Innovation Annual Report FY 20-21

Contra Costa Behavioral Health Services

Mental Health Services Act

Table of Contents

Innovation Introduction 3

Program Profiles A1

Innovation Project Annual and Final Reports… B1

Innovation Introduction

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

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

Approved Programs

The following programs have been approved, implemented, and funds have been allocated for Fiscal Year 2020-21:

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

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

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

3) Overcoming Transportation Barriers. Transportation challenges provide a constant barrier to accessing mental health services. A comprehensive study was completed via the County's Community Program Planning Process, and a number of needs and strategies were documented. Findings indicated a need for multiple strategies to be combined in a systemic and comprehensive manner. These strategies include training consumers to independently navigate public transportation, providing 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. Two Peer Specialists address these needs and provide a means to inform the mental health system of care regarding solutions for improving transportation access to care. The Overcoming Transportation Barriers Project began implementation in FY 2016-17.

4) Partners in Aging. Older adults who are frail, homebound, and suffer from mental health issues experience higher rates of isolation, psychiatric emergency interventions, and institutionalization that could be prevented. When fully implemented, this project will field three field-based peer support workers to engage older adults who have been identified by their IMPACT clinicians, primary care providers, or Psychiatric Emergency Services as individuals who need additional staff care in order to avoid repeated crises, engage in ongoing mental health treatment, increase their skills in the activities of daily living, and engage appropriate resources and social networks. The Partners in Aging 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 20-21
Partners in Aging	County Operated	Countywide	45	126,596
Overcoming Transportation Barriers	County Operated	Countywide	200	76,536
Center for Recovery and Empowerment	County Operated	West	80	1,158,439
Cognitive Behavioral Social Skills Training	County Operated	Countywide	240	368,489
Administrative Support	County	Countywide	Innovation Support	364,363
		Total	*565*	*$2,094,423*

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

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

Innovation (INN) Component Yearly Program Budget Summary for FY 20-21

Projects Implemented			2,094,423
		Total	$2,094,423

Program Profiles

Center for Recovery and Empowerment A2

Cognitive Behavioral Social Skills Training in Augmented Board and Cares A3

Overcoming Transportation Barriers A4

Partners in Aging… A5

Program: Center for Recovery and Empowerment (CORE)

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

a. **Target Population:** Adolescents between the ages of 14-17 with substance use disorders and co-occurring mental health disorders
b. **Total MHSA Funding for FY 2020/21:** $1,158,439
c. **MHSA-funded Staff:** 5.0 Full-time 1.0 Part-time equivalents
d. **Total Number served**: For FY 20/21: 6 individuals
e. **Outcomes**:
    - Reduce symptoms of mental illness and decrease substance use
    - Increase academic success
    - Reduce the need for (or return to) in-patient treatment
    - Improve quality of family relationships

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

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

a. **Target Population:** Adults aged 18 years and older who are currently living in a Board and Care Home, diagnosed with a serious mental illness and receiving services at a County-operated Behavioral Health Clinic.
b. **Total MHSA Funding for FY 2019/20:** $368,489
c. **MHSA-funded Staff:** 2.0 Full-time equivalents
d. **Total Number served**: For FY 20/21: 22
e. **Outcomes**:
    - Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7) will be given to all group participants.
    - Additional measuring tools would include the Recovery Assessment Scale (RAS) and the Independent Living Skills Survey (ILSS).
    - Client Satisfaction Survey
    - 5150's will be tracked for pre/post data and length of hospital stay.

Program: Overcoming Transportation Barriers

The Overcoming Transportation Barriers (OTB) program is a systemic approach to develop an effective consumer-driven transportation infrastructure that supports the entire behavioral health system of care. The goals of the program are to improve access to mental health services, improve public transit navigation, and improve independent living and self-management skills among consumers. The program targets consumers throughout the behavioral health system of care.

a. **Target Population:** Consumers of public behavioral health services and their families
b. **Total MHSA Funding for FY 2020-21:** $76,536
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 16-21: 182 clients
e. **Outcomes**:
    - Increased access to transportation resources and public transit navigation
    - Decreased stigma and discrimination associated with mental illness.
    - Increased acceptance and inclusion of mental health consumers in all domains of the community.

Program: Partners in Aging

Partners in Aging is an Innovation Project that was implemented on September 1, 2016. Partners in Aging consists of up to two Community Support Workers (CSWs), up to three Student Interns and 8 hours/week of Psychiatric Services to the IMPACT program. The project is designed to increase the ability of the IMPACT program to reach out to underserved older adult populations through outreach at the Miller Wellness Center and Psychiatric Emergency Services. Through Partners in Aging, IMPACT has provided more comprehensive services, including providing linkage to Behavioral Health, Ambulatory Care, and Alcohol and Other Drugs services. Peer support, rehab, and in-home and in-community coaching will allow the skills learned through psychotherapy to be practiced in the community. Partners in Aging also to provided SBIRT (Screening, Brief Intervention, and Referral to Treatment) services and referrals to IMPACT consumers who screen positive for alcohol or drug misuse.

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

a. **Target Population:** The target population for the IMPACT Program is adults age 55 years and older who are insured by Medi-Cal, Medi-Cal and MediCare, or are uninsured. The program focused on treating older adults with moderate to severe late-life depression or anxiety and co-occurring physical health impairments, such as cardio-vascular disease, diabetes, or chronic pain. Partners in Aging also focused on providing outreach and services to older adults who are experiencing both mental health symptoms and alcohol or drug misuse.
b. **Total MHSA Funding for FY 2019/20:** $126,596
c. **MHSA-funded Staff:** 2.0 full-time equivalents
d. **Total Number served**: For FY 20/21:
e. **Outcomes**:
    - Reductions in Level of Care Utilization System (LOCUS) scores.
    - Reductions in Psychiatric Emergency Service visits and hospitalizations.
    - Decreased Patient Health Questionnaire (PHQ-9) scores.

