (70)	100 (21)
Young Adult Activities	91 (33)	100 (11)
Healthy Living Program	90 (52)	75 (16)
Career Development Unit (assistance with education and/or employment)	88 (60)	90 (21)
Weekend Activities	85 (62)	100 (17)
Rides Program (transportation to/from Clubhouse)	82 (51)	95 (22)

Finally, both members and caregivers were separately asked to rank 10 Clubhouse programs/activities in order of importance to them. For the members the top three ranked activities/programs were Meals, Work-Ordered Days, and TGIF Fridays. For caregivers, the top 3 ranked activities/programs were Work-Ordered Days, followed by the Rides Program, and the Career Development Unit.

Table 10**: Ranking of Program Activities in terms of Importance by Caregiver and Member**

Clubhouse Programs/Activities	Member	Caregiver
Meals	1	8
Work-Ordered Day (Monday – Friday daytime activities)	2	1
TGIF Fridays	3	10
Weekend Activities	4	8
Career Development Unit (assistance with education and/or employment	5	3
Holiday programs	6	4
Wednesday Nights Expressive Arts Program (music and/or art)	7	6
Healthy Living program	8	5
Rides Program (transportation to/from Clubhouse)	9	2
Young Adult Activities	10	6

*program/activities ranked for Members

Overall, the caregivers and members alike had many positive things to say about the Clubhouse programs and activities:

"An absolute gem of an organization that does amazing things to support our family member(s) when they need it the most to be independent & live a useful life while struggling with mental illness. My personal gratitude for all you do!" (caregiver)

"I am grateful for the support that the clubhouse provides for my son. He really needs the social interaction he finds there. It is very good for him to have a schedule to follow. The staff works very hard and tirelessly." (caregiver)

"I REALLY appreciated the outreach. When members came to our house, it encouraged Amelia to go back to the Clubhouse." (caregiver)

"The clubhouse has never been stagnant. It is flexible, it changes in every way, it evolves, it becomes more creative, it challenges, it keeps growing in every way." (caregiver)

"Clubhouse program has enriched my life - added a big social component. Always there no matter when I come in. Always welcoming and receive that kind of support. Humbling to receive all the extras that the clubhouse gives." (member)

"I am on the whole very satisfied with the Clubhouse. The food is excellent, and I love the members and staff, and all that is given to me in time and trouble and friendship." (member)

"The clubhouse could bring anyone out of isolation." (member)

"The Clubhouse has been a tremendous blessing in my life. It gives me a place to go every day and do something meaningful and productive. I am very grateful for the Clubhouse and its presence in my life." (member)

"The clubhouse is like a second home to me. I have met some wonderful people here and I'd highly recommend the clubhouse to anyone who is finding themselves in a difficult place in their lives. Finding this place was one of the best things that's ever happened to me." (member)

The Clubhouse was successful in achieving all contract goals and objectives for the year 2018-19 contract. In addition, they more than made up for the few enrollment shortcomings last year by enrolling 86 new members this year (123% of the target), and engaging 28 young adults in activities (233% of the target)! With many of the prior year's staffing transitions stabilized this year, the Clubhouse was again able to place focus on growth. Revised policies this year also proved to be a successful strategy, as it made it much easier for new members to onboard into the program. Overall, the Clubhouse has demonstrated highly positive outcomes this year while remaining dedicated to its core values and the wellbeing of each and every member, both new and existing. This year's outcomes bode well for a promising future.

DEMOGRAPHIC DATA: X Not Applicable *(Using County form)*

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

N/A – County aggregate data form used.

EVIDENCE-BASED OR PROMISING PRACTICES:

What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

Since 2011, Putnam Clubhouse has been continuously accredited by Clubhouse International, the SAMHSA-endorsed, evidence-based recovery model for adults with serious mental illness. All Putnam Clubhouse programming meets the 37 standards of Clubhouse International. A rigorous accreditation process and maintaining fidelity to the model require Putnam Clubhouse to provide comprehensive program data to Clubhouse International annually, participate in ongoing external Clubhouse training, conduct structured self-reviews, and receive an onsite reaccreditation review every three years by Clubhouse International faculty. Learning about, discussing, and adhering to the 37 standards of the model are built into the work-ordered day structure. All program staff and program participants of Putnam Clubhouse commit to following the standards during program activities. Program participants are included in all aspects of program evaluation and accreditation.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Putnam Clubhouse is an intentionally formed, non-clinical, working community of adults and young adults diagnosed with SMI. The Clubhouse Model followed has been designed to promote recovery and prevent relapse. Putnam Clubhouse operates under the belief that participants are partners in their own recovery—rather than passive recipients of treatment. That's why Clubhouse participants are intentionally called members rather than patients, clients, or consumers. These members work together as colleagues with peers and a small, trained staff to build on personal strengths, rather than focusing on illness. The term "member" reflects the voluntary, community-based nature of the Clubhouse, making clear that members are significant contributors to both the program and to their own well-being. Thus the term "member" is empowering rather than stigmatizing. Clubhouse membership is voluntary and without time limits. It is offered free of charge to participants. Being a member means that an individual is a valued part of the community and has both shared ownership and shared responsibility for the success of the Clubhouse.

All activities of the Clubhouse are strengths-based, emphasizing teamwork and encouraging peer leadership while providing opportunities for members to contribute to the day-to-day operation of their own program through what's called the work-ordered day. The work-ordered day involves members and staff working side-by-side as colleagues and parallels the typical business hours of the wider community. Work and work-mediated relationships have been proven to be restorative. Clubhouse participation reduces risk factors while increasing protective factors by enhancing social and vocational skill building as well as confidence. The program supports members in gaining access to mainstream employment, education, community-based housing, wellness and health promotion activities, and opportunities for building social relationships.

Putnam Clubhouse operates under the belief that every member has individual strengths they can activate to recover from the effects of mental illness sufficiently to lead a personally satisfying life. Fundamental elements of the Clubhouse Model include the right to membership and meaningful relationships, the need to be needed, choice of when and how much to participate, choice in type of work activities at the Clubhouse, choice in staff selection, and a lifetime right of reentry and access to all Clubhouse programming including employment.

Additional components include evening, weekend, and holiday activities as well as active participation in program decision-making and governance. Peer support and leadership development are an integral part of the Clubhouse. The programming also incorporates a variety of other supports include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the wider community.

VALUABLE PERSPECTIVES:
Please include the stories and diverse perspectives of program participants, including those of family members. Feel free to attach case vignettes and any material that documents your work as you see fit.
Throughout this report we have included quotes from program participants and family members describing personal experiences and perspectives about the Clubhouse's impact on their lives.

CONTRA COSTA HEALTH SERVICES

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PEI ANNUAL REPORTING FORM

Due: August 15, 2019

IMPROVING TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS REPORTING FORM

FISCAL YEAR: 18/19

Agency/Program Name: Rainbow Community Center of Contra Costa County

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

SERVICES PROVIDED / PROGRAM SETTING:
Please describe the services you provided in the past reporting period. Please include who the program has targeted and how your services have helped in improving access to services. Where are services provided and why does your program setting enhance access to services?

During fiscal year 2019, The Rainbow Community Center provided services to members of Contra Costa County's Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community through the implementation of three different projects: Pride and Joy, LGBTQ Youth Support Programming, and Inclusive Schools Coalitions.

Project #1: Pride and Joy – Pride and Joy, an outreach and early intervention project, targets members of Contra Costa County's LGBTQ community. Special emphasis is placed on reaching LGBTQ seniors, people living with HIV, and community members with unrecognized health and behavioral health disorders. Pride and Joy assists our historically underserved community members in finding culturally affirming health and behavioral health support services, and increasing their ability to cope with oppression when they are required to access health and behavioral health services in less affirming settings. Pride and Joy also raises awareness about existing health/behavioral health disparities within the LGBTQ community (e.g. community members' increased rates of depression, anxiety, suicide, substance abuse, and victimization), delivers health promotion messages, and increases LGBTQ community members' knowledge of local and national behavioral health resources.

Tier 1 (Universal) – Rainbow Community Center organized outreach programming through multiple in-person events/groups such as the weekly HIV+ group for self-identified men and monthly HIV+ group for self-identified women, bi-monthly Senior Luncheon and Gender Voice support group,

annual Crab Feed Fundraiser, and Concord Pride. Through our email newsletters alone, Rainbow was able to reach and deliver health promotion messages and raise awareness about behavioral health/health disparities throughout Contra Costa County, in addition to Facebook and Instagram.

Tier 2 (Selected) – Rainbow carried out one-on-one brief-intervention services to the target community in our convening group level services, which are designed to support at-risk LGBTQ community members who are HIV+, low-income, coming-out, transgender, diagnosed with a Serious Mental Illness (SMI), and/or in need of early intervention behavioral health and psycho-education services.

Tier 3 (Indicated) – Rainbow provided one-on-one brief-intervention services (Tier 3/Indicated) to the target community in FY18. Tier 3 services are designed to assist at-risk community members in accessing needed care and treatment.

Senior Programming: Rainbow has identified LGBTQ seniors as a particularly vulnerable population. As such, programming for LGBTQ Seniors includes Tier 1, Tier 2, and Tier 3 components. Services include organizing two congregate meals (Outreach/Tier 1) per month, delivering regular in-person and telephonic Social and Support Groups such as Tai Chi, in collaboration with Meals on Wheels (Tier 2), and offering brief-intervention and screening services through the Friendly Visitor Program with the support of Rainbow's Clinical Department (Tier 3).

Project #2: LGBTQ Youth Support Programming – Rainbow has identified LGBTQ+ youth as a particularly at-risk population. As such, programming for this group incorporates components from all three tiers with services provided at Rainbow offices and in school and community-based locations throughout the county. Efforts also include continued development of support services designed to work with youth within a family-based context and transgender/gender nonconforming youth. Efforts reached youth via outreach activities, onsite group-level programming, and one-on-one mentoring. An additional youth were reached through school-based outreach (tabling, guest speaking engagements), the psycho-social group, QscOUTs, and behavioral health services.

Onsite programming consisted of ongoing youth groups, such as: Artistic Expressions, Youth Gender Voice, and Queer Open Mic. In some cases, groups centered around LGBTQ+ awareness and/or celebratory months/days: Day of Silence, LGBTQ+ Pride month. These groups were developed through an educational and empowerment lens to promote self and group development. In order to bring youth to these groups, we outreached to local school Gender and Sexuality Alliance/Queer Straight Alliance (GSA/QSA) clubs, managed resource tables, facilitated trainings, and hosted special events, while posting on social media and mobile outreach. We also promoted our youth program through flyers, email newsletter, and monthly calendars to school staff, health/service providers, GSA/QSAs, contacts within our Inclusive Schools Coalition, and community at large.

Collaborative events helped boost our outreach and advocacy. These events included: trainings/guest speaking engagements such as, "LGBTQ+ 101" at College Park High School and Acalanes High School, "Empowering LGBTQ+ YOUth" at Contra Costa County Office of Education, "Teens Tackle Tobacco" conference, and Gender & Sexuality Alliance Forums (California High School and College Park). In addition to this, we co-hosted an LGBTQ+ inclusive prom in East Contra Costa County with Center for

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Human Development.

Special events included: Gender Affirming Makeup Tutorial, Valentine's Day Party, and two LGBTQ+ Pride Events - Justice Prom and Concord Pride. With the planning and execution of weekly, monthly, and weekend special events, we were able to outreach to youth who may not otherwise attend our program. We collaborated with new and current community partners, to promote and provide services to marginalized LGBTQ+ youth. Overall, these youth groups and special events helped promote resiliency, collectivity, and youth leadership. These outreach efforts, youth groups and special events helped promote resiliency, collectivity, and youth leadership.

Project #3: Inclusive Schools – The Inclusive Schools Coalition continued the work of the MHSA Innovations Project to promote acceptance for LGBTQ+ youth in Contra Costa County schools, families, and faith communities. Rainbow ran the Central/East County Coalition, which focuses on collaborative work with school leaders, staff, and students to expand and solidify a base of action within four of the county's school districts: Mt. Diablo Unified School District, Pittsburg Unified School District/Pittsburg High School, and Acalanes High School District.

The Coalition also contributed to the ongoing development of county-wide collaborative efforts to establish a strong network of schools, faith communities, service providers, parents, and community leaders that will make a commitment to shared values, principles and practices in advancing acceptance of LGBTQ+ youth in Contra Costa County. Target populations included: a) LGBTQ+ students, their peers, and groups of students who were bullied and marginalized due to racial, ethnic, class, sex, gender identity, physical, and emotional differences; b) school boards, school teachers and staff, parents and other adults whose attitudes and behavior are intrinsic to creating an inclusive climate in CCC schools; and c) school and community-based organizations that interface with students and schools on a regular basis in order to create a seamless, no-wrong-door network of supportive services for marginalized students across Contra Costa County.

The Coalition held monthly meetings to plan goals for outreach and advocacy to support LGBTQ+ youth. Efforts have also consisted of reaching out to other faith communities and agencies/organization while supporting local schools, where Rainbow staff and Coalition members attended student club events such as the Gender Sexuality Alliance forums.

OUTCOMES AND PROGRAM EVALUATION:

Please provide quantitative and qualitative data regarding your services.

- ***How are participants identified as needing mental health assessment or treatment?***
- ***List of indicators measured, including how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***
- ***Average length of time between report of symptom onset and entry into treatment and the methodology used.***

LGTBQ people are often reluctant to access mainstream services due to experiences of feeling unsafe or unwelcomed by other agencies. As a result, many do not access mainstream services, and some feel

compelled to hide their HIV status or LGBTQ identities. These fears mean that LGBTQ people, especially those in the aging older adult population, struggle with greater isolation and other discrimination-related health concerns in comparison to their peers who are not living with HIV or do not identify as LGBTQ. Within Rainbow's social and support programming and clinical services, we provide a welcoming, culturally competent environment and various opportunities to identify the needs of the community members who utilize the services that we offer.

One of our primary methods of identifying the need for behavioral health assessment or treatment is through intake. Rainbow has recently implemented new intake procedures to ensure that all who seek services at Rainbow are assessed in a manner that is trauma-informed and culturally appropriate.

In conjunction with Rainbow's new intake process, staff can identify clients who might benefit from further health assessment or treatment through interaction and conversation. For example, if a participant in youth group brings up serious issues with Youth Outreach Counselors (YOC), the YOC will help make sure they have a warm handoff to our intake coordinator.

Sometimes individuals choose to self-disclose their need for further treatment, which is encouraged by the RCC's dedication to a safe, LGBTQ-affirming environment and through our promotion of health/behavioral health services.

We also participate in various intra-agency case rounds and care team meetings. Rainbow clinicians at Ygnacio Valley High School, Las Lomas High School, Campolindo, Acalanes, Mt. Diablo High School, and Concord High School attend care team meetings where they collaborate with other educators. When LGBTQ youth are discussed, clinicians work to connect them to services at Rainbow, other CBOs, and/or county programs. Within adult services, we participate in multi-disciplinary team meetings for human trafficking and domestic violence (as part of Contra Costa's Zero Tolerance for Domestic Violence Initiative). Lastly, we attend the Children's, Teens', and Young Adult's Reducing Health Disparities Meetings and Contra Costa Health Department AIDS Program's case rounds.

We continue to use our Salesforce database to collect data on consumers, including address, name, birthdate, ethnicity, sexual orientation, gender identity, and the types of agency programs that they attend. We also collect service utilization data on every time the consumers attend a program or service. This data is summarized monthly and submitted with our PEI demands for payment. With our new intake procedures we are tracking the amount of time between initial contact and initial assessment. Counseling charts note the amount of time symptoms were present.

DEMOGRAPHIC DATA: x Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

LINKAGE AND FOLLOW-UP:
Please explain how participants are linked to mental health services, including how the PEI program: 1) provides encouragement for individuals to access services; and 2) follows up with the referral to support successful engagement in services. Additionally, please

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

Rainbow uses multiple strategies to link participants into behavioral health services. One strategy is to bring resources directly to Rainbow programming. We routinely include speakers from outside agencies in our community programming. For example, during FY18 we had speakers at Senior Lunch to cover various topics, such as: fraud protection, fall prevention, higher care options.

Additionally, to support LGBTQ+ youth, collaborative events helped boost our outreach and advocacy. These events included: trainings/guest speaking engagements such as, "LGBTQ+ 101" at College Park High School, Acalanes High, "Empowering LGBTQ+ YOUth" at Contra Costa County Office of Education "Teens Tackle Tobacco" conference, and Gender & Sexuality Alliance Forums (California High School and College Park). In addition to this, we co-hosted an LGBTQ+ inclusive prom in East Contra Costa County with Center for Human Development.

Special events included: Gender Affirming Makeup Tutorial, Valentine's Day Party, and two LGBTQ+ Pride Events - Justice Prom and Concord Pride. With the planning and execution of weekly, monthly, and weekend special events, we were able to outreach to youth who may not otherwise attend our program. We collaborated with new and current community partners, to promote and provide services to marginalized LGBTQ+ youth. Overall, these youth groups and special events helped promote resiliency, collectivity, reduction of isolation, and youth leadership.

Another strategy we employ is utilizing our Inclusive Schools Coalition and our training program to outreach to other behavioral health and social service agencies. Rainbow provided a number of trainings, including to Antioch High School, Antioch Unified School District, Pittsburg Unified School District, Seneca Family of Agencies' Catalyst Academy, California State University Sacramento, Diablo Valley College, Pinole Middle School, and Strandwood Elementary School. As we increase our partnerships, referrals for services increase as a result.

Rainbow Community Center staff are trained to understand the importance of meeting people where they are at, in an effort to create a safe, welcoming, and friendly space. Having the 3 Tier Service Model is critical to connecting community members. Staff spend considerable time working to link participants to mainstream services and programs. As brokers for care between our participants and other providers, we are often able to educate providers who may be well-meaning but unsure or unfamiliar with how best to serve LGBTQ Seniors and people living with HIV/AIDS. We also help our community members by encouraging them to use social service programs, as well as inviting providers to partner with us and introduce themselves to our participants.

Once a referral is made to Rainbow's clinical program, we use a brief intake screening tool that is completed over the phone. This tool screens for needs of the individual, couple, or family. A clinician then completes the initial assessment and uses this opportunity to build rapport with community members, as well as share information about the variety of services and programs offered at Rainbow and with our community partners. Through use of the intake screening tool and staff's welcoming approach to engaging with clients, we encourage individuals to access services that are beneficial to

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their immediate and longer term needs.