Innovation Project Annual and Final Reports

Center for Recovery and Empowerment… B1

Cognitive Behavioral Social Skills Training in Augmented Board & Cares… B6

Overcoming Transportation Barriers… B15

Partners in Aging B2

CONTRA COSTA
HEALTH SERVICES

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

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: 2020/21

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

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

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

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

Day program schedule is as follows:

1) Transportation provided by van pick-up
2) Check-in with teacher for Golden Gate School Program
3) Complete Daily Goals Worksheet
4) School
5) Lunch and social skills integration
6) Individual therapy – clients are pulled from milieu twice a week, or as needed throughout the day.
7) Group therapy: Moral Reconation Therapy – 1x/week, Recovery Assignments are done in group 5x/week
8) Toxicology screening and individual consultation with nurse to discuss results 1x/week

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

9) Adventure Therapy – ecotherapy, mindfulness, and recreational activities for youth after lunch
10) Family therapy – Family therapy is conducted 1x/week per client in the late afternoon or evening
11) Community recovery meetings – Clients are transported to and from Young People in Alcoholics Anonymous (YPAA) meetings 2x/week. They attend with Recovery Coach and work with an individual sponsor from YPAA
12) Sober social events – Clients attend social sober events, weekly, in order to develop and establish a sober peer group. These events are sponsored by YPAA and linkage is provided by Recovery Coach. They include events such as sober dances, parties, bowling, dinners, camping, etc.

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

During FY 20-21, the CORE program provided a hybrid curriculum for the majority of the year. In-person services included adventure therapy (bike rides and other outdoor activities), while education support through Golden Gate Schools, YPAA (12-Step) meetings, and individual therapy were offered via Zoom. By the spring of 2021, the remaining three staff members left their positions, which made the program impossible to continue in its current state. A decision was made to temporarily close the program and conduct an extensive re-design. The six existing clients were transferred to the West County Children's Clinic where they were offered the opportunity to continue clinical and case management services. The CORE program began its re-design phase immediately and a workgroup was developed to guide this process.

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?

From the onset, the CORE program has faced significant personnel challenges, including high turnover and difficulty maintaining a fully staffed team. This was exacerbated during the pandemic when we also faced a workforce shortage. In addition, enrollment and retention were low. The general concept of this project, an intensive outpatient program for dually diagnosed youth, can only thrive in an in-person setting. Both staff and clients became disillusioned during COVID and found it difficult to maintain integrity to project.

When the program closed in the spring of 2021, Behavioral Health Services leadership seized the opportunity to re-design the program to better meet the needs of the community. This began with the implementation of a CORE Workgroup made up of key staff from both Mental Health and Alcohol and Other Drugs (AOD). Initial tasks included interviewing former clients, parents/caregivers and staff to determine what worked well and what should change. Valuable feedback was received, including the following suggestions: adopting a harm reduction framework to be less punitive and more welcoming, revising some of the recovery curriculum to be more orientated toward a cognitive behavioral framework, providing substance use disorder (SUD) training to staff, hiring an SUD counselor as part of the multi-disciplinary team, and incorporating more youth development opportunities. Other goals for CORE include providing more direct clinical and administrative

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

support and oversight, as the program is in a stand-alone location. Workflows and policies are being reviewed to allow for greater enrollment and program completion/success.

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 CORE program was very difficult to transition to a virtual platform. Staff attempted to provide telehealth services for individual therapy, and academic support to the extent clients were able to engage. They did deliver grocery bags to clients' homes, which was helpful for families who were struggling to make ends meet during the pandemic, particularly before a vaccine was available. As many families were experiencing economic hardship, some teens were forced to work to help support the family. Focusing on individual school and treatment became a luxury many could not afford. Vital elements of the program were shut down during the pandemic including sober social events and the physical space to connect with peers in a recovery-oriented environment.

In the spring of 2021, the supervisor and remaining three staff members all left their positions. A decision was made to put the program on hiatus due to extremely low enrollment and logistical problems operating the program during COVID. Stakeholders were informed. A workgroup was developed to focus on the CORE Re-Design. The group is led by administrators from Children's Behavioral Health and Alcohol and Other Drugs (AOD). During the workgroup's initial phase, they took the opportunity to speak to former staff, clients and family / caregivers through interviews and focus groups. It was determined that multiple improvements could be made to make the program more welcoming and accessible. These included embracing a harm reduction framework (vs. abstinence only) to prevent youth from being dismissed from the program for a relapse or in the event a family member used drugs or alcohol (which is out of their control), and increasing staff training and youth development opportunities.

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

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

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

Demographics. During FY 20-21, CORE served a total of 6 youth (5 male, 1 female). No new enrollments were made during the FY because of the severe impact of COVID on the program viability. The program typically serves BIPOC youth from the western part of the County.

Learning Goal Outcomes:
Learning goal outcomes were not obtained due to staff leaving their positions and the program going on hiatus during COVID.

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

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

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

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

- 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, they may be referred to activities such as sports, art, dance, summer jobs and other similar programs. There is no lapse in referral time therefore this is not a measured outcome.

VALUABLE PERSPECTIVES:

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

Not available due to the program being on hiatus during COVID.