As stated previously, Rainbow has recently implemented new intake procedures which tracks the amount of time between initial contact and initial assessment.

VALUES:

Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Rainbow reflects MHSA values of wellness and resilience by providing community members with a safe, inclusive space to build community in a stigma-free environment. Staff are educated on utilizing inclusive and culturally competent language when interacting with the LGBTQ community members. The LGBTQ community often faces discrimination in various aspects of their lives. Providing a safe environment where community members can access services free from fear of this discrimination is integral to the mission of the Rainbow Community Center. Our Community Agreements are designed to ensure that the space is kept welcome to all, and is enforced by all staff and volunteers, and encouragement is given to everyone who enters the space to further enforce these agreements.

In our behavioral health program, we utilize strength-based and trauma informed approaches in all of our interactions with consumers. We believe that our mission to build community and promote well-being is accomplished through providing high quality services while being mindful of the whole person and ways that programming we offer throughout our 3 Tier Service Model may benefit everyone we serve. Through ongoing training and utilization of a team-based approach to the work we do, Rainbow staff provide a safe environment where our clients receive non-judgmental, supportive services that help them feel welcome and accepted.

Our Inclusive Schools Coalition work is focused on creating support networks for LGBTQ youth and providing cultural competency training to other Contra Costa organizations. Through this work, we aim to make behavioral health services for LGBTQ+ people more visible, more accessible, and more culturally competent by providing relevant information, collaboration, and opportunities for networking and connection between providers and consumers alike. For example, during our annual Welcoming Schools & Communities Summit/Rainbow High, we invite several different organizations to run resource tables during the event. As a result we are able to provide appropriate resources, facilitate face-to-face connections, and encourage future collaboration between community members and organizations.

School-based youth programming was implemented through QscOUTs, social-emotional development groups, which were facilitated at El Dorado Middle School, Mt. Diablo High School, Campolindo, Ygnacio Valley High School, Acalanes High School, and Los Lomas High School. The QscOUTs' curriculum provides a safe space for LGBTQ+ students on their campuses and assists youth with identity development, healthy relationships, and team building. In conjunction with QscOUTs, students were provided with one-on-one support from onsite Rainbow interns. This support included behavioral

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health assessments, short-term counseling and case management, and linkage and brokerage services. As a result, youth were able to receive help with short-term issues and be linked into higher levels of 94553care when needed.

VALUABLE PERSPECTIVES:

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

"Travis"

"Travis" is an African American, male identified transitional aged youth (25 years old) from Antioch where there are very few LGBTQ+ youth programs. Hoping to find a safe space, to feel less isolated, and become more comfortable with his sexual orientation, he actively searched for a support system and came across the Rainbow Community Center. "Travis" began to attend several youth groups such as Artistic Expressions, Movie Screenings and Queer Open Mic and quickly found Rainbow made him feel "safe in a welcoming, relaxing and respectful environment", falling "in love with the sense of community that attendees, staff and volunteers bring to" Rainbow. As "Travis" attended more youth programming, he sought support from one of our Youth Outreach Counselors, on how to navigate coming out to his family and close friends. Successfully, "Travis" was accepted with open arms and was given a celebratory coming out party. Through attending our youth groups and one-on-one mentoring with a Youth Outreach Counselor, "Travis" was able to work on social-emotional development, build self-esteem, and set goals. He is continuing with his college education, working, and regularly attends youth groups. This past June 2018, he bravely sang at one of our biggest youth program events, Youth Variety Show, and has shown interest on planning and facilitating a youth group. "Travis" feels that youth program is a critical part of our Center because of the genuine, caring, resourceful and very helpful team. He states, "Rainbow Community Center adds value to people's lives and brings them together as one."

"Martin"

"Martin" is a Caucasian identified, transitional aged youth (20 years old), comes from a Mormon family and has struggled with coming out. He was referred to the Rainbow Community Center counseling and youth program by his counselor at Diablo Valley College. "Martin" states that he found our Rainbow Youth Program to be "very warm, open, professional, friendly, accepting and uplifting environment", finding a sense of community, good friends, and resources. "Martin" also sought counseling at Rainbow which helped him work through negative thoughts and learn more about self-care. As a result, working both with Rainbow Clinical Program and meeting one-on-one a Youth Outreach Counselor, he was able to find a job and is currently being promoted to an Assistant Store Manager. Rainbow Youth and Clinical gave him the space and support to navigate safe social settings as well as gain self-confidence, where other youth and Rainbow staff understand his story. He was able to come out to his Mormon family as a drag queen, feeling more accepted.

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MHSA

PREVENTION REPORTING FORM **FISCAL YEAR 18-19**

Agency/Program Name: RYSE

PEI STRATEGIES:
Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

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SERVICES PROVIDED / ACTIVITIES:
Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

MHSA services provided by RYSE in the past reporting period continue to facilitate access and linkage to mental health care (through a trauma-informed, healing centered approach), improve timely access to mental health services for young people in West County strategies that non-stigmatizing, non-discriminatory, and which actively address stigma and discrimination that creates physical, mental, and emotional harm and burden for young people in West County. We are pleased to report achievement of and meaningful progress towards key activities:

Direct Service
RYSE engaged young people and community members onsite through drop-in and structured programs and events (on-site and/or online) and offsite through trainings and workshops in high schools, continuation schools, partner agency sites and within juvenile hall:

- 242 new members enrolled, for a total of 542 unduplicated members attending during the reporting period.
- RYSE programming continues to be youth-directed safe spaces that encourage both joy and the difficult work of stepping outside comfort zones. From role-playing games to examine emotions via collective storytelling, to vulnerable letter-writing to themselves and creating life maps, to participating in activities from Boal's Theatre of the Oppressed, to using balloons to learn about trauma responses and triggers—RYSE youth are always modeling for us what it means to be courageous community leaders who continue to learn and grow.
- 87 young people completed Education, Career, Let's Get Free or Case Management Plans. RYSE's Hire Up model has engaged 6 reentry clients to-date, with the following report shared by our Career Pathways Specialist that reflects RYSE's capacity to address young people's needs: *"Yesterday in Hire Up we worked on our career life maps understanding what things in our life have brought about the passions of what we want to do in our lives. It was a very open and vulnerable space members shared aspects of their lives that are truly entangled with deep pains but they have now translated those things to be driving forces to see change in their worlds. Every member wanted to do a type of work that aims towards serving their communities, bringing healing to those in need of it, and implementing justice in our society."*
- RYSE disseminated Spanish-language Sanamente (via Each Mind Matters) mental health awareness and access materials to young people and their families through front desk outreach at RYSE, as community members come into the space, as well as during outreach efforts at local schools and parks.
- Tasty Tuesday programming continued to be held weekly, providing healthy cooking and community-building workshops addressing food scarcity. We continue to receive donations from the food bank, however, must navigate the challenge of receiving an excess of sweet/unhealthy food items rather than nutritious options. Throughout the grant period, we continued to utilize the RYSE garden as a source of fresh healthy food, however in July 2019 the garden will be closed during the construction of RYSE Commons. We are actively seeking new partnerships for healthy and fresh food sources.
- On May 31, 2019, we held a community health resource fair titled, 'Rich in Health'. The event focused on promoting social services that were local and accessible for Spanish speaking families. We had 8 community providers attend with services ranging from mental health, access to primary care, sexual health and STI testing, financial literacy, environmental justice information, free dental screenings, legal consultation, and acupressure/massage therapy demonstrations. One of the purposes of the event was to connect community members with local organizations provide free or low-cost services. We had over 70 community members attend the event.
- The youth-produced RYSE Pride Video was developed to celebrate queer joy at RYSE (June 2019)
- The youth-produced Student Voices Video shared the impact of the arts on young people's wellbeing (March 2019)
- Young people developed original poetry and spoken word, performed at over 15 public and/or youth-led events.
- RYSE members produced the Youthtopia Mixtape, pieces were all components of the May 2019 Multimedia Production.
- 146 Member Liberation Impact Surveys were completed (May 2019)
- 84 Program Impact Surveys were completed in throughout Spring season 2019
- 29 Partner Impact surveys were completed (May 2019)

RYSE continues to receive referrals from the Probation Department and hospital-linked TRRS system following acute or lethal injury. RYSE has been working with youth to provide transitional support and reentry services for youth leaving juvenile hall and the Boy's Ranch and has successfully deepened our relationship with the Contra Costa Probation Department.

- 39 new members were referred through Probation or hospital linkages; case management was provided for all participants, building integration and access to RYSE's full model.
- Services provided this month include, but are not limited to: welcome home care packages; support with transportation to and from court; providing information to incarcerated clients family; clothing support; DMV appointments; transportation; grocery shopping; housing assistance; character letters; community service hours support; anger management programming.
- Individual clinical therapy ranged from 2-5 stabilizing counseling sessions, to continuous relationship and monitoring between the therapist and young person over the entire year. A Spanish-speaking therapist joined RYSE in January 2020, and she has since taken on a caseload of 11 young people who require Spanish for themselves or in communication with their parent/guardian. When we are unable to take a referral, we inquire with the referral site and young person about engaging at RYSE in other capacities until an opening is available.
- Hip Hop Heals, a collaborative educational experience for youth committed by Juvenile Court and staff at the Orion Allen Youth Rehabilitation Facility in Contra Costa County, was piloted over this grant period. The project promoted community, healing, social-emotional learning, creativity, intellectual curiosity, and confidence for young people and staff at the facility.

RYSE continues to raise visibility and promote action on gender justice and queer liberation in WCCUSD as integral to youth leadership and to creating safe space for young people of color. By staying committed to serving young people through all their varied experiences, self-discovery, and changing identity awareness and expression, RYSE served youth identifying as LGBTQ, and maintains an environment that prioritizes queer safety and leadership for all members.

- RYSE Alphabet Group programming utilized art for healing and queer expression.
- Let's Talk about Sex discussion space were held, centering queer and trans experiences and including a trauma informed framework makes accurate sexual health information more accessible and relatable.
- Two Let's Talk About Sex Interns were hired and participated in facilitation and sexual health trainings to develop skills in public health and sexual health education. Completion of this internship ended with a Let's Talk about Sex week of workshops led by peer-health interns, as well as with each receiving a Planned Parenthood endorsed Sexual Health Peer Educator Certification.
- All RYSE Staff were involved in a continued Sex Positivity Training to increase awareness and build collective best practices in supporting young people in navigating conversations around sexuality (including homophobia, transphobia, sexism).
- RYSE members and staff performed and participated in the following community events:
    - 2/4/19, Blacker Side of the Rainbow: Black Queer and Trans Identity dinner and discussion- RYSE Center
    - 3/22/19, Full Bloom Queer Youth Performance Event- Aja & Luris Fierro (member) facilitated cultural opening- Oakland, CA
    - 4/19/19, BlaqOUT Conference- UC Santa Cruz, Black Queer & Trans identity conference
    - 5/28/19, Queer Poetry Slam - Part of the 2019 National Queer Arts Festival- RYSE Center- The Queer Cultural Center (Bay Area) hosted its first Queer Poetry "Cash Prize" SLAM at RYSE. Community members, RYSE members, and RYSE Staff performed.
    - 6/21/19 Rhythms and Rainbows: Queer Pride Party- RYSE Center

- 6/2019: Workshop for AMP Gender/Sexuality and Queer & Trans visibility in music industry- RYSE Center

- In March 2019, RYSE members participated in Grassroots Womxn Rising, the first statewide convening bringing together girls and womxn for social change, self-care, and developing leadership skills, and also attended The California Endowment's Queer and Trans Youth Leadership Summit.

Systems Change

- **Kids First Richmond:** In December 2018 a Director was appointed for the Department & Fund. Since then RYSE has been in deep partnership, alongside the Invest in Youth Coalition and the Richmond Kids First Campaign Committee, ensuring that the vision & goals of the Kids First Initiative is enlivened within the implementation and launching of the Department the community and youth oversight board.

- **John Muir Resident Trainings:** RYSE continued our pilot with John Muir Medical Center, participating as a training site for their Family Residency Program. As part of their rotation, the medical residents come to RYSE to learn how to connect, refer, coordinate supports for patients to RYSE, and to gain a better understanding of the ways in which trauma and violence impact young people of color in our communities, and how they can best support and care for our communities in their roles as doctors.

- **Training and Sharing Praxis:** In May, RYSE presented for Resilient Napa - Resilience, Resistance, and Relationship, the 3 Rs of Systems Change. RYSE developed and provided a two-day training to East Bay Parks and Recreation Department staff about trauma informed and healing centered practices for adults working with youth. The training centered around understanding the correlation between climate and environmental justice work and communities most impacted by health inequities, understanding adolescent brain development and short-term/long term impacts of trauma, and learn strategies for coordinating supports for young people navigating trauma that can be applied to their roles. RYSE is participating in Contra Costa Health Services Strategic Planning Process, including supporting the design of stakeholder convenings. RYSE recently joined the Steering Committee of the California Children's Trust, and participating on the Equity, Accountability, and Outcomes Design Team. RYSE was selected to participate on the Statewide All Children Thrive Initiative, convened by Public Health Advocates. The aim of ACT-CA is to support and move cities to develop and implement child-centered, trauma-informed, healing-based policies, investments, and practice. The Sacramento My Brother's Keeper Initiative launched a Trauma and Healing Learning Series based on RYSE's Series. RYSE presented at the Launch session in May.
  - January 10, 2019 Healing-Centered Organizing for Youth Organize! California Partners
  - January 16, 2019 Contra Costa County Behavioral Health-Community Forum-Focused on Serving the Immigrant Community
  - January 17, 2019 Mental Health Services @ RYSE for Lifelong Medical Care (1 hour)
  - January 31, 2019 Non-Violent Communication and Restorative Practices
  - February 1, 2019 Gender Justice Training
  - February 13-14 Trauma, Healing, and Resilience Training for East Bay Regional Parks District

- **WCCUSD Trainings:** We scheduled a training with the WCCUSD Executive Board to take place in April 2019 to discuss the School-to-Prison Pipeline and the position played by the District in patterns of suspension, expulsion and push-out. The training was cancelled, however, and will be rescheduled for October 2019. RYSE continues to work to connect District administrators with renowned experts in areas of racial trauma and healing with Drs. Ken Hardy and Shawn Ginwright, adolescent brain

development with Dr Joyce Dorado, school to prison pipeline research and policy with Tia Martinez, JD. We plan to continue to hold launch of school-year trainings, are in school-specific conversations across the district about initiatives that support trauma-informed efforts, and continue to offer Listening to Heal as a pathway for building collective capacity to respond to trauma. RYSE is set to conduct new WCCUSD teacher training for the 19-20 school year. This will take place on August 12th and focuses on cultivating Healing-Centered Classrooms.

- **Positive School Climate Resolution:** RYSE continues to build community awareness and promote implementation of the WCCUSD Positive School Climate Resolution, committing to ensuring that positive behavior and restorative practices are embraced, modeled, and reinforced in the District. RYSE began participation in Georgetown's Center for Juvenile Justice Reform 2019 Reducing Racial and Ethnic Disparities working group, which includes the CC County District Attorney office, public defender's office, Office of Reentry and Justice, a school representative and a law enforcement representative, and Probation. During a workshop at Georgetown University the group developed two project ideas: 1) development or enhancement of alternatives to detention and 2) the development of a protocol among police, schools, and juvenile justice officials aimed at reducing arrests of students. Next steps are to hire researchers to evaluate and gather school data that District has about rates of expulsion, suspension and calls to police. This data will be used to make protocol recommendations.

- **Youthtopia: In the Face of Gentrification Multimedia Showcase:** In May 2019, RYSE members produced Youthtopia which premiered at East Bay Center for the Performing Arts and included an interactive audience mapping project of Richmond in the lobby as well as a talk back after each show. Youthtopia featured musical numbers, poetry, and interviews with HERE Action Research Project Interns about systematic workings of gentrification in Richmond and the broader Bay Area.

- **Restorative Justice Diversion Pilot:** In May 2019 RYSE launched a collaborative agreement with the District Attorney's Office to bring restorative justice diversion to Contra Costa County. This is the result of early conversations and coalition-building meetings held over the past 5+ years, as well as ongoing advocacy by young people about the harms of our current system. The program is post-arrest/pre-charge where the young person will be diverted instead of processed through the juvenile legal system. The program will be run by RYSE independent of any law enforcement or systems partner. Staff training in restorative circle-keeping will begin August 29th.

- **RYSE Commons:** RYSE has launched our capital campaign and begun construction to expand into RYSE Commons. RYSE has qualified for and has closed a New Market Tax Credits (NMTC) transaction through the Opportunity Fund, and has been approved for a $5.7 million Bridge Loan from the Raza Development Fund. As part of our sustainability plan, RYSE has acquired our current building as a free and clear asset. Our building and outdoor properties have a current market value of $1,350,000. We also recently acquired another property for the RYSE Commons campus free and clear valued at $465,000. This property will allow RYSE to develop a Health Home for young people of color as a key component of RYSE Commons. A Health Providers Roundtable, youth-participatory action research, and a business/sustainability plan process are each beginning this summer toward the development of this reimagined health system and linkages.

RYSE was also featured on and contributed to the following sites during this reporting period:

- RYSE released a co-authored SF Chronicle Op Ed about the need for more mental health resources in schools and cited radical inquiry research among students in Richmond schools.
- Following our YPAR publication in the Journal of Family Violence, YPAR Intern Leili Lyman authored an article for the Chronicle of Social Change - For Youth In My City, Marijuana is the Go-To Treatment for Trauma.
- Youth Today: https://youthtoday.org/2019/03/how-to-help-youth-activists-change-the-world/
- PACE Funders: YOUTH CIVIC ENGAGEMENT FOR HEALTH EQUITY & COMMUNITY SAFETY
- KQED: If Cities Could Dance
- East Bay Times: https://www.eastbaytimes.com/2019/05/14/contra-costa-explores-an-alternative-to-sending-kids-to-juvenile-hall/
- Opportunity Fund: https://www.opportunityfund.org/media/blog/opportunity-fund-finances-$11mm-expansion-of-youth-center-in-richmond/
- ACES Connection: Program Offers Young Men and Boys a Safe Space to Heal from ACES and Build Connections
- KPFA: Trauma and Healing in Communities
- The Alliance for Media Arts & Culture: Healing through the Arts: LoveTopia
- RYSE continues to engage in advocacy efforts and develop guidance materials and forums for communities to collectively reflect on the opportunities presented by Proposition 64 (2016 marijuana legalization) and to consider their local, regional and statewide application of funds. RYSE co-authored the following report, Recommendations Roadmap for Prop 64
- RYSE's model has been highlighted Fast Company's World Changing Ideas for RYSE Commons; and our Executive Director, Kimberly Aceves-Iñiguez and Associate Director, Kanwarpal Dhaliwal, were recipients of the Jefferson Award for Public Service.

OUTCOMES AND MEASURES OF SUCCESS:

Please provide quantitative and qualitative data regarding your services.

- ***List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

Health and Wellness

A. 70% of RYSE members report benefits of RYSE programs and services that support mental health and wellness. ACHIEVED.

- 93% report that RYSE has helped them pay more attention to their feelings and emotions
- 97% report that RYSE has helped them feel that it is okay and beneficial to be in programs that support mental health
- On a scale from 1-100, RYSE members selected an average rating of 77 that they feel loved at RYSE, and that however they come in, staff love them.

B. 70% of RYSE members report positive or increased sense of self-efficacy, positive peer relations, youth-adult relations, and agency in impacting change in the community. ACHIEVED

- 97% report positive relationships with RYSE staff
- 90% report positive peer relationships with peers at RYSE
- 92% report positive or increased sense of self-efficacy and agency

C. 70% of members demonstrate progress toward desired skills/goals related to their participation at RYSE (subset of members with a defined plan) ACHIEVED. Results of Spring 2019 Program LITs:

- Digital Storytelling: 100% agree or strongly agree that they learned something new in the workshops and will be able to use what they learned.
- College A-Z: 77% agree or strongly agree that they learned something new in the workshops and 74% will be able to use what they learned.
- Education & Career Case Management: 100% agree or strongly agree that their GPA improved and 100% agree or strongly agree that they reached one or more of their education or career related goals.
- Hire Up: 87%-100% agree or strongly agree that they feel more prepared and confident as job applicants along seven key measures.
- Young Men's Group: 90% agree or strongly agree that they have a better understanding of how social conditions of violence affect individual and community health.
- Transition & Reentry: 100% agree or strongly agree that RYSE supports have helped them know more about their rights and choices when navigating public systems.
- RYOT Leadership Skills Training: 87% - 100% agree or strongly agree that they feel more skilled and prepared as leaders across eight key measures.
- RYOT Political Education: 100% agree or strongly agree that they have a better understanding of issues affecting their local and global communities.

D. RYSE members who are identified as needing more intensive MH services will be linked to culturally competent MH services. ACHIEVED, ongoing.

- Among members engaging in RYSE Intervention/Diversion/Reentry and hospital-linked violence intervention, 100% reported an improved sense of emotional and mental health and destigmatization.
- During this time period, we've referred at least 1 person to receive support through Contra Costa Behavioral Health Services. This client was referred to therapy via the R2P2 program. RYSE supported her in therapy for one year. She was in need of more intensive therapy that included being able to be seen in the home several times/week and support with obtaining and maintaining medication for both Post-Traumatic Stress Disorder and Depression. She is also managing chronic pain due to a bullet in her back from having been shot, which is one of the reasons she was needing in-home supports. She continues to utilize those mental health services and is still connected to RYSE, receiving case management.

Some quotes from our Member LIT (May 2019) - "What makes RYSE Special"

- How accepting they are.
- Inclusive, variety of programs, space for everyone
- No other place like RYSE anywhere, it's like a second home, supports and accepts everyone.
- A safe place to learn, grow, and advocate for your community.
- All the programs it offers for the youth
- Everybody gets along even when they don't like each other they still find ways to work with each other, there's a lot of programs to participate in.

- Different people's happiness and backgrounds
- Good community
- I am accepted for who I am, as I am.

Trauma Response and Resiliency

E. 80% of the total number of stakeholders involved in TRRS series will report increased understanding and capacity to practice trauma-informed youth development. ACHIEVED.

- On a Yelp-like scale about RYSE as a partner, partners gave RYSE an average of 4.9 stars out of 5.
- 89% of surveyed partners agreed or strongly agreed that RYSE has supported them in new ways of thinking and doing their work.
- 94% agreed or strongly agreed that RYSE provided a sense of community.

F. At least 40 stakeholders demonstrate shared commitment to trauma-informed policy that promotes the optimal health and wellness of West Contra Costa youth and young adults.

- RYSE has hosted seven trainings for John Muir residents to-date, with initial evaluation results trending at "strongly agree" related to relevance and value.
- We are still planning a Gender Justice series, pushing timeline back to be mindful of planning for activation of RYSE Commons. In preparation for the space, it feels critical to engage in some of the trainings and praxis that RYSE already does to bring partners together in responding to young people.

Inclusive Schools

A. 70% of RYSE members who self-identify as LGBTQQ report positive sense of safety and belonging at RYSE and positive or increased sense of self-efficacy, positive peer relations, youth-adult relations, and agency in impacting change in the community

- 100% of RYSE members who self-identify as LGBTQQ report positive sense of belonging at RYSE
- 87% of RYSE members who self-identify as LGBTQQ report positive peer relationships at RYSE
- 100% of RYSE members who self-identify as LGBTQQ report positive relationships with staff at RYSE
- 86% of RYSE members who self-identify as LGBTQQ report improved sense of agency and self-efficacy
- 100% of RYSE members who self-identify as LGBTQQ report improved understanding of self and self in relationship to other people, cultures, sexual identities

B. 70% of RYSE members report an understanding and capacity to build community with races, cultures and sexual orientations and genders different from their own.

- 92% of RYSE members report a better understanding of people of different cultures
- 91% of RYSE members have a better understanding of LGBTQ identity
- 98% of RYSE members have a better understanding of how different groups in their schools or communities share common challenges

C. 75% of the total number of adult stakeholders involved in the Inclusive Schools Coalition and/or Trainings will report increased understanding of the priorities and needs of LGBTQQ youth and their peers.

- RYSE conducted trainings for Career Health Pathways staff at various WCC schools in preparation for leading summer student internships, as well as for incoming teachers at WCCUSD. The next training is scheduled for August 12, 2019.
- Audience feedback from Youthtopia: in the Face of Gentrification:
    - *"The cast touched subjects I'm not able to speak about a lot on a serious level."*

- *"It's always a learning experience hearing youth in each generation express their fears, concerns/ hopes. I work in the education sector teaching and seeing how students felt just reinforced the motivation I have to teach and care for our kids."*
- *"I'm inspired by the resilience and talent."*

DEMOGRAPHIC DATA: ☐ Not Applicable ***(Using County form)***

If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

- While the total number of youth served during this reporting period is 424, the Race section adds up to more because youth marked both more than one race and the races they identified. Similarly, the Gender Identity and Sexual Orientation sections add up to more because some youth selected multiple responses.
- Part 2 is blank because we collect info on race and ethnicity together and with some differentiated categories than MHSA.
- Part 5 is blank because RYSE does not ask about specific disability on the member application. We noticed that there is no place to document atmospheric trauma and distress our members experience.
- Regarding referrals out for question 9a. We do refer youth to outside services (clinical and non-clinical), however they often report negative or uncomfortable experiences with outside referrals. On occasion, members will inform us that they were unable to make an appointment.
- Regarding Part 7: Item 10 requesting the average duration of untreated mental health issues,

RYSE defines and addresses trauma and distress as historical, structural, and atmospheric, operationalized through racial oppression and dehumanization of young people of color (RYSE Listening Campaign,2013; Hardy, 2013; Leary, 2005; Van der Kolk, 2015). Therefore, RYSE's work is focused on addressing the conditions and systems that induce and perpetuate distress and atmospheric trauma, cultivating and supporting community building for collective healing and mobilization to address the harmful conditions and their generational impacts, and providing tailored supports and services necessary to provide safety, stabilization, and hope for individual young people and as a community.

We measure impacts related to RYSE's core strategies and prioritization of relationships as prevention and early intervention of mental health issues (reflected in our service workplan). We do not measure duration of untreated mental health issues, as it does not fully reflect, and is dismissive of, the context and magnitude of what young people are experiencing and embodying. It falls short of the rigor and dynamism we employ as a community

mental health and healing organization. That said, we work in persistent proximity with individual members to listen to, validate, and hold their lived experiences and articulations of distress, as well as those of resistance and resilience.

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

Please see previous reports sharing RYSE's Theory of Liberation and Radical Inquiry.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

RYSE centers the experience, priorities and needs of young people we work with, believing that they have the expertise to direct the services needed for their wellbeing. With this orientation, RYSE staff form relationships with systems-involved young people to learn about their short and long term goals, their personal relationships and advocates, their familiarity and comfort navigating systems, and learning how their past experiences have impacted the options available to them and existing barriers. When needs and interests have been identified either by a youth participant or by a staff member; the staff member will work to obtain consent from participants to make a referral. Values guiding our approach include:

1. Youth consent: knowing that participants have endured systems harm and non-consensual decisions profoundly affecting their lives, consent is required for referrals to services within and outside of RYSE.
2. Supported self-advocacy: young people are encouraged and supported to take the lead in connecting to services they need and identifying supports that are relevant for them.
3. Relationship-based: RYSE has done the work to build relationships with partner organizations and in and outside of institutions. In this way, we have a clear idea of what they offer that RYSE cannot offer in-house. If desired by participants, RYSE staff accompany youth to first meetings and/or bring partners into Bridge Meetings with probation for a "warm hand off".
4. Culturally-relevant: young people have shared a need for culturally appropriate and culturally-rooted services with strong youth development competency of providers, gender and sexuality affirming services and care, and active countering of implicit and explicit bias among providers.
5. Accessibility: limitations on travel, especially for youth on probation, are taken into account when referring services within our broadly dispersed and public transportation-limited county. While RYSE works to do all we can to provide and coordinate multi-dimensional supports for the dynamic health needs of young people, we experience firsthand the limitations of health systems in providing quality care for them and their families. For example, there is only one psychiatrist for children's mental health in all of Contra Costa County. RYSE is the only mental health provider that will see young people for clinical supports regardless of insurance status.

VALUABLE PERSPECTIVES:

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

In June, RYSE held RYSE Pride Month activities, which were shared in our July newsletter. The idea of a chosen family was a theme that young people chose to speak about. They reflected on the safe space and healing relationships that RYSE cultivates and the ways that RYSE sees them in all of their identities, the intersections of being Black and Queer in Richmond:

On the importance of chosen family:
"It doesn't matter what race you are, there are parents that will not accept you. There are people who will not like it and I think that's the main reason why they do Pride, because there's nowhere to turn and I feel like the only way is when you're around people that are in your shoes as well...My chosen family means a lot because most of the people I know are like me, they like girls. There might be a couple of them that's straight, but they still support me. They still support the other people that's in our [Queer] family and they mean a lot to me and that's very important to me."

On growing up in Richmond, CA
"In my experience, growing up it was very difficult to be myself, to show my true self to my family without them lookin' at me crazy or with my family feelin' like I'm not accepted to them and I have to fit their standards of what should be the perfect son and boy. In my family if you cry, you cry. But don't cry for unnecessary things. Growing up in a Black family or an area like Richmond, not many people were very accepting of the LGBTQ [community] or just being them self, but as I got older, I tend to notice most of my friends that were out and about like being LGBTQ. Everybody was cool with them. And I'm just like, a few minutes ago people didn't care and now people are cool with it. And it's a big change, and I'm happy about that I really am. Like I'm happy that people are really accepting people for who them are and love is love no matter what."

On the importance of chosen family:
"...For me, I have a household of five sisters. I'm the baby of the family so I never had a brother or like another male that was my age to hang out with on a constant basis. …having a chosen family especially for me, like Marques. Even though we're not blood related, he is my whole brother. I treat him like he's my whole brother; He's the brother that I never had that I always wanted...He's one of the few straight males that are Black that don't care...who I am as a person and who he is as a person he just don't pay close attention to every particular detail"

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PREVENTION & EARLY INTERVENTION
SEMI-ANNUAL REPORTING FORM

FISCAL YEAR: 2018-2019

Reporting Period: Please Select One
☐ Semi-Annual Report #1 (July – Dec)
☒ Semi-Annual Report #2 (Jan – June)

Agency:	**STAND! For Families Free of Violence**	**Project:**	9

SERVICE PLAN:

Briefly *summarize the Scope of Services as outlined in the Service Work Plan. What did you set out to accomplish?*

For the Fiscal Year 2018-2019 we plan to:

1. Deliver the "You Never Win with Violence" presentations to 500 middle and high school youth in Contra Costa County.
2. Deliver informational presentations to 100 school personnel, service providers and parents on the effects and causes of teen dating violence, including bullying and sexual harassment to increase knowledge and awareness of healthy relationships.
3. Provide secondary prevention activities to 200 youth experiencing, or at risk for teen dating violence.
4. Conduct sixteen (16) gender-based support groups that are fifteen (15) weeks long.

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SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include procedures re: referrals and follow up. Attach case vignettes and any material that documents your work as you see fit.

1. You Never Win with Violence: 1,730 participants served in 70 presentations. **Goal exceeded.**
2. Expect Respect and Promoting Gender Respect Support Groups: 252 participants and 24 groups served. **Goal exceeded.**
3. Twenty-four (24) gender-based support groups that are 10 weeks long each. Goal **Partially achieved.**
4. Adult Allies: 35 teachers and other school personnel trained. Goal **Partially achieved.** (See attached evaluation report)

OUTCOMES, MEASURES OF SUCCESS, DEMOGRAPHIC DATA:

Please provide quantitative data re: your services.

- *For report #1 (half-year report, Jan 15): numbers served year-to-date.*
- *For report # 2 (year-end report, July 15) please include*
  - *a) **year-to-date** demographic information for clients served (see demographic form).*
  - *b) Report on measures of success indicators as defined in Service Work Plan (see separate form)*
  - *c) Narrative of Outcomes*
  - *d) (See evaluation attachment A through H)*

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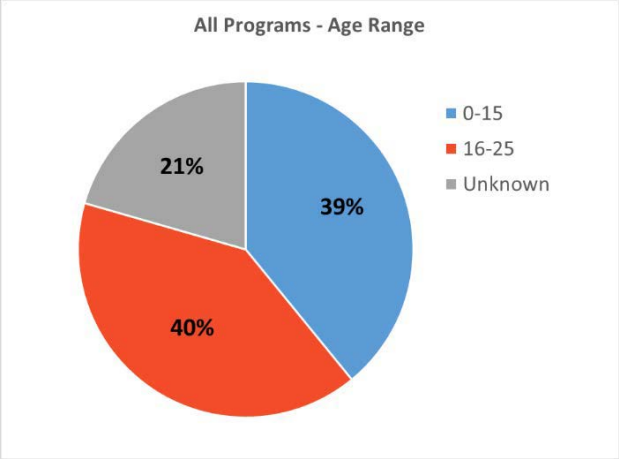
All STAND! Prevention Programs:

Total Clients Served:

We have served a total of **1,903** clients through all our Prevention programs throughout the Fiscal Year.

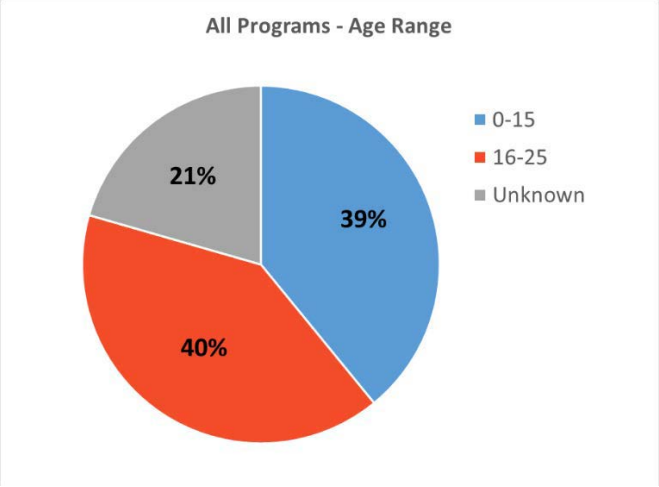
Gender:

Male Identified: 913 clients; Female Identified: 924 clients; Transgender: 9 clients; Unknown/Unreported: 57 clients.



Age:

0-15: 744 participants; 16 – 25: 768 participants; Unknown/Unreported: 391 participants



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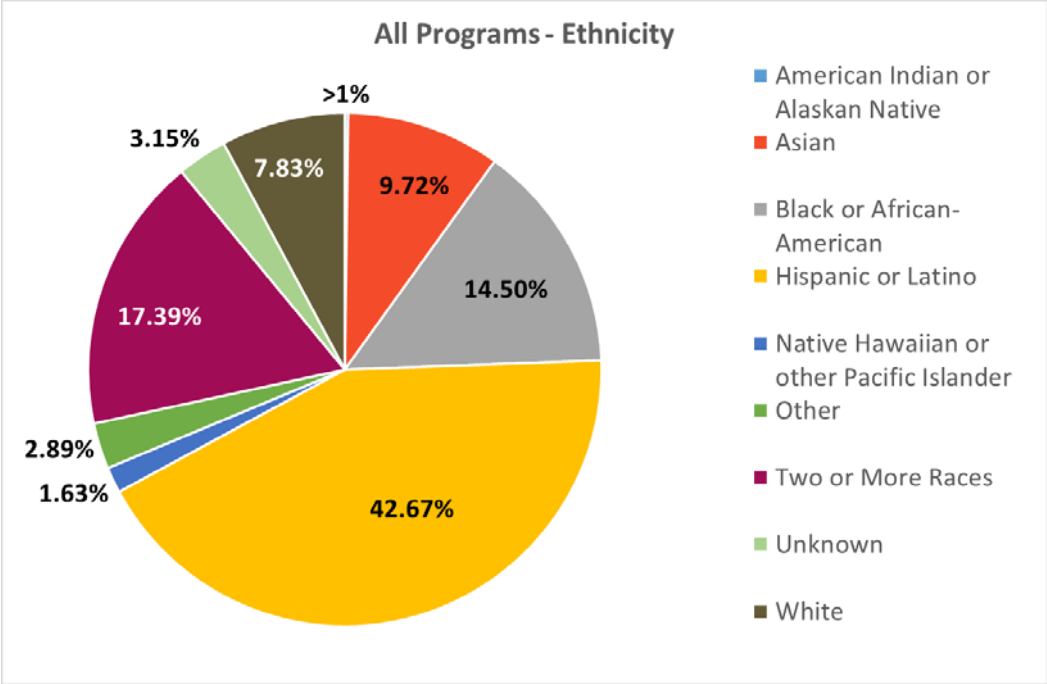
Ethnicity:

African American/Black: 276 participants; American Indian/Alaska Native: 4 participants; Asian: 185 participants; Native Hawaiian/Pacific Islander: 31 participants; Caucasian/White: 149 participants; Hispanic/Latino: 812 participants; Other: 55 participants; Multi-racial: 331 participants; Unknown/Unreported: 60 participants



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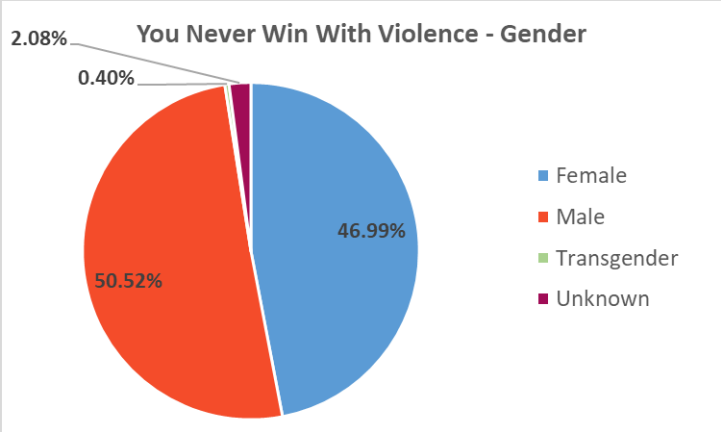
"You Never Win with Violence" and You Never Win with Sexual harassment combined Presentations:

Total Youth Served

We have served a total of **1,730** youth through our YNWWV presentations this Fiscal Year.