INNOVATIVE PROJECT ANNUAL REPORTING FORM

FISCAL YEAR: FY 20-21

Project Name:

Cognitive Behavioral Social Skills Training in Augmented Board and Cares

Innovation Project Type:

Increase the quality of services, including better outcomes

OVERVIEW:

Cognitive Behavioral Social Skills Training (CBSST) is an evidenced-based practice that combines Cognitive Behavioral Therapy (CBT), Social Skills Training (SST) and Problem-Solving Therapy (PST) into one treatment protocol. It's been effectively used around the world as a therapeutic, non-medication-based intervention for clients with SPMI diagnoses. Contra Costa Behavioral Health Services' Innovation project uses CBSST to assist clients residing in Board and Care Homes (B&C's). The intent is to offer a more service-enriched housing model by optimizing B&C's with the goal of them becoming healing centers where residents are able to learn and practice skills in the environment in which they live. B&C's have historically served to house our most functionally impaired clients but offered little in the way of recovery services. The CBSST in Board and Cares Project seeks to bring evidenced-based practical interventions to the settings where problems are most likely to occur and assist B&C residents in achieving practical goals to enhance wellness, self-sufficiency and improve overall quality of life.

The project involves a team consisting of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility is to lead CBSST groups at B&C's that house Contra Costa Behavioral Health Services (CCBHS) clients. Long term goals include expanding to include additional Clinician / Peer teams that can serve a greater geographic area. The project is in its third year. It was approved in 2017 and began implementation in 2018.

SERVICES PROVIDED:

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

The CBSST project is designed to enhance the quality of life for those residing in B&C's by incorporating meaningful activity and skills into their daily routines and increasing overall functional improvement. This involves both group and individual work provided by a licensed clinician or a peer support worker. During FY20-21, the project provided the

following services:

- Served seven small (6-bed) Adult Residential Facilities (ARF)
- Served 1 large (70-bed) Residential Center for the Elderly (RCFE)
- Provided CBSST individual and group rehabilitation services to 22 individuals this FY, and 45 cumulatively (unduplicated)
- Support to Board and Care operators (psychoeducation, partnering on goals utilizing CBSST framework and skills, consultation re: concerns/consumer needs)
- Served individuals (alumni of programs at ARFs) living in other settings including family home, room & board, and MHSA-funded shared housing

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?

As we worked through year two of the pandemic, we continued to incorporate many of the lessons learned from the previous year. Some of these included: longer engagement periods to develop rapport with B&C operators and clients; repeating module content to consolidate learning (due to a significant number of clients presenting with cognitive impairment and/or symptoms interfering with learning); and generally going at a slower pace to improve clients' ability to absorb and retain information, as well as strengthen the therapeutic relationship.

We continued to do much of the work on an individual basis and utilized telehealth where appropriate. Staff discovered some clients did better with this type of engagement. It also allowed those who were reluctant or less able to participate in groups (due to symptoms of their mental illness such as paranoia, thought blocking, or active auditory hallucinations) to engage more successfully with providers and better absorb content. In-person group sessions were also held throughout the year in outdoor settings, as appropriate, due to varying Covid restrictions.

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.

During FY 20-21, the project operated fully under COVID conditions. This meant restrictions around in-person work. Clients received appropriate support with

existing technology so they could continue to participate in the program to the fullest extent possible. It was discovered that some clients required one-on-one assistance, which was offered via Zoom, telephone and in-person (outdoors) during times of the year when it was safe to do so. Groups resumed outdoors in Spring 2021. In order to address the issue of *access to technology*, the project received approval to purchase laptops to be used in the B&C's, and is in the process of having them set up as "kiosks" by our IT department. Through kiosks, clients will have access to the internet, basic Microsoft Suite programs, and telehealth appointments. Easier access to technology will further support clients' participation and growth.

Similar to last year, we experienced the closure of another small B&C home. The team worked with residents and used the Problem-Solving Skills module to help with this transition. Clients were moved to alternative housing such as apartment, Room & Board or other B&C homes.

CBSST staff worked closely with B&C operators to advocate for clients' self-care needs. During the shelter-in-place, operators were reluctant to allow residents to leave the house. CBSST staff helped negotiate compromises that allowed residents to take walks and have opportunities to get fresh air, which supported mental health. Staff also took residents on outings that included hiking and picnics in local regional parks.

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 CBSST have a positive effect on the client's mental stability and growth? (e.g., decrease need for intensive clinic services, reduce 5150 holds, increase likelihood of compliance with mental health treatment, increase likelihood of reaching out voluntarily to mental health supports when needed)**
2. **Will CBSST lead to a higher overall functionality and quality of life? (e.g. , increase engagement with community resources and social supports, increase independent living skills, increase self-reported life satisfaction)**
3. **Will CBSST help clients develop skills to maintain a stable living environment?**

Client Satisfaction Survey

In 20-21, we introduced a Client Satisfaction Survey, an additional tool to help gauge improvements in overall functionality and quality of life. The survey elicits direct feedback *from the clients' perspective* as to whether the project is having a positive impact. Questions relate to quality of life, independence and ability to maintain a

stable living environment. Surveys were administered annually and a total of 12 surveys were received. Overall, responses were highly favorable.