Gender

Male Identified: 874 participants; Female Identified: 813 participants; Transgender: 7 participants; Unknown/Unreported: 36 participants



Ages

0-15: 713 participants; 16-25: 644 participants; Unknown/Unreported: 373 participants

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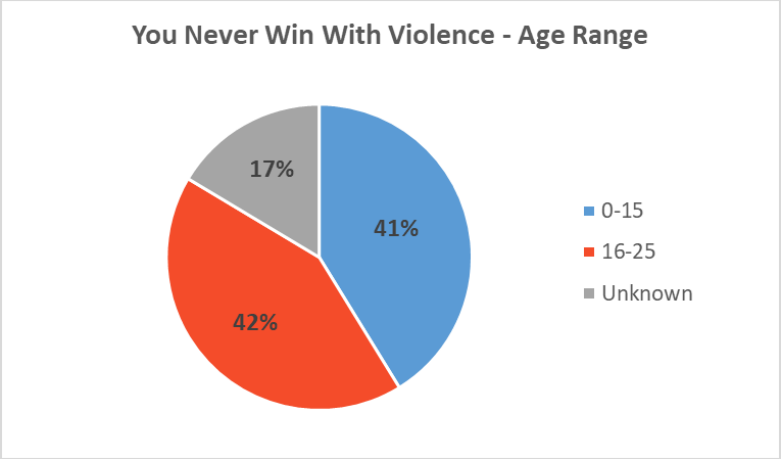

Race/Ethnicity

African American/Black: 246 participants; American Indian/Alaska Native: 4 participants; Asian: 174 participants; Native Hawaiian/Pacific Islander: 27 participants; Caucasian/White: 140 participants; Hispanic/Latino: 772 participants; Other: 53 participants; Multi-racial: 290 participants; Unknown/Unreported: 24 participants

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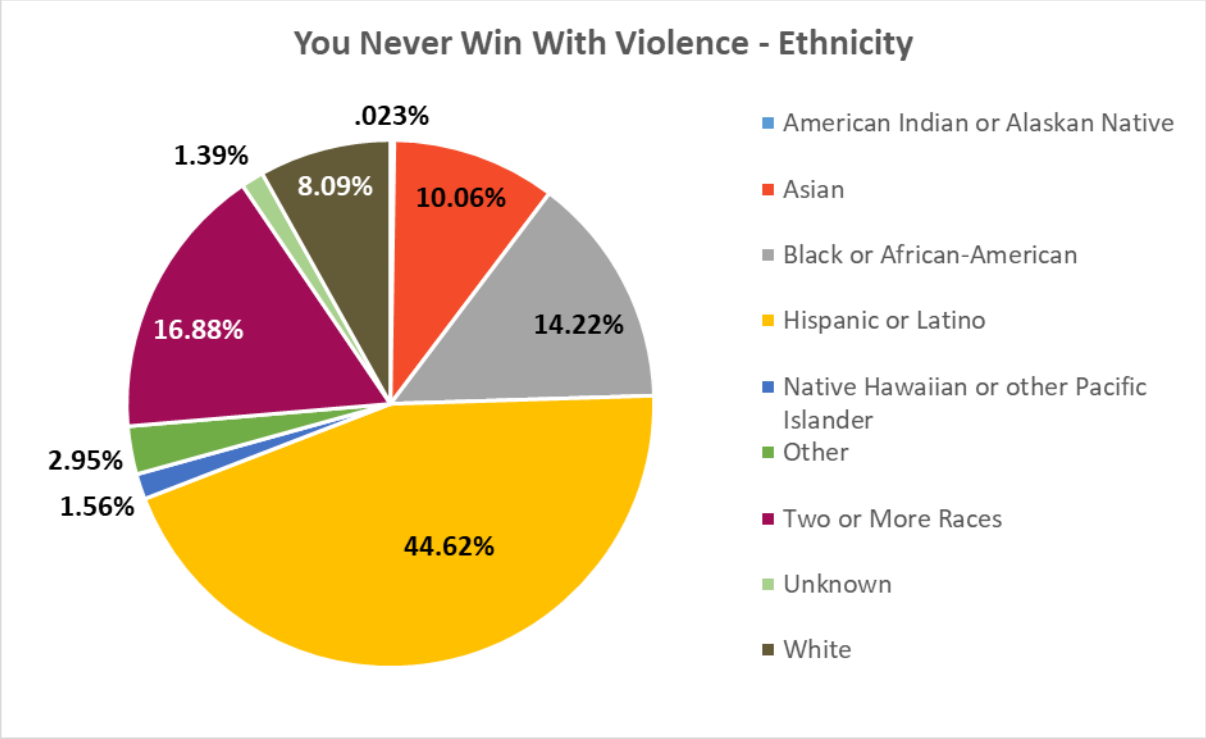

Summary

This year, we served **1,730** students, surpassing our goal of 500 students and resulting in total compliance with this goal. We provided 70 in class workshops throughout West and East Contra Costa County. Our team provided 38 workshops in West County, and 32 workshops in East County. This included reaching most of the Antioch High's Freshman class for the second year in a row. We provided most of our workshops in East County at Pittsburg High. Since Pittsburg High, unlike our West County partners, does not have a health center, we relied entirely on staff contacts and cooperation to schedule workshop presentations. A select number of staff at Pittsburg High have become great resources and on campus support for our team – letting us provide workshops in their classes, providing referrals and even providing us classroom space to conduct our support groups. Throughout the County, our team was able to provide these services with limited staffing and despite significant delays in the contract process with WCCUSD.

The YNWWV workshops continue to be the most successful source of sign-ups for support groups as well as an entry point to a cluster of services offered at STAND! and at each respective school. By

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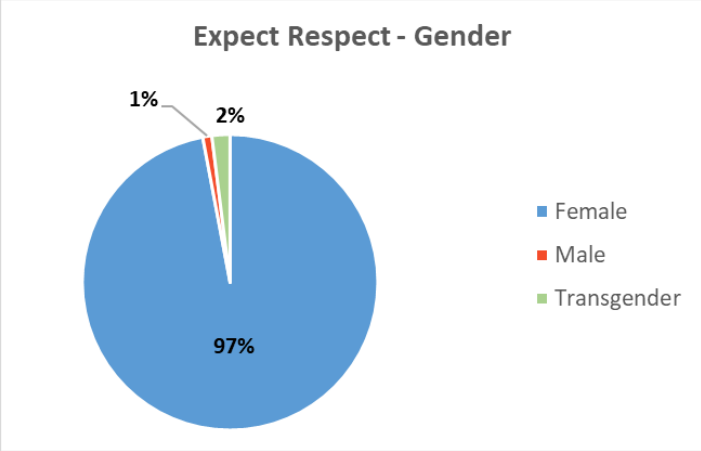
highlighting support groups, crisis line access, and other on-campus services we discretely and safely promoted supportive services. Workshops were also the entry point to accessing intervention services as we had multiple instances where youth asked for advice or reported sexual abuse, sexual harassment, teen dating violence, or domestic violence following a workshop. This year, after a workshop presentation, our prevention staff were approached by a student who thought they might be in an abusive relationship. Our staff were able to meet with her individually in the health center to provide emotional support, safety planning and ultimately assist them to safely leave this unhealthy relationship. Through this interaction and the subsequent follow ups, this youth also enrolled in one of our semester long support groups where they were able to receive continual services, peer support and continue in their journey towards healing.

Expect Respect Total Youth Served

We have served a total of **101** youth through **13** Expect Respect support groups this Fiscal Year.

Gender

Female Identified: 98 participants; Male Identified: 1 participant; Transgender: 2 participants; Unknown/Unreported: 0 participants



Ages

0-15: 29 participants

Unknown/Unreported: 43 participants

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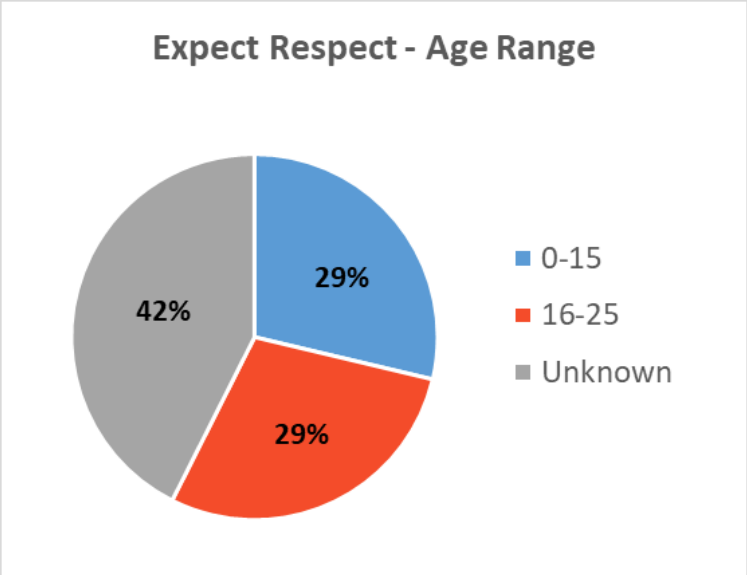

Race/Ethnicity

African American/Black: 22 participants; American Indian/Alaska Native: 0 participants; Asian: 6 participants: Native Hawaiian/Pacific Islander: 3 participants; Caucasian/White: 9 participants; Hispanic/Latino: 30 participants; Other: 0 participants; Multiracial: 31 participants; Unknown/Not reported: 0 participants

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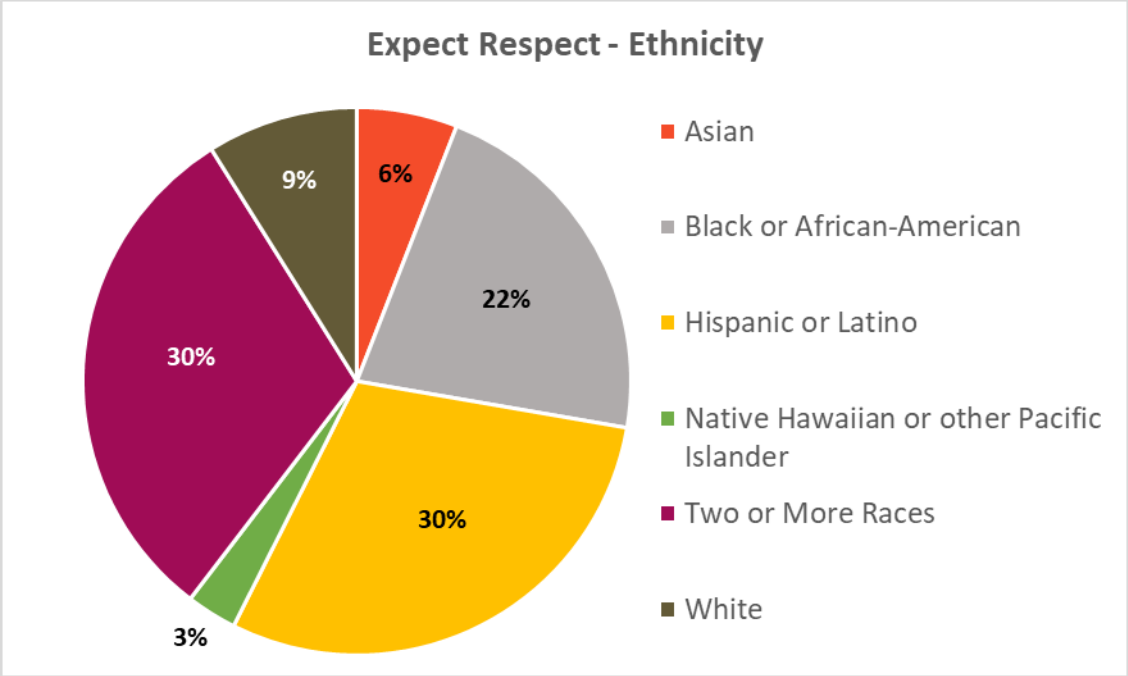

Summary

Our Expect Respect groups served **101** participants in **13** different support groups during this Fiscal Year. When combined with our Promoting Gender Respect Support groups (**151** participants and **11** support groups), which are geared towards male identifying youth, we surpassed our goal of providing 200 gender-based participants, with a total of **252** group participants and **24** support groups. When focusing solely on Expect Respect, we did provide services to less participants than in previous year primarily because there was a staff vacancy with only one remaining facilitator to serve our female-identifying youth. This staff member is also responsible for co-delivering workshops among other direct service efforts. The combination of WCCUSD contract delays and lack of infrastructure in many east county schools (lacking health centers or no full-service community schools) were also factors that reduced our participant numbers this year.

Despite these challenges, we continued to find that smaller support groups are far more effective than previous years' larger groups, thus creating a more intimate forum for youth to learn and share. Smaller groups (10 participants or less) allowed for more natural rapport building and trust.

This year we also found that STAND!'s consistent presence on campuses throughout the County has helped improve external and peer referrals to our programs more than in previous years. In West County Schools, we have been receiving increasing numbers of referrals to our programs than in

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previous years. At De Anza High for example, we had an equal number of students sign up for support groups during our workshop presentations as we had referrals through the health center. These referrals help us provide services to students who might not reach us during our classroom presentations, and signal that health center and school staff have an increased understanding of the services and support that STAND! provides.

Additionally, more and more students on campus recognize our staff and services and are either self-referring to our group or recommending their friends to our services. In one instance, a student who had seen our workshop presentation two semesters previously was in an unhealthy relationship and in need of support. They were able to access their health center and ask to speak with somebody from STAND! That student was then enrolled in a Expect Respect support group where they were a highly active participant and was provided one on one counseling for emotional support, safety planning, and other supportive services. Ultimately, they successfully and safely left their unhealthy relationship.

We are particularly proud of these developments, however subtle, because they signify the continual integration of our agency and our services into school and student culture. We hope that our continued presence and increased recognition on campuses throughout the County will assist us in reaching more and more students who might otherwise be overlooked if left to the traditional pathways to service.

Expect Respect PRE/POST Survey Results

In total, 87 Expect Respect students completed their PRE and POST surveys this Fiscal Year.

Students were surveyed on their general knowledge of the forms and dynamics of abusive relationships. Of the 87 students who completed both surveys **86%** showed improvement or mastery of the subject.

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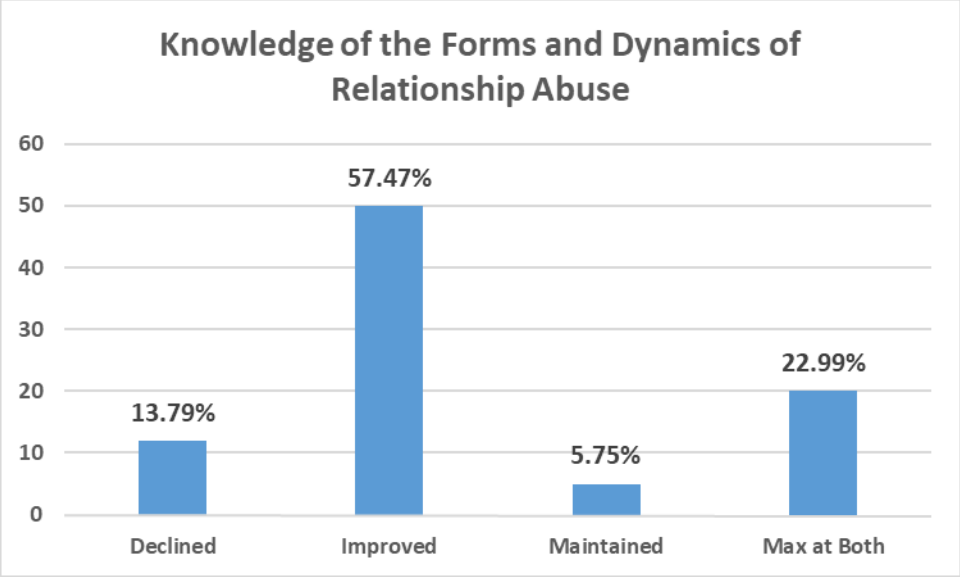
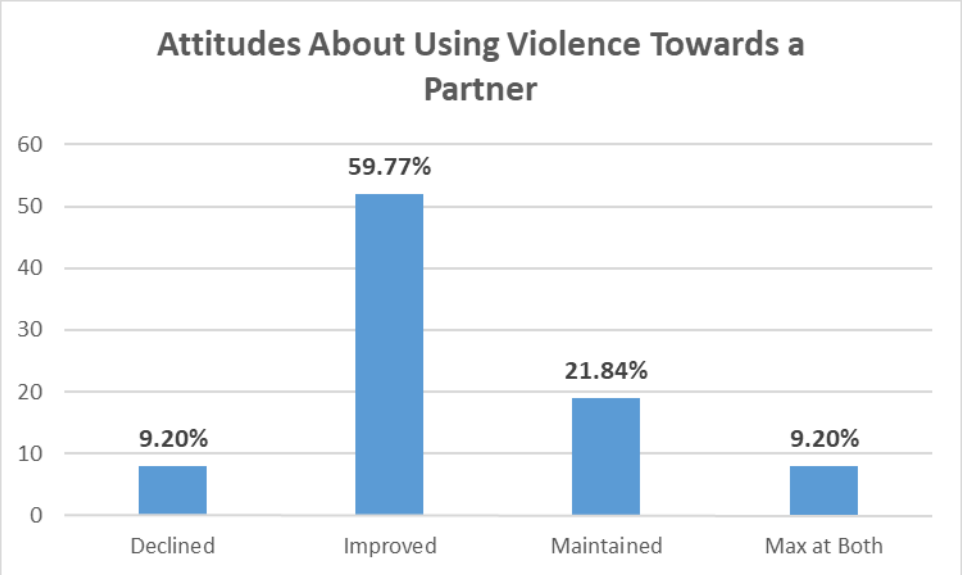


Students were also surveyed on their attitudes about using violence or abuse towards a dating partner. Of the 87 students who completed both surveys **91%** showed improvement or mastery of the subject.