Survey Questions *N=12*	**Average Response**
Q1: CBSST has given me tools that improve my overall quality of life	4.75/5
Q2: CBSST has taught me skills that help me live more independently	4.25/5
Q3: CBSST has helped me maintain a stable living environment	4.58/5
Client Comments	
• *It was a great experience to gain tools to learn in almost any situation* • *Shaunna and Anna coming out and answering questions we have is helpful. I would like the modules to be more detailed.* • *Happy to be here!* • *I am glad I am here!* • *I thought that group sessions have helped me stay stable and I've learned many valuable lessons, thank you! Anna and Shaunna, thanks a bunch!* • *Better to have the group, rather than being alone.* • *The therapy was very helpful. The way they let me express my feelings openly and being there to talk to me.*	

Table 1: Client Satisfaction Survey Results FY20-21

Decreasing Psychiatric Emergency Services (PES) Utilization

Of the 22 clients enrolled in CBSST during FY20-21, there were a total of nine trips to PES by six different people. During the previous year (FY19-20), that same group of 22 had 25 visits to PES by ten different people. This indicates that enrollment in the CBSST has an overall beneficial influence on reducing PES utilization. This could be attributed to development of new tools and coping skills, which can be implemented by individuals when feeling stressed and anxious, and potentially avoid the need to access crisis care.

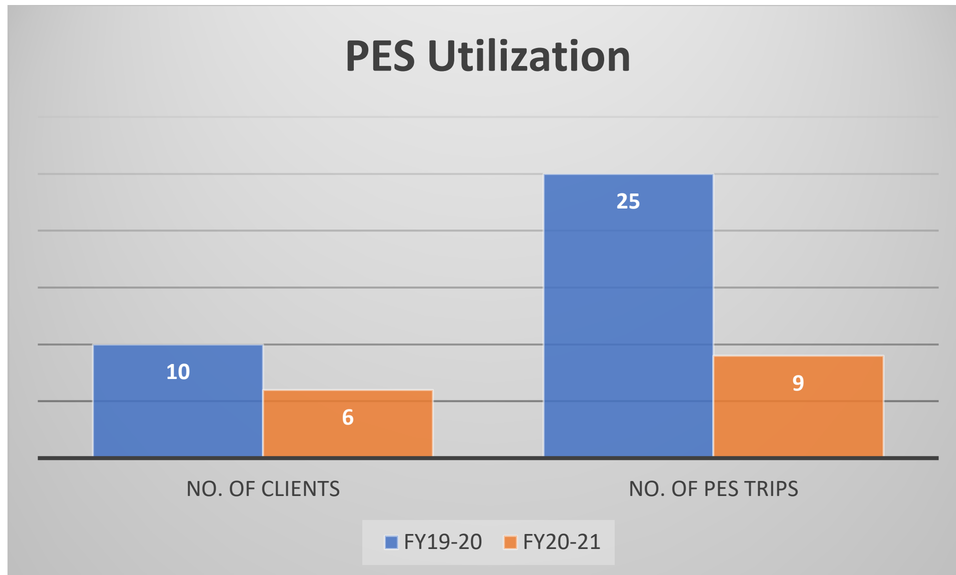


Table 2: PES Utilization 19-20, 20-21 Comparison, Epic

CBSST Standardized Surveys
We utilize four different surveys to measure the impact on participants' symptoms, self-perception and functioning. These include:

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

The PHQ-9 and GAD-7 were adopted to align with tools utilized in the regional specialty mental health clinics to track symptoms for all clients. The ILSS is used 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. Strengths of the tools may include: providing a consistent way to flag an uptick in symptoms and identify unhelpful thoughts and beliefs. Weaknesses may include

inconsistencies in administration (not administering the same survey to the same individual repeatedly over time), and survey fatigue.

Changes in data collection during this period included administering the RAS, PHQ-9 and GAD-7 separately from group. Responses appear to be more genuine if completed during an individual meeting, after trust and rapport have been established. The ILSS is administered only at the end of modules. Survey results are now entered directly into the electronic health record (EHR). This allows providers easier access to tools that can monitor client progress and supports overall coordination of care.

The CBSST team remains connected to CBSST-trained staff in the county clinics and is part of the existing Evidence Based Practice Workgroup. They meet regularly and receive training and supervision around the CBSST framework and best practices, which supports fidelity to the model.

Table 1: Percent Change in Average PHQ-9 Scores, July 1, 2020 through June 30, 2021

Fiscal Year	Average Score of First Survey of this Fiscal Year (n=16)	Range	Average Score of Second Survey of this Fiscal Year (n=7)	Range	Percentage of Change
2020/21	4.9	(0-14)	4.6	(0 - 10)	-6.1%

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

Table 2: Percent Change in Average GAD-7 Scores, July 1, 2020 through June 30, 2021

Fiscal Year	Average Score of First Survey of this Fiscal Year (n=17)	Range	Average Score of Last Survey of this Fiscal Year (n=8)	Range	Percentage of Change
2020/21	4.1	(0 -18)	5.0	(0 - 8)	22%

GAD-& Score Key: 0-4 Minimal Anxiety, 5-9 Mild Anxiety, 10-14 Moderate Anxiety, 15-21 Severe Anxiety

Table 3: Percent Change in Average RAS Scores, July 1, 2020 through June 30, 2021					
Fiscal Year	**Average Score of First Survey of this Fiscal Year** (n=14)	**Range**	**Average Score of Final Survey of this Fiscal Year** (n=2)	**Range**	**Percentage of Change**
2020/21	102.1	(75-115)	108	(96-120)	5.8%
Total possible RAS score = 152					

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 CBSST groups are connected to the County Behavioral Health Clinics. Many have psychiatrists and/or case managers and regularly scheduled visits. If a client is not participating in services and needs to be connected, the CBSST provider will proceed with linking the client to appropriate services by reaching out to clients' assigned clinic and collaborating to further engage the client in care. The CBSST team also advocates with clinics to provide the appropriate level of service (i.e. case management services instead of money management services), as well as the optimal level of housing. In June 2021, Putnam Peer Connections opened its doors in Contra Costa County. This is a drop-in day program operated with the support of peers to provide wellness support, links to resources, community outings, daily lunches and transportation. The CBSST team supported clients in membership applications to the Putnam Peer Connections program.