Promoting Gender Respect:

Total Youth Served:

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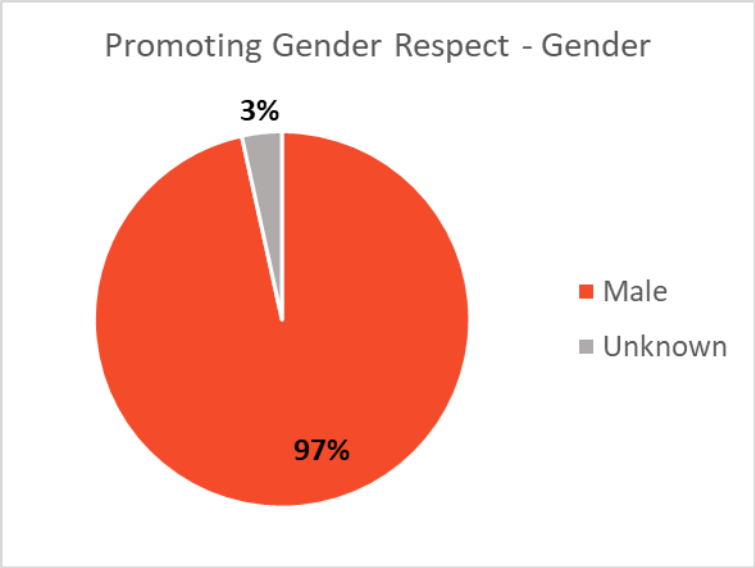
We have served **151** students through **11** Promoting Gender Respect groups this Fiscal Year. **

Gender:

Male Identified: 150 participants; Female Identified: 0 participants; Transgender: 0 participants; Unknown/Unreported: 1 participant.



Age:

0 -15: 2 participants; 16 – 25: 1 participant; Unknown/Unreported: 148 participants.

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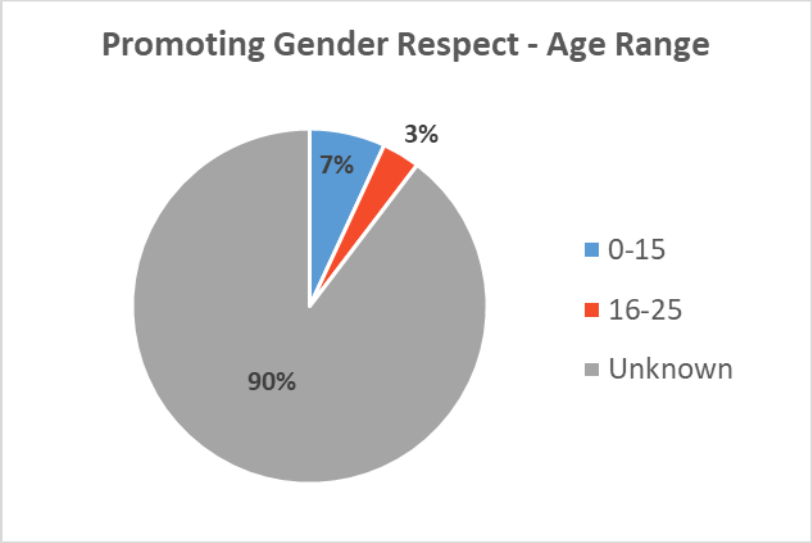
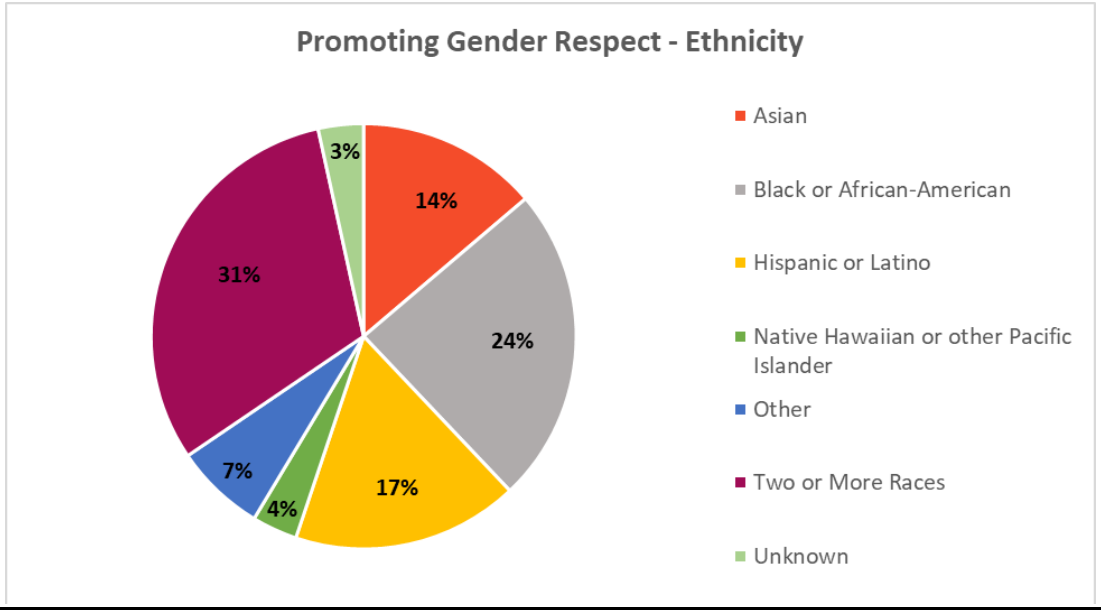


Race/Ethnicity:

African American/Black: 37 participants; American Indian/Alaska Native: 0 participants; Asian: 21 participants: Native Hawaiian/Pacific Islander: 6 participants; Caucasian/White: 0 participants; Hispanic/Latino: 25.5 participants; Other: 10.5 participants; Multiracial: 46.5 participants; Unknown/Not reported: 4.5 participant



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Promoting Gender Respect PRE/POST Survey

Promoting Gender Respect PRE/POST		
Adults at my school teach students how to respect each other	**14.63%**	Improved
Bullying behaviors like name calling, physical fighting, etc. can lead to teen dating violence.	**27.50%**	Improved
Girls always have the right to say no to any sexual activity.	**-1.79%**	Decline
I believe I can prevent teen dating violence.	**5.26%**	Improved
I feel fine telling a boy that it's not ok to hurt girls.	**19.05%**	Improved
If I heard a boy call his girlfriend a name, I would tell him it isn't cool to do that.	**0.00%**	No Change
If I saw a girl hit a boy abusively, I would tell an adult.	**6.98%**	Improved
If I saw a girl yelling at a boy or calling him names, I would try to help him.	**2.00%**	Improved
If I see a boy being bullied by a girl, I would try to stop her.	**15.63%**	Improved
If I see a girl being bullied by a boy, I would try to stop him.	**1.89%**	Improved
I know where I can find help/info on teen dating violence and /or sexual assault.	**25.53%**	Improved
I learned about healthy relationships in middle of school.	**22.86%**	Improved
I would speak out if I knew someone was in an unhealthy relationship.	**13.33%**	Improved
This program will make me a better leader.	**10.20%**	Improved

Summary

In total, **151** students participated in PGR groups. This total combined with the ER total of **101** group participants, provided gender-based support group services to **252** participants. However only **29** PGR in **3** groups students completed their PRE and POST surveys this Fiscal Year. **

These students were surveyed on their attitudes towards relationship abuse, gender norms, campus culture and more. We are most proud to see significant improvement in student's knowledge of where to seek supportive services, with **25%** of those surveyed showing improvement. Additionally, we can see improvement in bystander intervention with **19%** of students stating that they would "tell a boy that it's not ok to hurt girls". Overall, we saw improvements in all but one category.

****(Please note that all 252 participants completed the pre/post survey and were entered in the database; however due to technical difficulties with our database, not all participant survey data is available. We note that we captured our YTD and PGR numbers by manually counting our sign-in rosters for group.*

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Adult Presentations:

Total Clients Served:

We provided trainings to **35** adults through a total of 17 presentations during the fiscal year. This resulted in partial compliance of 35%.

Gender

Male Identified: 8 participants; Female Identified: 7 participants; Unknown/Unreported: 20 participants.

Ages

0-15: 0 participants; 16-25: 0 participants; 26-59: 16 participants; 60+: 4 participants; Unknown/Unreported: 15 participants

Race/Ethnicity

African American/Black: 4 participants; American Indian/Alaska Native: 0 participants; Asian: 0 participants; Caucasian/White:8 participants; Hispanic/Latino: 4 participants; Native Hawaiian/Pacific Islander: 0 participants; Other: 2 participants; Multi-racial: 2 participants; Unknown/Unreported: 15 participants

We served a total of **35** adults through a total of **17** trainings and presentations throughout the fiscal year. 15 of those adults were served through our You Never Win with Violence Presentations. During each presentation, the teacher was present in their classroom and was able to participate, contribute and learn about teen dating violence. In many cases, those teachers have become valuable resources on campus – allowing us to use their classroom for group space and referring students to our groups.

Adults were also reached through trainings run at Pittsburg High aimed to teach school staff about trauma informed practices within school environments.

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Additionally, staff trainings were offered on various occasions to health center and school staff but did not take place due to lack of staff interest and/or lack of time for presentations. Our pre/post surveys were not completed by school staff during these trainings and presentations.

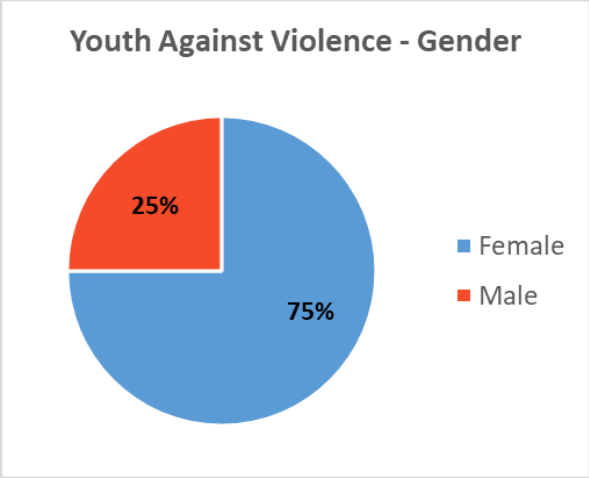
Youth Leadership:

Total Youth Served:

We trained 8 new Youth Against Violence Leaders during the Fiscal Year.

Gender

Male Identified: 2 participants; Female Identified: 6 participants



Ages

0-15: 0 participants; **16-25**: 5 participants; Unknown/Unreported: 3 participants

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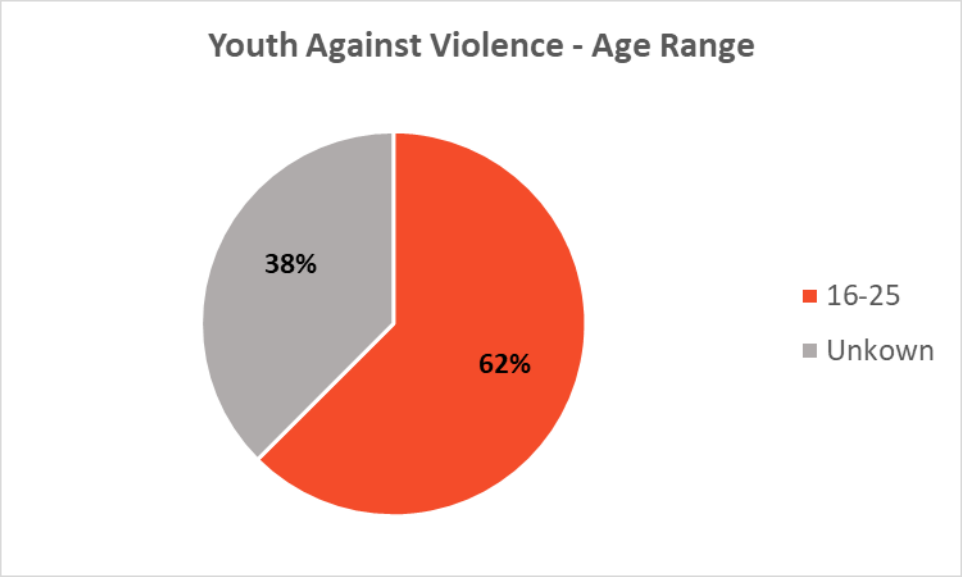
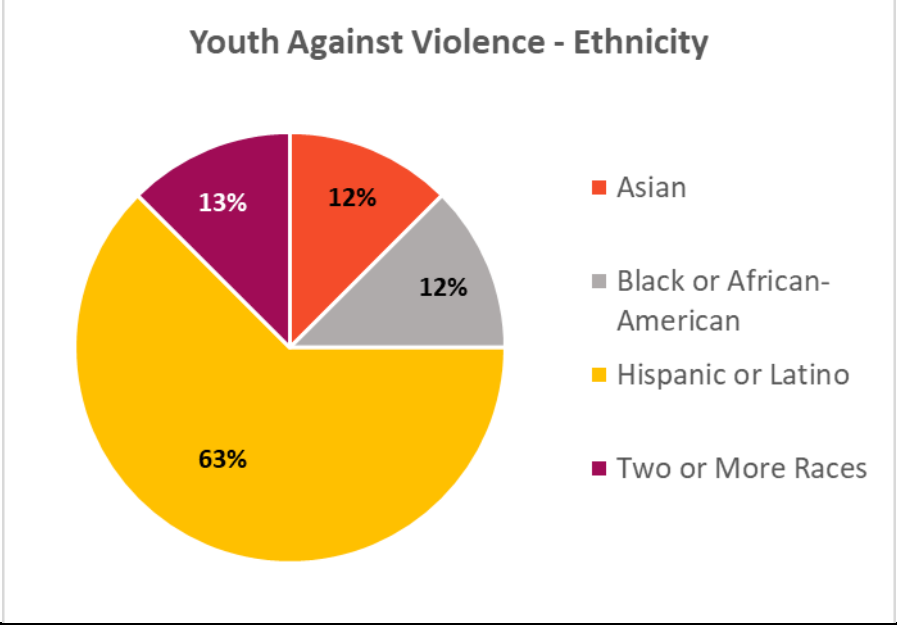


Race/Ethnicity

African American/Black: 1 participant; American Indian/Alaska Native: 0 participants; Asian: 1 participant; Caucasian/White: 0 participants; Hispanic/Latino: 5 participants; Native Hawaiian/Pacific Islander: 0 participants; Other: 0 participants; Multiracial: 1 participant; Unknown/Unreported: 0 participants



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Summary:

During the summer of 2018, eight new YAV members were trained in varying levels of leadership (peer presenter trainees, peer facilitator trainees, and community mobilizers.) This summer we had two male and six female youth join our youth leadership training program. All eight participated in our in-class support groups. Youth leaders received training on peer support, community organizing, and awareness campaigning. Our youth leaders were able to visit other domestic violence and advocacy organizations throughout Northern California. These included La Casa de Las Madres and the Women's Building in San Francisco, and CALCASA and the California Partnership to End Domestic Violence in Sacramento. Additionally, the youth leaders visited the Contra Costa animal shelter to highlight the intersections of animal abuse and domestic violence. This led to a social media pet adoption campaign. Throughout the school year, we retained two previous youth leaders who joined our eight new leaders in their year-long work. Five of our previous youth leaders graduated high school the previous spring and are currently attending college.

During Teen Dating Violence Awareness Month (TDVAM) in February, our YAV leaders conducted an awareness campaign titled "Happiness over Relationship History. Our youth leaders created personalized wristbands to give away at school on two specific days – February 12th which is nationally recognized as "Orange Day" for teen dating violence awareness and February 14th for Valentine's Day. On both days, our youth leaders not only gave away over 1400 wristbands and accompanying information cards to their peers, but also got them to write down their own definitions of a healthy relationship. In addition, they created "healthy relationship" valentines goodie bags to give away. (See attached pictures). On each campus, our youth leaders reached out to health center staff, teachers, peers, on campus police officers, morning announcements, clubs and more to spread awareness of their campaign and their message. Following up on their on campus outreach, our youth leaders created a short video (please see link to view) to summarize their campaign and continue sharing their message of "Happiness over Relationship History".

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We were also able to bring this campaign to Pittsburg and Antioch High, two schools where we do not have active youth leaders. There, in addition to our youth led campaign, we were able to bring Teen Dating Violence trivia to youth during lunch time outreach activities.

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FUTURE PLANNING / ADJUSTMENTS:

Reflections on your work: How does it measure up to your goals and the needs of the community? Are you planning any revisions? Lessons learned.

You Never Win with Violence-

We have exceeded our goal of reaching 500 youth. We reached 1730 youth during this Fiscal Year. The presentations were a crucial opportunity for youth to opt into supportive services. Additionally, these workshops afforded us an opportunity to provide secondary follow up services on site. Such was the case for Antioch High. We plan to continue to offer workshops as an entry point to support groups and other comprehensive services.

Expect Respect

We were able to conduct four groups at Pittsburg High School and have re-engaged our Middle School partners in WCCUSD. By working with East County high schools and with WCCUSD middle schools we have expanded our reach to youth that otherwise might not be acknowledged. Smaller groups (10 or less participants) also proved to be much more manageable. In order to travel to various parts of the county and provide support groups, we will have to reduce the overall goal for the number of participants in anticipation of the effort involved in coordinating services at under-resourced schools.