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.

Vignette: JM – Afu's One Voice Board & Care

JM is a 33-year-old female living in a six-bed board and care (ARF). She came from Crestwood Pleasant Hill (The Bridge), a 66-bed facility. While there, she participated in DBT, which gave her skills that helped her connect well with us in our CBSST groups.

Upon entrance to Afu's One Voice on 1/3/2020, she struggled with anxiety, disorganized thoughts, and difficulty communicating in a linear way. She also struggled with topics from her past that made her uncomfortable and often worried about what other's views of her were (family, housemates, teachers and people of authority.)

Most services over the past year have been virtual, but during the in-person groups that we could hold, she demonstrated how to "lay out a plan" and role-played scenarios she had prepared including "making positive requests" and "expressing unpleasant feelings". She practiced these role-plays at home with housemates, and she called us to excitedly share her experience.

Due to Covid-19, most of our services shifted to individual telehealth via Zoom, which allowed us to develop stronger one-on-one relationships. JM thrived with the consistency. She utilized the "thought checking" and connected to her feelings accurately. When in doubt, she reached out and shared her thoughts and made requests to help her understand situations. She often advocated for herself with providers, asking questions, and getting her needs met. She spoke up for what she needed from care managers and psychiatrists. At one point, she fired her care manager and requested a new one (which she got).

Really aware of the understanding of our group, she took notes, asked questions for clarity and shared her appreciation of our time. She shared her success by practicing how to apply the skills in real time. She continues to be enrolled in school, taking classes 3-4 days a week. She has reunited with her family and child. She shares her feelings in a positive way, sets healthy boundaries, and speaks up for what she needs.

Utilizing CBSST with her knowledge of DBT, along with the support and consistency of check-ins, she has persevered and continues to grow daily. She is an exceptionally smart and wonderful young lady. Leading by example, demonstrating how she incorporates and manages a meaningful life.

Client Journal Entry - Anonymous

Yesterday a group of us, headed by Anna and Shaunna, went to Point Pinole Regional Shoreline Park for a picnic. It was a bright sunny day, nicely mild. After a slow start to get the food, we left Family Courtyard, a board & care facility.

It took about twenty minutes to get to the park, which was not bad. I had a problem getting in the van, because of my stiff, sensitive left knee. It was hard to bend it, and awkward traveling, but worth the effort.

To get to the picnic area, with a view of the Bay, it took longer, but again worth the effort! It was so nice, the panorama of the water – so different from where I live! It was pleasant, with good company – especially with my boyfriend, RF. And the food that was laid out was very delicious! I pigged out on the chicken, but I was starving for protein! I do not eat red meat or pork – so that presents a problem where I live. They cannot cater to one individual's diet needs.

So I enjoyed the spread very, very much!

Afterward, RF and I, and a few others went on a walk. I was busy with my cell phone taking pictures or videos of the scenes, so foreign to our hum-drum lives. Then I spotted something fascinating – a pier jutting out over the Bay. I persuaded by boyfriend to venture with me. RF uses a walker, for fear of falling only. Nearing the end of the pier, RF had to sit and rest while, but I continued to its end. Then there was an excitement. A fisherman had caught something large! So RF got up and joined me at the pier's end in time to see the fish fighting being caught – it was a two or three foot long leopard shark! I had only seen one in Steinhart Aquarium in San Francisco. I turned around for I did not want them to catch it to eat it – I eat fish, but shark, no!

But then another commotion. I turned around in time to see the fisherman raising the net, empty! For there was a hold in it that led to the shark's escape, yeah! On that positive note, it was time to return to our uneventful Family Courtyard. RF tried to remind me it is the only place we have. Still that feeling of freedom, like the shark's escape permits me to doubt!

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

INNOVATION PROJECT FINAL REPORT

Fiscal Years: 2016-2021

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

INNOVATIVE PROJECT TYPE:

Increased Access to Mental Health Care

INNOVATION:
Please provide a 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.

During the fall of 2011, Contra Costa Behavioral Health Services' (CCBHS) Transportation Committee (comprised of peer providers, clinical staff, administrative staff, community stakeholders and one member of the mental health board) engaged in a stakeholder process to address barriers to accessing behavioral health services that are caused by transportation challenges. Goals of the Committee were to:

- Understand the current need for better transportation options for clients
- Understand current capacity
- Examine current policies and procedures on transportation of clients
- Examine current job roles and functions in both the Children's and Adult's Systems of Care for Case Managers and Community Support Workers

Building on the work of the Committee, the MHSA Three Year Program and Expenditure Plan for FYs 2014-2017 identified transportation priorities including: getting to and from services, navigating the system and assistance with engaging in meaningful activity. With this roadmap in place, the Innovation Committee further developed the idea for a transportation project, which resulted in the Overcoming Transportation Barriers (OTB) Innovation project.

The project began implementation in September 2016 with the goal of helping clients (existing consumers of Contra Costa Behavioral Health Services) build self-sufficiency and independent travel skills, while increasing access to behavioral health services.