Gender -based Support Groups-

Promoting Gender Respect (PGR) support groups compliment the Expect Respect support groups, making the total count of 252 participants and 24 groups receiving secondary supportive services. PGR targets boys, whereas the Expect respect targets girls. However, participants of any gender can attend both or either group. We will continue to offer these groups, which are effective in discouraging teen dating violence and sexual harassment.

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Adult Presentations-

We did not meet our goal of adult allies trained this year. We trained 35 school personnel. Our school partner's limited availability for hour-long presentations is a challenge for this goal. However, we did a substantial amount of outreach and individual support to adult allies. Outreach and informal information sharing have long been a successful way to provide adults with tools to help youth at-risk or experiencing Teen Dating Violence. Perhaps these efforts as opposed to formal trainings ought to be our measure of success in the upcoming year.

Youth Leadership-

We trained 8 new youth who volunteered during the school year. These new leaders and our five recurring leaders provided critical youth representation in our programs. This cohort spearheaded our Teen Dating Violence awareness campaign and they met bimonthly to execute their year of volunteerism. Their energy and innovative ideas enhanced the outreach and presentations, giving our activities a youthful presence and credibility with the students.

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PEI ANNUAL REPORTING FORM

PREVENTION REPORTING FORM **FISCAL YEAR: 2018-2019**

Agency/Program Name: Vicente Martinez High School

Reporting Period (Select One): ☐Semi-Annual Report #1 (July – Dec)
X Semi-Annual Report #2 (Jan – June)

PEI STRATEGIES:

Please check all strategies that your program employs:

X Provide access and linkage to mental health care

X Improve timely access to mental health services for underserved populations

X Use strategies that are non-stigmatizing and non-discriminatory

---

SERVICES PROVIDED / ACTIVITIES:

Please describe the services you provided in the past reporting period. Please include types of problems/needs addressed, any activities that address these problems/needs, and any functional outcomes targeted by the services provided.

The PEI program at Vicente Martinez High School and Briones School is an integrated mental health focused learning experience for 10th-12th grade at-risk students of all cultural backgrounds. The program is facilitated by MUSD and in partnership with NLC within a unique partnership between Martinez Unified School District (MUSD) and the a 503c3, New Leaf Collaborative (NLC) to assist Contra Costa Mental Health in implementing the Mental Health Services Act (MHSA) Prevention and Early Intervention Program. Together we provide 10th-12th grade at-risk students a variety of experiential and leadership opportunities that support social, emotional and behavioral health, career exposure and academic growth while also encouraging, linking and increasing student access to direct mental health services.

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Key services include student activities that support:

1. Individualized learning plans
2. Mindfulness and stress management interventions
3. Team and community building
4. Character, leadership and asset development
5. Place-based learning, service projects that promote hands-on learning, ecological literacy and intergenerational relationships
6. Career-focused preparation and internships
7. Direct mental health counseling

Services support achievement of a high school diploma, transferable career skills, college readiness, post-secondary training and enrollment, democratic participation, social and emotional literacy and mental/behavioral health. PEI services are provided by credentialed teachers and an administrator, qualified office staff, marriage family therapists, a Pupil Personal Services credentialed academic counselor, an internship coordinator, peer mentor, environmental educator and other independently contracted service providers. All students also have access to licensed Mental Health Counselors for individual and group counseling.

All students enrolled in Vicente and Briones have access to the variety of PEI intervention services through in-school choices that meet their individual learning goals. Students sometimes switch between Vicente and Briones schools at different points in the school year. Mental health and social emotional activities and services are offered to all students at both schools and are deeply integrated into the Vicente school day. Data is collected for all students who participate in these programs no matter which school they attend, but demographics and statistics are based upon Vicente total enrollment.

This year the PEI program continued providing students experiential opportunities that fostered a strong sense of positive, personal identity, leadership skills and intergenerational connection to the community and place that they live. These opportunities provided students an alternative to a traditional high school education while they continue to make progress toward earning the necessary credits for an accredited high school diploma. Experiences that enriched the curricula are presented below in the following categories:

- Service Learning
- Team-based Projects
- Career-Focused Internships
- Mental Health Focus
- Leadership Development
- Academic Skills Development
- College and Careers
- Outdoor Appreciation and Field Trips
- Teacher Professional Development
- Outreach

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Service Learning:
Students continue to be involved in short-term, one-day service learning opportunities and team-based, hands-on, service-learning projects that benefit the local community and environment.

Career-Focused Internships:
The internship program continues to be an increasingly important and valuable tool in our efforts to prepare students for rewarding and successful futures as individuals, citizens and community members. To ensure the success of the internships and the growth of the interns, interns learn, present and are evaluated through a series of tiered experiences designed to prepare them for future college and career opportunities. The internship coordinator continues to organize the internships in partnership with community professionals. Academic support is provided by the Vicente teaching staff.

Mental Health Focus:
Students continue to participate in holistic health activities and seminars that support their emotional, social and academic health.

Leadership Development:
Students continue to participate in leadership programs and mentorships that support students needing increased academic or emotional skill development.

Academic Skills Development:
Students continue to receive academic instruction and support from teachers/contracted service providers through integrated, project-based curriculum, specific academic skills instruction and individualized, differentiated instruction.

College and Careers:
Students continue to be exposed to a variety of careers and colleges through guest speakers, introduction to internship seminars and field trips in order to help them prepare for a successful transition into independent adulthood.

Outdoor Appreciation Activities and Field Trips:
Students continue to be exposed to nature and being outdoors in ways that promote a healthy connection to the natural world and encourage students to utilize natural resources to promote environmental and community health. Nature and gardening are also used as a stress management tool and healing agent.

Teacher Professional Development:
Teachers continue to attend professional development opportunities to increase knowledge about supporting at-risk students.

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Outreach:
Vicente Martinez High School continues to advertise the program and to inform the public about the educational opportunities that the school offers for at-risk students and to dispel misconceptions about the school and the population who attend the school. This year Vicente had a waiting list of students wanting to attend due to the focus that is placed on mental and social emotional wellness.

Vicente/Briones staff and outside service providers have worked cooperatively to continue to create opportunities for all students to develop academically, socially, emotionally and mentally through participation in hands-on, place-based learning and experiential projects. Currently, all Vicente teachers and staff are actively engaged in supporting and implementing PEI program services.

In addition, New Leaf Collaborative (NLC) provided two employees working at Vicente/Briones to support the expanding PEI program. They have worked closely with the principal, teachers, counselors and coordinating partners to best fuse the program offerings together.

During the 2018-19 school year a Memorandum of Understanding (MOU) was signed into agreement between MUSD and NLC for PEI services. In short, the two organizations:

1) Continue to provide a variety of services to all students;
2) Continue to encourage a collaborative culture between New Leaf Collaborative staff and Vicente staff;
3) Continue to develop NLC's 501c3 structure to support the implementation of the PEI program and to provide the protocols and agreements necessary to support the differentiation of PEI responsibilities between NLC and MUSD.

Overall Summary of Services:
Throughout the 2018-19 school year the Vicente/Briones staff and New Leaf Collaborative staff organized and hosted over 70 different types of activities and events. Experiences that were found to enrich the curricula are presented below in the following categories: Service Learning, Career-Focused Internships, Mental Health Focus, College and Careers, Career Pathways, Outdoor Appreciation, Academic Support, Student Leadership Development, Teacher Professional Development and Outreach.

Of the 125 students who were enrolled at Vicente over the course of the school year, 97% of the student body or 121 students participated in PEI activities. Students participated in an average of seven different services per individual over the course of the year.

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Service Learning:
One of our PEI fundamental values is Service. To that end, staff place great emphasis upon student participation in service learning opportunities. Vicente and Briones require seniors to volunteer for at least 15 hours their final year and many participate in more than that. Students were involved in short-term, one-day service learning opportunities and team-based, hands-on, service-learning projects that benefited the local community and environment. These activities were organized primarily by the New Leaf Collaborative Internship Coordinator and our Mental Health Counselor and were open to all students of Vicente and Briones.

- ***Alameda Food Bank:*** Over the Thanksgiving holiday break, students worked with the Alameda Food Bank to prepare food packages for those in need.

- ***Coastal Clean Up:*** Students attended a beach clean at the local shoreline.

- ***Dia de Los Muertos:*** Students enjoyed volunteering at the Dia de Los Muertos event in downtown Martinez.

- ***Downtown Martinez Clean-up:*** Students volunteered at the annual Downtown City Clean-up Day to remove graffiti, power wash windows and streets, remove trash, weed and prune trees and bushes in the downtown blocks of Martinez. Students reported an increased sense of connection to and pride in their community.

- ***MEF Run:*** Students and staff volunteered at the Martinez Education Foundation Run for Education, which is a fundraiser for Martinez Unified School District schools.

- ***Service-learning guest speakers & presentations:*** Service-learning focused guest speakers shared their experience, passion and expertise with students. Students were positively engaged, asking questions and some of whom committed to participating in various aspects of the speakers' groups.

Career-Focused Internships:
The internship program continued to grow. All students at Vicente and Briones were given the opportunity to apply, interview and participate in these career-focused internships. The New Leaf Collaborative Internship Coordinator and Vicente teachers organized the internships in partnership with community professionals. Internships for the year included:

- ***Culinary Academy:*** Five students participated in a culinary training program hosted and facilitated by Loaves and Fishes. For ten weeks these students went to Loaves and Fishes headquarters in Martinez to learn culinary skills four days a week after school. Training in a state of the art kitchen provided by Loaves and Fishes has inspired some of our students to move forward in this career pathway. Students reported going long hours or entire days without eating in their homes, and since attending the culinary program they've gained skills to make

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food on their own. The five students who participated and completed the program are now certified food handlers. All students have been hired in the hospitality industry and two are considering enrollment in Diablo Valley College's culinary certificate program.

- ***Martinez Early Intervention Preschool Program:*** Three students held internships with MEIPP. For the first semester of the school year, twice per week they were classroom aides in special needs classrooms at our district's pre-school program.

- ***Martinez Teen Police Academy:*** Four students participated in an eight week teen police academy sponsored by Martinez Police Department. They learned about the work of a police officer and had real life experiences such as working with a police dog, going on a ride along and many other experiences.

- ***National Park Service Cultural Landscapes & Phenology Internship:*** Students were hired for this internship working with an NPS at the John Muir National Historic Site.

- ***Career and Internship Focused Guest Speakers:*** There were a variety of guest speakers throughout the school year.

Mental Health Focus:
All Vicente, Briones and New Leaf Collaborative staff seek to infuse a social emotional and mental health focus into every aspect of each student's experience. Students participate in holistic health activities and seminars that support their emotional, social and academic health. This school year we had two full time mental health counselors on campus daily. When once students were resistant to participating in mental health counseling, now it is the norm among our students. We also had a peer mentor who was a Briones graduate. She also served as our environmental educator.

- ***Basketball Club:*** One of our mental health counselors worked with small groups of our at-risk boys on the basketball court, mixing mental health counseling with athletics and exercise.

- ***Briones Book Club:*** Our mental health counselor created a book club for our independent study students. The students meet weekly to interact and socialize since independent study school can be isolating.

- ***COPE Family Support Services:*** Mid-year, Vicente contacted with COPE Family Support Services. A clinical case manager was on campus four days per week to provide individual counseling, workshops to augment individual counseling, parent coaching and workshops.

- ***Feet First:*** Thanks to a generous donor, a group of our students participated in Feet First through the local FightKore gym. This program promotes discipline, self-awareness, empathy and self-control while building self-confidence and increasing focus.

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- ***Girls' Groups:*** One of our mental health counselors created a Girls Group for each age group: Sophomores, Juniors and Seniors. These groups met weekly to discuss challenges that they were having personally or at school. They also planned some special events to give back to our school community, including a teacher appreciation breakfast and a few spirit days to bring the community together.

- ***Guest Speakers:*** Speakers from Martinez Unified School District presented on their career path and educational experience. Mental Health focused guest speakers included a School Psychologist and Special Needs high school teacher. Various other fields were represented as well.

- ***Lunch & Games Club:*** Before school and at lunch our mental health counselor welcomed students to sit with her and either play board games or get together for lunch. This allowed our students to have group to be a part of and feel a sense of belonging.

- ***MFT Counseling Opportunities:*** Vicente and Briones students have access to individual and group mental health counseling.

- ***Mindful Based Substance Abuse Treatment:*** Our mental health counselor is trained in mindful based substance abuse treatment. Twelve students voluntarily attended this twelve-week group. It was embedded in the school day to draw more students. The group was full, and several other students wished they could have attended. We will be offering this group twice in the coming school year.

- ***NAMI School Workshop:*** Three students attended this workshop to learn how to create a NAMI Club on campus.

- ***Psychology Club:*** Psychology Club met once a week for hour long sessions after school with the mental health counselor. Students created group norms which were reviewed and agreed upon at the beginning of each session. Students were given the opportunity to choose what to learn about along the lines of behavioral health, throughout the year twelve students participated in Psych Club. Topics that were covered in depth included:
    - stigma of mental and behavioral health
    - substance abuse
    - parent child relationships
    - coping strategies

  Allowing students to have a say in what they were learning and using teaching tools they were familiar with created a platform for safe sharing of personal experiences with the content they were learning about simultaneously. Often students had valuable moments of clarity in regard to their past or present experiences. Psychology Club students also took field trips to

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Sacramento to serve on the Mental Health Advisory Workgroup at the California Department of Education that included meeting both the outgoing and incoming State Superintendent. They

were invited to speak at a variety of organizations who were interested in mental health in schools and/or who wanted to learn more. The club also started a weekly pod cast where they would interview professionals in the field of psychology. They also produced a public service announcement about suicide prevention for the Directing Change contest.

- ***Restorative Practices:*** For the second year in a row, Vicente and Briones contracted with Services that Encourage Effective Dialogue and Solutions (SEEDS) for restorative conversations and practices. We began holding restorative circles with students when a wrong needed "righting" and in an effort to remedy challenges on campus instead of turning students away through suspension. Teachers and staff also learned strategies for working with students in the classroom in lieu of sending students to the office.

- ***Sandy Hook Promise:*** Students were trained in the Say Something Program. Students also participated in a variety of Sandy Hook Promise activities that took place throughout the year. The Vicente Psychology Club members were featured in the SAVE Promise Club newsletter.

- ***StrengthsFinder Workshop:*** All Vicente and Briones students and staff completed the Strengths Finder assessment to identify their top five strengths. A Vicente teacher and a certified Strengths Finder facilitator lead eleven workshops through math classes throughout the school year. Students learned about their personal talents and strengths and how to use them in all aspect of their lives. Each participant created and shared a talent map, discussed their strengths with other students and learned how to use their strengths in their personal, academic and professional lives. Seniors included naming their strengths and how they play out in their lives as a part of their senior portfolio and presentations. Staff also engaged in workshops to build professional capacity.

- ***Suicide Prevention:*** A representative from the Contra Costa Crisis Center provided a forty-five minute workshop to all of our students about suicide prevention.

- ***Welcoming Schools Summit:*** Several students attended this summit to learn more about creating an inclusive and accepting school community for LGBTQ students.

Leadership Development:
Many students volunteered for leadership roles in activities and events that were offered.

- ***Get Real Academy:*** A Vicente teacher and counselor took fifteen senior girls to the Get Real Academy. The girls attended various workshops on how to manage their finances, their health, solutions to violence, how to secure a job and insurance.

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- ***Senior Community Service:*** All Vicente and Briones seniors completed a minimum of 15 hours of community service at various events and organizations. Students reported this assignment was pivotal in learning how to work in a professional environment, as well as manage their time.

- ***Teens Tackle Tobacco:*** Ten Vicente students attended this event that took place at UC Berkeley and was hosted by Alameda County Office of Education. Students participated in conversations about tobacco use, presentations about the effects of drug and tobacco on the body and other workshops.

Academic Development:
Students continued to receive common core centered academic instruction and support from their Vicente and Briones teachers. Strategies used included integrated instruction, project/place-based curriculum, specific skill instruction and individualized and differentiated instruction.

- ***Alternative School Setting:*** Vicente Martinez High School and Briones School are both alternative school options. Both schools offer individualized, scaffolded and differentiated instruction, small class sizes, engaging activities, project based learning, skills instruction, on-line courses, self-pacing, flexible scheduling and chunking of instructions and assignments.

- ***History Club:*** Students attended field trips to the Maritime Museum and Rosie the Riveter Museum. These field trips were led by a Vicente teacher who has her master's degree in Museum Studies. Students who attended created presentations for the students who did not attend.

- ***Individual Success Plans:*** Teachers, the academic counselor and principal facilitated weekly appointments with students. Students created goals for academic skills, attendance and self-care. Their ultimate goals were chunked into small weekly goals and adjusted which the student reviewed every Friday.

- ***Multi-Tier System of Support & Response to Intervention:*** Vicente staff met weekly to discuss students of concern and academic progress of students. Staff came up with interventions and supports for each individual student as needed based up their challenges and struggles. The principal developed a shared Google Doc where data was provided on each individual student including attendance, credit accrual and social emotional wellness. Teachers and staff could view the document for insights about each student as well as provide their own comments about what was working for the student.

College and Careers:
Students continued to be exposed to a variety of careers and colleges through guest speakers, introduction to internships, seminars and field trips in order to help them successfully transition to young adulthood.

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- ***College Visits:*** Students had the opportunity to visit and tour Diablo Valley College, UC Davis, Cal State East Bay, Mills College and Chabot College. Diablo Valley College staff visited our campus as well to facilitate a FAFSA Workshop, application workshop and information on summer program offerings.

- ***Concurrent College Enrollment:*** Twelve Vicente students were concurrently enrolled at Diablo Valley College over the course of the school year. Our academic counselor and internship coordinator supported the students who were enrolled by checking in with them weekly. The objective was to provide support for students for them to be able to complete their courses successfully. Discussions took place among students regarding their successes and challenges.

- ***FAFSA Workshop:*** All seniors received a workshop on how to complete and file the Free Application for Federal Student Aid (FAFSA). Most of our students qualify for some level of free assistance for college and most are unaware of this. Once they realize that funding is available this removes the financial obstacle for our students moving on to college.

- ***Internship Coordination*:** The coordinator worked one-on-one with students to develop their resumes, job search, interview tips, volunteer hours and career exploration opportunities. Students have the option to explore individual internships or to join group internships. There were dozens of events and activities throughout the year.