The initial phase of the project involved a community survey, which was made available between November 2016-May 2017. A total of 601 responses were received from clients and care givers (9%

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

of responses were in Spanish). Surveys examined barriers to appointments and transportation concerns, as well as other related issues such as travel times to appointments and modes of transportation. The below table identifies ***transportation*** as the number two reason for missed appointments and ***cost*** the number one concern around transportation.

Table 1. Barriers to Appointment Adherence (*n*=330)

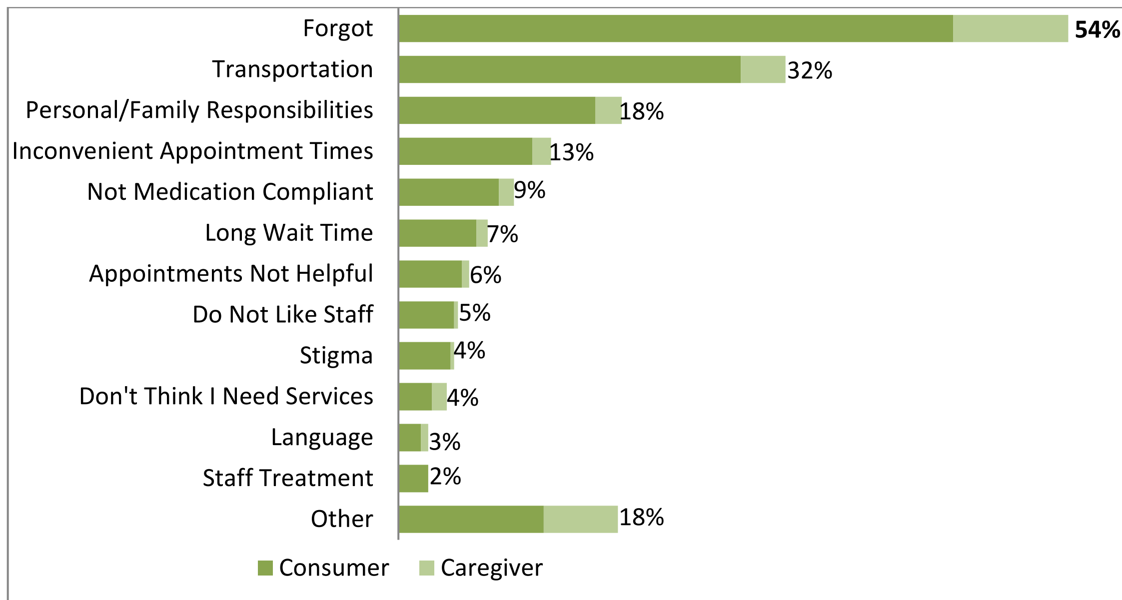
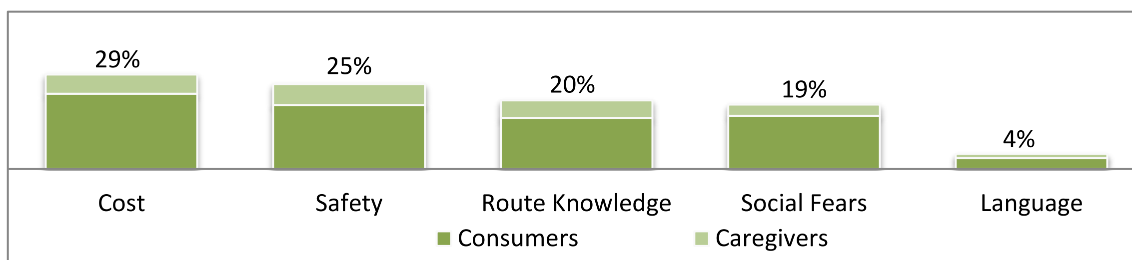


Table 2. Public Transportation Concerns (*n*=54)



PROJECT OVERVIEW:

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

The Overcoming Transportation Barriers (OTB) was a five-year Innovation project that was implemented from 2016 – 2021 to address the problem of transportation and access to care. The project proposed a unique and different service model including peers helping peers through the

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

coordination and utilization of transportation resources. The project was fully operated and staffed by peer support workers and those with lived experience. The target population was consumers of behavioral health services and their family members (or caregivers) or those trying to get connected to the behavioral health system of care. The project offered a systematic approach to develop an effective client/family/caregiver-driven transportation infrastructure that supports the entire Behavioral Health system of care. Goals of the project included the following:

- Help build self-sufficiency
- Apply independent travel skills
- Increase access to behavioral health services
- Improve transit system navigation
- Expand independent living and self-management skills
- Encourage self-advocacy
- Identify transportation barriers faced by clients

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 was located in CCBHS Administration's Office for Consumer Empowerment and primarily consisted of 2 FTE staff working in the Community Support Worker (Peer) role. Their duties evolved over the course of the project. The initial phase consisted of networking with various transit service providers to fully understand the resources available to the community. They built relationships through regular meetings. A great deal of effort was put into outreach and education. Multiple presentations were done early in the project phase to county programs, community providers, stakeholders and members of the public. Once the project was fully operational, most of the time shifted to directly supporting clients and family members with accessing public transit resources.

Staffing changes and COVID 19 Impact
The project was staffed by 2 FTE Community Support Worker (CSW) positions. During year four, one of the CSW's was promoted to a position in a different department. This left the remaining CSW to work on the project solo for the final year. Since it was during COVID and there were restrictions placed on public transportation, the remaining staff person was able to fulfill the essential duties associated with keeping the project going. Community members were not utilizing transportation services as much, as most of their appointments were conducted via telehealth. OTB staff continued to host regular Transportation Committee meetings via Zoom. The OTB Ride Sharing initiative remained in its planning phase and was never able to fully launch due to pandemic-related delays.