- ***Resume & Cover Letter Workshop:*** In addition to individual appointments with the internship coordinator, students worked in groups to complete their resumes. Support was also given to students to create cover letters for job and internship applications.

- ***Senior Portfolios and Exit Interviews:*** Each senior was required to complete an extensive career portfolio and prepare a written packet and multi-media presentation that then was subsequently presented at an exit interview in front of staff. The internship coordinator supported students with this process and coordinated the presentations.

Outdoor Appreciation Field Trips:
Students continued to enjoy nature and outdoor activities in ways that promoted a healthy connection to the natural world and encouraged them to utilize natural resources for environmental and community health. Students could see that nature is a stress management tool and healing agent.

- ***School Garden:*** Students had opportunities to work in our school garden throughout the school year.

Teacher Professional Development:
Teachers continued to participate and lead professional development opportunities to increase their knowledge about how to better support at-risk students.

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- ***Brief Intervention: An Approach for Substance Using Adolescents:*** Our administrator was trained in this restorative approach and will be implementing it in the coming school year for students who show up to school under the influence of a substance or who are being impacted by substance use.

- ***Restorative Practices:*** Throughout the year, Vicente and Briones contracted with Services that Encourage Effective Dialogue and Solutions (SEEDS) for restorative conversations and practices. We held restorative circles with students when a wrong needed "righting" and in an effort to remedy challenges on campus instead of turning students away through suspension.

- ***StrengthsFinder Workshop:*** All Vicente and Briones students and staff completed the Strengths Finder assessment to identify their top five strengths. Staff worked together to learn how to leverage their talents among their professional peers. A Vicente teacher and a certified Strengths Finder facilitator lead eleven different workshops in math classes throughout the school year. Students learned about their personal talents and strengths and how to use them in all aspect of their lives. Each participant created and shared a talent map, discussed their strengths with other students and learned how to use their strengths in the personal, academic and professional lives.

- ***Training Seminars:*** The Vicente and NLC staff were both trained by the mental health counselor in how to work with at-risk students and conflict management. This was a shared training so there are common responses to students. We also developed universal responses to students around expectations and behaviors which allowed students to know what was expected of them. Teachers and staff were also trained in a variety of child welfare topics, including suicide warning signs and prevention.

Outreach:
Vicente and Briones continued its efforts to promote the program and to inform the public about the PEI opportunities.

- ***Community Events:*** The staff supported the development and student involvement in many community events such as Martinez Run for Education, Earth Day, Dia de Los Muertos, City Clean Up, Kiwanis Club, etc.

- ***Community Organizations:*** The principal and other staff members were invited to present to various groups in our community, such as Kiwanis and Rotary. Vicente hosted the Mental Health Services Act Community Forum. The Vicente-Briones Psychology Club presented to the Martinez Unified School District School Board regarding the mental health services at Vicente-Briones and advocating for services in other schools in the district. Vicente students also presented to the Mental Health Services Act staff, City Council, California Department of Education's Mental Health Workgroup Meetings that included both the outgoing and incoming State Superintendent.

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- ***Mental Wellness Conference:*** Two staff members attended the 2019 California Mental Wellness Conference sponsored by the California Department of Education. They made a presentation entitled: Using Data to Strengthen Your School-Based Mental Health Program.

- ***Model Continuation School Recognition:*** Vicente is a recipient of the Model Continuation High School Recognition through the California Department of Education. The award highlights the mental health focus and other schools have sought guidance from Vicente regarding best practices to support the social emotional growth and development of students.

- ***New Family Orientation:*** The principal meets one-on-one with each family before enrolling a student to orientate the family as to the school program, including the PEI services offered.

- ***Partnerships:*** Staff continued to work in close partnership with National Park Service Park rangers to complete agreed upon partnership goals and items identified in work plan. The Psychology Club worked with Contra Costa Crisis Center to develop a Public Service Announcement regarding their Crisis Line. A Vicente student's art was featured on the Contra Costa Crisis Center posted that was distributed countywide. We continued to work in partnership with Martinez Unified School District personnel and other local organizations to connect to various funding streams to support additional internships and service projects.

- ***Western Association of Schools and Colleges:*** We completed our accreditation process and received another six year term of accreditation. This means that all graduates receive a fully accredited high school diploma.

OUTCOMES AND MEASURES OF SUCCESS:
Please provide quantitative and qualitative data regarding your services.

- ***List of indicators that measured reduction of risk factors and/or increase in protective factors that may lead to improved mental, emotional and relational functioning. Please include how often data was collected and analyzed, as well as how the program evaluation reflects cultural competency and protects the integrity and confidentiality of the individuals served.***

The following are our outcome measures of success from the 2018-19 PEI work plan.

Engagement Focus:

- Increase identification of students that have a greater risk of developing a potentially severe mental illness and those who need additional supportive/protective factors.
- Increase engagement of identified Vicente/Briones students in PEI services.

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Engagement Focus Goals:

- At least 70% of enrolling students will receive a) an orientation on program offerings; and b) a self-identified needs assessment targeting risk factors may include, but are not limited to, poverty, ongoing stress, trauma, racism, social inequality, substance abuse, domestic violence, previous mental illness, prolonged isolation.
    - Met. This goal was met at a rate of 95%. The Adverse Childhood Events (ACE) needs assessments showed that Vicente students have an average score of 6. Those with a score of 4 or more are 460% more likely to experience depression and 1220% more likely to attempt suicide.

- At least 85% of identified students will participate in two or more PEI services per quarter that supports their individual learning plan.
    - Met. The average number of PEI activities of those who participated was five.

Short Term Focus:

- Increase timely access and linkage to supportive and mental health service.
- Increase mental health resiliency among Vicente/Briones students.

Short Term Focus Goals:

- At least 85% of students identified as facing risk factors will be referred to supportive services and/or mental health treatment and will participate at least once in referred support service or mental health treatment.
    - Met.

- At least 70% of students participating in two or more services within at least one full semester will report an increase in their Developmental Asset Profile or other risk management tool.

    - Not met. We did not administer the Developmental Asset Profile this year due to shortage in staffing.

Intermediate Focus:

- Increase student ability to overcome social, emotional and academic challenges, by working toward reduction of stigma and discrimination while increasing academic success, vocational awareness relational vitality and the ability to set and achieve other life goals.
- Increase faculty's ability to facilitate agreed upon community practice-based standards of prevention to better ensure an increase of protective factors**.**

Intermediate Focus Goals:

- At least 70% of students who participate in four or more services and who have had chronic absenteeism will increase their attendance rate by 5% as measured at the end of the school year.
    - Met.

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- At least 70% of students who participated in four or more services and who regularly participated in mental health counseling will earn 100% of the expected grade level credits as measured at the end of the school year.
    - Met.

Measurement/Evaluation Tools
1. ACE Assessment
2. Individual Success and Achievement Plan (developed by teacher, internship coordinator and mental health counselor)
3. AERIES (school database) – Attendance, credit accrual and disciplinary data
4. Multi-Tier System of Support Google Spreadsheets
5. Stages of Leadership Character Traits Evaluation Forms
6. Student Work Samples
7. California Healthy Kids Survey
8. Brief Mood Survey

DEMOGRAPHIC DATA: X Not Applicable ***(Using County form)***
If your agency has elected to not utilize the County Demographics Form AND have chosen to not collect specific demographic domains (i.e. Veteran Status, Disability, etc.), please provide justification.

Not applicable, using county form.

EVIDENCE-BASED OR PROMISING PRACTICES:
What evidence-based, promising practice, or community practice based standard is used in your program and how is fidelity to the practice ensured?

ACE Survey: ACE stands for Adverse Childhood Events. The ACE questionnaire is scored 0-10 based on how many adverse events were experienced before the age of 18. The areas are physical, emotional sexual abuse; physical and emotional neglect; and household dysfunction including mental illness, divorce, incarcerated relative, substance abuse and mental illness.

Brief Mood Survey: Students take this survey before and after counseling sessions to determine if the counseling session eliminated risk factors. Our post counseling session statistics this year include: a 61% decrease in depression, a 65% reduction in anxiety, a 70% reduction in anger and a 100% decrease in suicidality.

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California Healthy Kids Survey: The California Healthy Kids Survey (CHKS) is the largest statewide survey of resiliency, protective factors, risk behaviors and school climate in the nation. Across California the CHKS has led to a better understanding of the relationship between students' health behaviors and academic performance, and is frequently cited by state policymakers and the media as a critical component of school improvement efforts to help guide the development of more effective health, prevention and youth development programs. It provides a means to confidentially obtain data on student knowledge, attitudes and perceptions about the topics it covers. The CHKS, along with its partner surveys, the California School Staff Survey and the California School Parent Survey, is highlighted as a model program in a research document released by the US Department of Education highlighting the research behind the Obama administration's Blueprint for Reform: The Reauthorization of the Elementary and Secondary Education Act (pdf). With the CHKS, schools, districts, counties and the state have a standard tool that promotes the collection of uniform data within and across local education agencies that are also comparable to existing state and national survey datasets.

Cognitive Behavioral Therapy: Our counseling program utilizes Cognitive Behavioral Therapy (CBT) and Mindfulness. CBT is utilized in individual sessions and CBT techniques are taught to our psychology club students. At every counseling session, our head counselor utilizes a brief mood survey and evaluation of therapy form to evaluate student progress and therapist effectiveness. Additionally, our head counselor attends a bimonthly CBT supervision and consultation group as well as yearly workshop trainings. Mindfulness is taught at our weekly workshop on Mindfulness and Substance Abuse. Students also learn mindfulness strategies in individual counseling sessions. Every class period starts with a moment of quiet and reflection.

Expected Schoolwide Learner Outcomes: A requirement of the Western Association of Schools and Colleges (WASC) Accreditation process, these are outcomes determined by the school of what we expect students to learn, know and be able to do when they leave our program. Our outcomes closely align with our work around student wellness, connection to others and post-secondary plans.

Multi-Tier System of Support (MTSS): Formerly Response to Intervention (RTI), a Multi-Tier System of Support is a multi-tier approach to the early identification and support of students with learning and behavior needs. This process begins with high-quality instruction and universal screening of all students in the general education classroom. Vicente teachers, staff and administrator and the NLC internship coordinator work together to provide services that all students receive (Tier 1), such as support with service learning, college applications, senior projects, resume-cover letter writing. If there is a student who needs more supports, whether academic, attendance related or behavioral, than what is offered to all students, the team brainstorms other interventions to support the student (Tier 2). If these supports are not effective and more resources are needed for the student, the team determines the needs and implements the more intensive interventions (Tier 3). If there continue to be needs, then other measures are taken, such as a special education assessment, placement change, etc.

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Schoolwide Expectations: As a schoolwide practice, all students have knowledge of the expectations for them relating to behavior, attendance, credit earning and protocols at our school site. This allows students to be able to know exactly what is expected of them. We hold students to a high level of accountability while providing a high level of support for them to achieve these expectations. This puts all students on a "level playing field" in knowing what is expected of them. Many students rise to the occasion when expectations are clear and consequences are outlined and fair and therefore, can be highly successful while rebuilding confidence and self-esteem in the school setting and beyond.

VALUES:
Reflections on your work: How does your program reflect MHSA values of wellness, recovery, and resilience; provide access and linkage to mental health care, improve timely access to services for underserved populations, and use strategies that are non-stigmatizing and non- discriminatory?

Our program reflects MHSA values of wellness, recovery and resilience. Our whole staff embraces these values for our students, and we strive to ensure our students are held accountable and are supported in these ways in order for them to thrive. We provide access and linkage to mental health care by providing individual and group services during the school day and referrals to outside mental health services for students needing longer term support and services. The students at Vicente and Briones are some of our most underserved and at-risk students in our school district. Thirty-eight percent of students are on free and reduced lunch which means their families are in a low socio-economic status. The teaching staff, mental health counselor, principal and special education teacher meet regularly to discuss the needs of students and to review and analyze data. We practice the Multi-Tier System of Support or Response to Intervention Model in order to provide students with the individualized supports that they need to be successful. While there are interventions built into the regular school day such as small class sizes, explicit expectations and universal responses to students, those who need something more are discussed, and it is determined what they need. As a staff we also utilize restorative practices and restorative conversations among ourselves and our students.

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

Here is what current students have said about Vicente Martinez High School:

Throughout my academic history I've struggled to thrive or even succeed in a school environment. Every day was a cycle of stress, anxiety, fear, and eventually regret. Even after starting a new year fresh I eventually fell behind. After transferring to Vicente all those problems dissipated. I was finally meeting and surpassing expectations, becoming more involved with extracurricular activities and

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volunteer work, and just in general becoming a better version of myself. Classes were no longer just a chore and I was properly understanding the curriculum. I believe that the experiences I've had at Vicente and the skills that I've learned here have more than properly prepared me for life post-high

school. I am grateful for the opportunities I have been given and, with all of this pushing me forward, I am more than eager to continue my journey through life.

I feel like there are many things about this school that has helped me personally. With that being said, I think that being able to have one on one conversations with teachers is a great way to ask questions. Being at another school where not many teachers really care is sad because they don't pay attention to students as much. Here the teachers ask if "we are ok"? or "How is your day"? This is something you don't see in schools with so many students. I really like how we are still being taught our academics by lectures. We as students also have independence to work freely and be flexible with our work. We can work on our Math independently but still feel comfortable asking our teachers for help. In conclusion this school has helped my mental health in many, many ways which is very important to me. This is why I like this school.

I like Vicente Martinez High School because the small classes have helped my anxiety. The teachers are very welcoming, as well as very helpful. Credits are easy to make up with the teachers' help. Teachers are available to help whenever students need it. If it wasn't for Vicente my grades would still be bad and that goes with my attendance. I love coming to school and talking to the Counselors when I need it. Whenever I leave school I get very sad and can't wait for the next day to get started.

My proposed graduating date is June 2020. Before I went to Vicente Martinez High School, I never liked school. I stopped going to school and I would just stay at home. When I started Vicente I remember being scared, however, I made friends easily and started to catch up on my credits. When I'm in class I feel like I'm being heard and understood. The support the teachers give makes me feel smart, capable and cared for. The thing I like the most is the flexible schedules. I am able to leave school at noon each day. This allows me more time to focus on myself and my goals outside of school.

This school has helped me in many ways. They offer internships and help us apply for jobs. I struggle with school a lot and suffer from anxiety, depression and ADHD. Sometimes these prevent me from working effectively. I would often get overwhelmed and leave class. The teachers here help me to stay motivated and they are very supportive. Not having any homework to bring home each night has helped me majorly. I know at the end of each class that I'm done for the day and I can go home and work on myself and my happiness.

By attending Vicente I've had a much better experience than I have in the past at other schools. The classes are small, and the teachers and counselors are amazing. I actually get up and go to school now. Whereas before while I was attending Alhambra it seemed to make my life worse. The people and energy here at Vicente is much better. I will also get to graduate early if I stay on track. The staff at

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Vicente has also help me to get a job by helping with write my resume and check to see who is hiring. They also offer me many other experiences here that I couldn't get anywhere else.

The things I like about Vicente is I don't have any homework and I can earn my credits faster. This will allow me to start college earlier. Here at Vicente they offer outside activities like kickboxing. I enjoy kickboxing as it is a great way to get rid of stress. The teachers here have helped me with me resume so I could get a job. The teachers are also available to help me whenever I need it. The school also offers Girls Group so we can talk to each other and what is bothering us. This group has helped me a lot and has helped prepare me for the Big World.

Using the brief mood evaluation of therapy form, here are a few comments from students…

"learning how to deal with negative thoughts"
"thinking about the pros of being shy"
"I got helpful tips to help resolve my problems"
"fighting my anxiety"
"the fact that I was able to express myself"
"being able to talk"
"always a good listener and understands"
"evaluating my problems"

Contra Costa County Board of Supervisors

Subcommittee Report

FAMILY AND HUMAN SERVICES COMMITTEE **9.**

Meeting Date:	11/23/2020
Subject:	Innovative Community Partnerships
Submitted For:	David Twa, County Administrator
Department:	County Administrator
Referral No.:	#110
Referral Name:	Innovative Community Partnerships
Presenter:	Devorah Levine **Contact:** Devorah Levine (925) 608-4890

Referral History:

On January 6, 2015 the Board of Supervisors referred oversight and receipt of updates on the Employment and Human Services Department's (EHSD) Innovative Community Partnerships to the Family and Human Services Committee (F&HS). On June 7, 2016, the Board approved expanding F&HS Referral No. 110 "Innovative Community Partnerships" to include the subject of Whole Family Services. This change was necessary to incorporate a major EHSD initiative, which refocuses client-facing benefit eligibility to assess the status and needs of the "whole family" while they are also determining benefit eligibility. Key to the new initiative is working with community partners to form a network of family resource centers in current place-based centers such as SIT (Service Integration Team) and SparkPoint sites, Family Justice Centers, First 5 centers, *et al.*

On May 13 and May 21, 2019, the Family and Human Services Committee and Board of Supervisors, respectively, received the most recent annual report on Innovative Community Partnerships.

Referral Update:

Attached is a status report and presentation on EHSD's Innovative Community Partnerships program.

Contra Costa County Employment & Human Services Department (EHSD) works with numerous County agency partners, community-based organizations, elected officials, community advocates and other stakeholders to provide a diverse range of programs and services that benefit more than 250,000 people annually.

Policy trends at the federal level continue to pose negative impacts and funding cuts to entitlement programs and delays to federal relief to states and local jurisdictions. In addition, there

are threats to affordable health care and efforts to penalize immigrants who access public benefits by blocking their pathways to legal permanent residence. All of these factors add urgency to building effective, innovative partnerships and sustainable funding for core programs.

Included in the report are updates on the work of the:

- Family Violence Prevention Task Force;
- Food and Nutrition Task Force;
- Equitable Economic Recovery Task Force;
- Children's Well Being Task Force; and
- Other COVID Relief Partnerships.

Recommendation(s)/Next Step(s):

ACCEPT the attached report on the Employment and Human Services Department's Innovative Community Partnerships.

Fiscal Impact (if any):

There is no fiscal impact; the report is informational only.