Addition of Flex Fund
As transportation costs were identified in the community survey as the number one concern, the OTB project was able to initiate a transportation Flex Fund to address this barrier. Through a

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

collaboration with Putnam Clubhouse, one of our CBO partners, flex funding was available to cover one-time costs specific to transportation needs for existing CCBHS clients or caregivers to support treatment engagement. Examples included: purchasing a pre-loaded Clipper card; providing gas cards; one-time costs associated with auto registration, smog or repair; walking shoes; bicycle; bike lock; and bike helmet. Flex fund requests were made by the provider (therapist, case manager, community support worker). OTB staff developed a relationship with a local auto body shop, who became the preferred referral source for car repair as they were supportive of the project's mission and provided services at a reasonable rate.

OUTCOMES AND DELIVERABLES:

Please provide quantitative and qualitative data regarding your services.

2016-2017 – Implementation Phase.

- Service Improvement Survey administered to define transportation needs for individuals receiving services at County Clinics
- Established collaboration efforts with transit agencies and compiled transportation resources available in each region of the County
- Regional brochure/Transportation guide developed which provided key information in one document that clients could utilize when having difficulty understanding available resources in their community
- Standardized Bus Ticket Log across regional clinics
- Began directly serving clients in April 2017

2017-2018

- Dedicated Peer Support Transportation Line established.
- Services provided included: peer support, mapping bus routes, links to resources, discount/disabled transit passes, fare information.
- Travel training provided in partnership with Tri Delta to deliver direct support and "field trip" including accompanying clients on bus rides to support learning new routes.
- Provided support to SPIRIT students – navigation and mapping transportation routes to class. Participated in Work Study Fair and Internship program.
- Established Transportation Sub-Committee – bi-monthly meetings, provided peer support, resource sharing, agency presentations, learn about self-advocacy

2018-2019

- East County Transportation Guides, 2018 (in Spanish and English)
- Central County Transportation Guides, 2018 (in Spanish and English)
- Transportation Coping Wallet Cards, 2019
- All County Transportation Guides, 2019 (in Spanish and English)

2019-2020

- Transportation Sub-Committee moves to Zoom platform
- Flex Funds introduced – pilot began in Central County Clinic
- Kept participants up to date on transportation changes during COVID

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

- Tri-fold Wallet Cards – translated to Spanish
- OTB posters designed with client input

2020-2021

- Suspended 1:1 Peer Travel Training Program due to COVID
- Continued to provide resources and updates to community during COVID
- Acted as liaison between county staff and transportation agencies around transportation updates and route changes
- Continued to host Transportation Sub-Committee meetings via Zoom
- Created and distributed Transportation Packets to East County Clinics for new clients which included:
  - ADA Paratransit application
  - BART transit schedules
  - Regional Transit Connection (RTC) Discount ID Card application
  - OTB brochure and OTB trifold cards

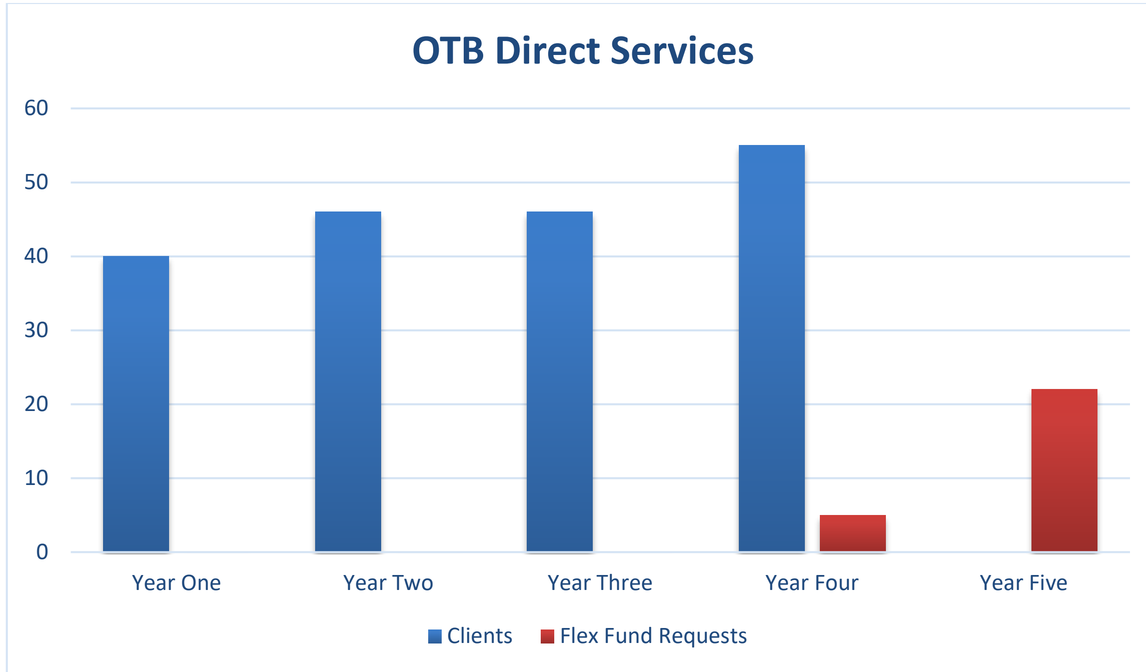
- Assisted in production and dissemination of the Peer Perspectives Newsletter
- Engaged with local transportation providers
- Facilitated four virtual Community Transportation Meetings
- Planning around Rideshare Program (potential new pilot) – did not launch

OTB Project Highlights:

Transportation Guides
Coping Wallet Cards
Tri Fold Coping Wallet Cards
Hosted Transportation Sub Committee Meeting
Transportation Flex Funds
Transportation Hotline
One-on-one direct assistance to learn and practice new bus routes
Outreach and Education

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

Table 1: Direct Peer to Peer and Flex Fund Services, 2016-2021



PROJECT EVALUATION:
Please provide quantitative and qualitative data regarding evaluation during the course of the project.