Attachments

Staff Memo
Staff Presentation

CONTRACOSTA COUNTY

EMPLOYMENT & HUMAN SERVICES

MEMORANDUM

Kathy Gallagher, Director

40 Douglas Drive, Martinez, CA 94553 • (925) 608 4800 • Fax (925) 313-9748 • www.ehsd.org

To: Family and Human Services Committee
Supervisor John Gioia, Chairperson
Supervisor Candace Andersen, Member

Date: November 23, 2020

From: Kathy Gallagher, Director

Subject: FHS Referral #110 Innovative Community Partnerships

RECOMMENDATION

ACCEPT the attached report on the Employment and Human Services Department's (EHSD) Innovative Community Partnerships

INTRODUCTION

Contra Costa County Employment & Human Services Department (EHSD) works with numerous County agency partners, community-based organizations, elected officials, community advocates and other stakeholders to provide a diverse range of programs and services that benefit more than 250,000 people annually.

Policy trends at the federal level continue to pose negative impacts and funding cuts to entitlement programs and delays to federal relief to states and local jurisdictions. In addition, there are threats to affordable health care and efforts to penalize immigrants who access public benefits by blocking their pathways to legal permanent residence. All of these factors add urgency to building effective, innovative partnerships and sustainable funding for core programs.

In light of the global COVID pandemic, EHSD has been at the forefront of response and relief efforts in partnership with Contra Costa Health Services (CCHS). EHSD jointly developed a Coordinating Body with Health Services and community partners to accelerate information-sharing and creative problem solving in response to the pandemic. EHSD staff continue to make contributions to the CCHS-led Historically Marginalized Task Force and its African American, Asian Pacific Islander (API), Latinx, Youth and Older Adults work groups. EHSD also partnered with the County Administrator's Office and Board of Supervisors to enact an Evictions Moratorium & Rent Freeze Ordinance to help ease the burden for many struggling families and displaced workers facing unemployment and financial hardship due to job loss, reductions in staff or furlough due to the ongoing economic recession.

EHSD led the development of COVID-19 Task Forces to coordinate efforts of government, business, nonprofit, and community stakeholders for the purpose of defining and implementing COVID-19

response and recovery plans. The four task forces include Equitable Economic Recovery, Food & Nutrition, Family Violence Prevention, and Children's Well-Being.

This report details highlights of COVID relief and other departmental efforts for which innovative community partnerships have played a key part in ensuring the continuity of vital safety net and social services to communities most in need.

FAMILY VIOLENCE PREVENTION TASK FORCE

The Family Violence Prevention Task Force addresses immediate needs related to COVID-19 and moves forward several goals and strategies outlined in Contra Costa County's Call to Action: Preventing Interpersonal Violence, a guide officially launched in February 2020 for coordinated and strategic action to address and prevent interpersonal violence.

When COVID-19 hit the Bay Area in March 2020, the Alliance to End Abuse (Alliance), in partnership with Contra Costa Public Health, revisited the Call to Action in light of a national pandemic and emergency. Furthermore, it became clear that a space was needed to address and respond to immediate COVID-19 needs related to interpersonal violence. Creating protective environments to prevent violence became essential as we faced social and physical isolation during shelter-in-place orders, increased anxiety, and increased inequity. Because of this, the Alliance narrowed in on a few specific Call to Action goals and strategies to move forward during this time:

1. Building sustainable, race conscious and value driven prevention infrastructure.
    - Racial equity trainings, workshops, and agency specific technical assistance
    - Formalizing partnership between the Alliance and Public health to move forward violence prevention work

2. Fostering early childhood development and whole family supports.
    - Community engagement and education campaigns including the "Summer Camp at Home" campaign launched June 2020

3. Encouraging community connectedness.
    - Multi-generational community building include a pilot "Generations Connect" program connecting older adults and youth online

The Family Violence Prevention Task Force has focused its most immediate efforts on multi-generational community building, which resulted in a pilot project for inter-generational community building, directly in line with Goal 3 of the Call to Action, "Encourage Community Connectedness". The pilot brings together older and younger generations online to learn about online safety and build relationships. The Task Force has also focused on child abuse prevention, and is working with the Child Abuse Prevention Council, First 5 Contra Costa and Family Justice Center to promote a child abuse prevention campaign.

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FOOD & NUTRITION TASK FORCE

In response to COVID-19 and an increase in food insecurity, multiple County agencies and organizations across Contra Costa came together to respond to immediate food needs related to the pandemic. Contra Costa's Aging & Adult Services Bureau launched the Great Plates Senior Food Program and worked in partnership with Health Services Nutrition Services to increase meals for seniors. The Alliance to End Abuse, in partnership with the For Our Families Program, launched the Social Services Rapid Response team to focus on wrap-around social services including food needs. Health Services, with support from the Alliance, launched a Food++ Program connecting high risk patients with grocery delivery services, and 211 and the County - in collaboration with 211 - launched a GIS interactive food map tool. Furthermore, the existing network of food providers across the County, including the Food Bank of Contra Costa, Meals on Wheels Diablo Region, Salvation Army, Monument Crisis Center, as well as Contra Costa Voluntary Organizations Active in Disasters (VOAD), went into emergency response mode to increase food access and support to their communities.

As COVID-19 persists, a Food & Nutrition Task Force continues to coordinate services across agencies and departments in order to share knowledge and increase collaboration to transform food systems beyond response to the pandemic. The purpose of this task force is to provide robust and consistent support to Contra Costa residents dealing with food insecurity.

The Food & Nutrition Task Force (previously the Senior Nutrition Task Force) is led by Aging & Adult Services in partnership with the Alliance to End Abuse and Workforce Services Bureau. Partners include Meals on Wheels, Food Bank of Contra Costa and Solano, Volunteer Organizations Active in Disasters (VOAD), White Pony Express, Mt. Diablo Unified School District, 211, Fresh Approach and Health Services.

Two immediate goals of the Task Force are:

1. Streamline and coordinate food distribution efforts across the County.
    - Deliverable: food referral flow chart to formalize structure across the County

2. Collect, review and analyze data regarding food access, resources and distribution.
    - Utilize data to address gaps in services
    - Utilize data to inform funding decisions
    - Deliverable: data collection plan/outline & food data dashboard

A food resource flow chart currently in production will allow the community to more easily navigate the myriad of food services. This flow chart be interactive and live on 211's website in order to help providers and community members navigate through food needs and challenges. Furthermore, a draft data collection plan has been drafted, and partners are beginning to look at what data is easily collectible.

In addition to the work of the task force, EHSD continues to collaborate with the CalFresh Partnership to reduce barriers, increase outreach and improve community access to CalFresh through partnership and collaboration with the Food Bank and other stakeholders.

EQUITABLE ECONOMIC RECOVERY TASK FORCE

The Equitable Economic Recovery Task Force is an alliance formed to Identify and support equitable opportunities to rebuild the economy that has been damaged by COVID-19 and its effects. It is co-led by the Workforce Development Board (WDB), EHSD and the Contra Costa Economic Partnership (CCEP). EHSD staff are participating in the Task Force, along with more than 20 local business and community leaders. The COVID-19 pandemic has amplified systemic barriers to economic opportunity in Contra Costa County. The task force will align efforts, track and guide actions to support job creation in the public and private sector, identify and promote policies to retain local employers, and expand connections to training and employment for those disproportionately impacted by recent layoffs. Since its first meeting in July 2020, the task force has organized into work groups focused on five priority areas:

Funding Priorities

- Where could resources be concentrated in Contra Costa County to support small businesses?

Improving Broad Band Access

- What policies, programs and permitting changes could most improve broadband access?

Hiring Displaced Workers through Wage Subsidies

- What is the largest barrier to businesses taking advantage of government sponsored incentives and wage subsidies that support hiring displaced workers in need of re-training? Can we do better at communicating and streamlining these options?

Growing and Supporting Contra Costa's Industrial Base

- How can we identify and close workforce gaps in this sector? Do businesses need more support (consulting) or more partnerships from educational institutions?

Growing the Health Care Workforce

- How can we clarify and strengthen pathways to health care careers in Contra Costa County?

The task force is committed to including the voices of those most negatively impacted by COVID-19 and has a designated work group convening impacted individuals and businesses to capture their personal experiences. A leadership team of these individuals will participate in the Task Force to ensure the voices, experiences, and recommendations of those most impacted are included in these efforts.

The work groups are developing additional strategies for each priority area and actions items including short and long term plans for continued impact.

CHILDREN'S WELL-BEING TASK FORCES

In March 2020, EHSD collaborated with CoCoKids, the Contra Costa Office of Education, First 5 Contra Costa, the Local Planning Council, and Contra Costa Health Services to implement the Emergency Child

Care Program, which offered support for all essential workers serving our community's needs during the COVID-19 crisis. The highest priority went to health care workers. The program ran from March 17 to June 5, 2020.

The program successfully allowed our county's most important workers to perform essential duties while ensuring that their child care needs were addressed during this critical period. During the three-month period that the program was in place, approximately 872 requests were made to CoCoKids for emergency child care. 565 children of essential workers participated in the program. Approximately 405 essential worker families were issued state-funded emergency child care subsidies.

Last year, the Children's Leadership Council (CLC) convened for the first time in March 2019 to champion a unified vision, voice, and action plan for ensuring all children and families in Contra Costa are healthy and thriving. We envisioned the CLC as a vehicle for strengthening partnerships, practices, policies, and investments that improve opportunities and outcomes for children and families.

Over the course of three meetings in attended by over 100 parent leaders, service providers, policymakers, funders, and community advocates, the CLC built agreement on:

- A Framework for Collective Action that defines the CLC's purpose, vision of success, values and guiding principles, and examples of actions.
- A Roadmap for Collective Action that aligns three broad goals with the CLC's role and overarching strategies:

    1. Center the CLC's collective action on community voices and partnerships.
    2. Ensure Contra Costa has a holistic, thriving ecosystem of prevention for children, youth, and families.
    3. Engage policymakers and systems leaders in championing a data-driven, outcome-oriented "Child & Youth Well-being Agenda".

The Roadmap provides a structure for both "mapping" existing collaborative efforts and identifying new synergies that support the CLC's goals. The CLC intended to convene ad hoc work groups in early 2020 to further define specific actions and the necessary resources for each goal. Then the COVID-19 crisis took over every aspect of our lives, disrupting life as we know it.

In the face of the pandemic's continued impact on our community's children, youth, and families, an ACEs Aware grant presented an immediate opportunity to meet an urgent need by drawing on the strength of our partnerships and putting the vision of the CLC into action. First 5 Contra Costa (First 5) was one of 100 organizations throughout California that received an ACEs Aware grant from the Office of the California Surgeon General (CA-OSG) and the Department of Health Care Services (DHCS). ACEs Aware is designed to help Medi-Cal providers and organizations that serve Medi-Cal beneficiaries understand the importance of screening for Adverse Childhood Experiences (ACEs), respond with trauma-informed care, and strengthen the medical, social, and community networks of care.

First 5's grant proposal was developed in partnership with members of the CLC: Contra Costa Health Services including Behavioral Health, Health Centers, and Public Health, Employment and Human Services, and Trauma Transformed. As the ACES Aware grant project manager, First 5 will be responsible

for implementing specific activities between now and June 2021 that will rely on key partners, such as the CLC, to help share important information, provide input and guidance, develop or enhance relationships, and adopt or adapt policies and processes that strengthen the networks of care for children, youth, and families. In addition to supporting this immediate opportunity, the CLC will work to create a sustainable, action-oriented structure that can be applied to many future needs and opportunities beyond the ACEs Aware grant.

OTHER COVID RELIEF PARTNERSHIPS

As noted earlier, EHSD worked with the County Administrator's Office and Board of Supervisors to provide research on data, trends and anecdotal information from housing partners to inform and enact its county-wide Evictions and Tenant Protections ordinance. Community partners include Health, Housing and Homelessness (H3), Council on Homelessness, Contra Costa Crisis Center (211), Bay Area Legal Aid, EBASE, Monument Impact and others. Since then, EHSD created a number of reports and various materials related to Evictions and Tenant Protections for the Contra Costa County Board of Supervisors and other audiences. This information provides a foundation for ongoing discussions about how the county may address housing-related risks going forward.

EHSD launched the Season of Sharing (SOS) COVID Emergency Relief Fund managed by Volunteer & Emergency Services (VES). In partnership with Health, Housing and Homelessness (H3), VES coordinated snack packs and hygiene kits for delivery to unsheltered homeless due to the closure of congregate shelters. In addition, VES was awarded a Travis Credit Union $20,000 donation through VESTIA 510c3 non-profit to fund COVID relief supporting EHSD clients.

Now more than ever, innovative partnerships are critical to delivering needed services. Through robust partnerships with community-based agencies, county departments, law enforcement, funders, businesses and policymakers, EHSD's services help make Contra Costa County a safer, healthier, and more equitable place to live for all residents.

Employment & Human Services

Innovative Community Partnerships

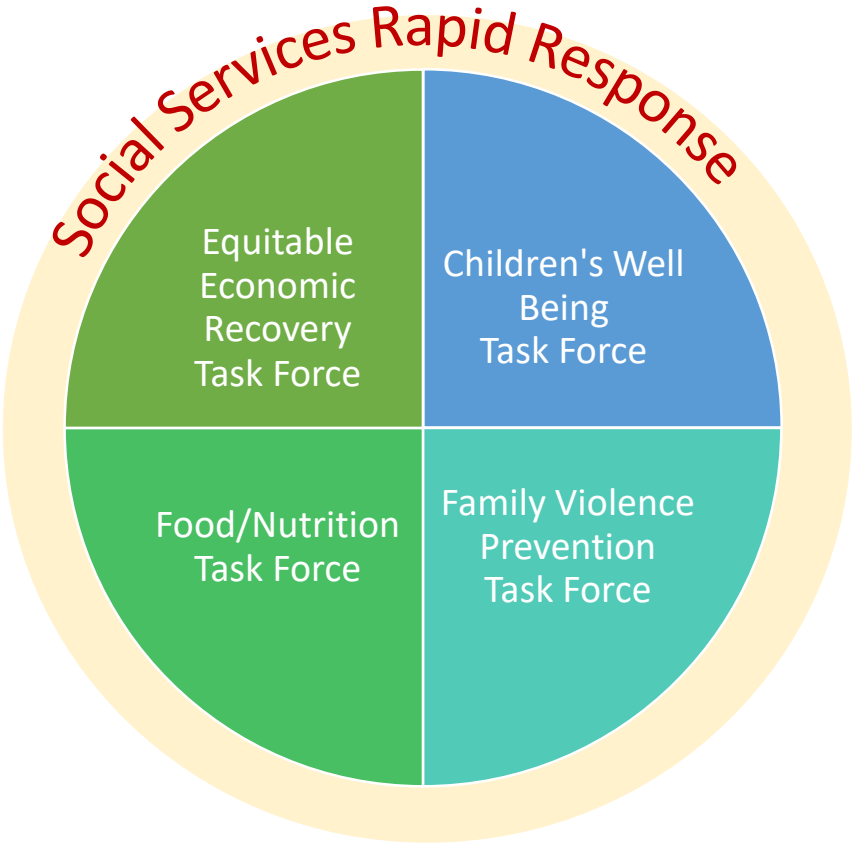
REPORT TO FAMILY & HUMAN SERVICES COMMITTEE

NOVEMBER 23, 2020

CONTRA COSTA COUNTY

EMPLOYMENT & HUMAN SERVICES

COVID response designed for partnership



Family Violence Prevention Task Force

The Partnership

- EHSD Alliance to End Abuse
- Contra Costa Public Health
- Child Abuse Prevention Council
- First 5 Contra Costa
- Family Justice Center
- Community agencies and advocates

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Family Violence Prevention Task Force

The Mission

Contra Costa County's Call to Action Preventing Interpersonal Violence

1. Building sustainable, race conscious and value driven prevention infrastructure.
2. Fostering early childhood development and whole family supports.
3. Encouraging community connectedness.

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Food & Nutrition Task Force

The Partnership

- ✓Contra Costa Health Services (CCHS)
- ✓Food Bank of Contra Costa & Solano
- ✓Meals on Wheels Diablo Region
- ✓Salvation Army
- ✓Monument Crisis Center
- ✓Contra Costa Voluntary Organizations Active in Disasters (VOAD)
- ✓EHSD Workforce Services Bureau
- ✓White Pony Express
- ✓Mt. Diablo Unified School District
- ✓211
- ✓Fresh Approach
- ✓CalFresh Partnership

Great Plates Senior Food Program

- ➢EHSD Aging & Adult Services Bureau
- ➢CCHS' Nutrition Services

Social Services Rapid Response

- ➢EHSD's Alliance to End Abuse
- ➢For Our Families Program

Food++ Program

- ➢CCHS
- ➢EHSD Alliance to End Abuse

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Food & Nutrition Task Force

The Mission

1. Streamline and coordinate food distribution efforts across the County.
2. Collect, review and analyze data regarding food access, resources and distribution.

Equitable Economic Recovery Task Force

The Partnership

- EHSD Workforce Development Board
- Contra Costa Economic Partnership (CCEP)
- 20+ local businesses, community leaders, and displaced workers

Equitable Economic Recovery Task Force

The Mission

[Equitable Economic Recovery Task Force Website]

1. Funding Priorities
2. Improving Broad Band Access
3. Hiring Displaced Workers through Wage Subsidies
4. Growing and Supporting Contra Costa's Industrial Base
5. Growing the Health Care Workforce

Children's Well-Being Task Forces

The Partnership

ACE's Aware Grant Project

- First 5 Contra Costa
- Children's Leadership Council (CLC)
- Contra Costa Health Services
- Trauma Transformed

Emergency Child Care Program

- EHSD's Community Services Bureau
- CocoKids
- Contra Costa Office of Education
- First 5 Contra Costa
- Local Planning Council
- Contra Costa Health Services

Children's Well-Being Task Forces

The Mission

1. Center collective action on community voices and partnerships.
2. Ensure Contra Costa has a holistic, thriving ecosystem of prevention for children, youth, and families.
3. Engage policymakers and systems leaders in championing a data-driven, outcome-oriented "Child & Youth Well-being Agenda."

Other COVID Relief Partnerships

Historically Marginalized Task Force

Active member of a partnership led by Contra Costa Health Services

Evictions and Tenant Protections Ordinance

Partnership with Contra Costa Health Services, Health, Housing & Homeless Services (H3), Council on Homelessness, Contra Costa Crisis Center (211), Bay Area Legal Aid, EBASE, Monument Impact

Seasons of Sharing (SOS) COVID Emergency Relief Fund

Volunteer & Emergency Services (VES) in partnership with Contra Costa Health Services and Health, Housing & Homeless Services (H3)