Below is a list of competed objectives.

Action #1: Compile and develop resources and workshops to share transportation information with 200 stakeholders, comprised of staff and clients and their families.

- Action Met. Finalized and distributed approximately 350 Transportation Guides; Organized and planned a Clipper Card Workshop; Shared various transportation related materials with 96 clients and staff members during reporting period; Created maps with direction to seven CCBHS events and distributed to over 200 people.

Action #2: Liaise between CCHS service providers and transit authorities, as well as act as County Representative in community forums related to transportation.

- Action Partially Met. Attended transit authority meetings and advocated for clients; Represented the County at a Disaster Preparedness event geared toward seniors and persons with disabilities.

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

Action #3: Attend at least one transportation meeting per month, and share information with stakeholders.

- Action Met. Attended 6 Advisory Committee meetings for County Connection and 7 Tri Delta Transit Board of Directors meetings during reporting period; attended Senior Mobility Action Council meetings approximately every other month; Shared related information with stakeholders.

Action #4: Facilitate four Transportation Sub-Committee meetings per year.

- Action Met. Transportation is a Sub-Committee of the Committee for Social Inclusion. At these meetings, transportation and behavioral health-related information was shared and input on the project was received. Attendance at meetings ranged from 10-19 participants.

Action #5: Hold Transportation Trainings.

- Action Partially Met. Facilitated Clipper Card Workshop. The task was limited due to COVID 19.

During the course of the project, a log was kept to track and monitor inquiries and requested services. Initially, requests were geared more toward mapping bus routes, providing transportation resources and providing direct peer to peer navigation support. As COVID hit in early 2020 and staffing was reduced, the focus of the program also shifted. The Flex Fund was introduced, so much of the work was around fielding those requests which supported various modes of transportation including auto repair, bicycle, wheelchair and walking shoe requests. As public transit was reduced or shut down during the pandemic, people relied on alternative forms of transportation and project was able to shift gears in order to accommodate that need.

Other Outcomes Achieved:

- Increased access to wellness and behavioral health services
- Helped decrease missed appointments by addressing transportation barriers
- Increased empowerment, knowledge and skills around transportation navigation
- Increased acceptance and inclusion of behavioral health consumers in all domains of the community

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.

Overcoming Transportation Barriers was a County-operated program housed within the Office for Consumer Empowerment in Contra Costa Behavioral Health Services Administration. As the Innovation project sunset in the fall of 2021, stakeholders were in support of retaining certain

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

elements of the project and incorporating them into the System of Care. These included:

- Transportation Hotline
- Transportation Flex Fund

These continue to be operated by OCE staff and are available to the community. The ongoing funding source has been changed to PEI.

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

The OTB Project set out to achieve the goal of assisting clients of Behavioral Health Services in Contra Costa County with improving access to services by addressing transportation barriers. Other goals included decreasing the stigma associated with mental illness and increasing acceptance and inclusion of behavioral health consumers in all domains of the community. With increased access to transportation, individuals are empowered to live more independent lives and achieve optimal wellness while continuing their journey toward recovery.

A summary of learning goals and achievements is listed below:

1. Transportation Flex Fund - piloted in East County, and later offered County wide.

2. Transportation needs changed during COVID 19. While public transit ridership was drastically decreased, the Flex Fund was still in operation to support various modes of travel (auto repair, bicycles, wheelchairs, walking shoes, etc.). Transportation comes in many forms!

3. Transportation Sub Committee successfully shifted to a virtual platform and continued to meet during the pandemic. This provided a safe space for peers, providers and community members to network and share resources.

4. During the final project year, OTB Staff became very involved with local transportation agencies including Contra Costa Transportation Authority and attended regular meetings regarding the Accessible Transportation Strategic Plan. Peer advocacy was supported throughout this process.

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. <u>Please attach any relevant presentations, brochures or other marketing materials.</u>

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

The Innovation Project has been shared routinely with stakeholders throughout the course of the project. During the launch phase, staff gave presentations to multiple groups throughout the Behavioral Health System of Care to introduce the project and educate community on how to access OTB services. Similarly, when the Flex Fund initiative launched, presentations were also offered and information distributed throughout the stakeholder networks. OTB staff regularly attended the Innovation Committee Meeting, where they provided updates to the group. OTB staff also attended the MHSA monthly advisory workgroup (CPAW), where they shared updates as requested during the project's lifespan. Most recently, they gave a final presentation just after the project ended at the 10/7/21 monthly CPAW meeting.

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.

During COVID, a survey was developed to assist project staff in gauging impact and eliciting feedback. Below is a sample of valuable perspectives obtained through survey responses:

1. **To what extent did your client find the services received from OTB helpful?**
    - Due to OTB's help, my client was able to attend in-person appointments without the fear and anxiety of breaking down on the side of the road or being in an accident. Overall, it has helped the attend to other basic needs as well, such as getting groceries and going to medical appointments. The client has expressed deep gratitude for OTB's assistance.
    - Client found the service extremely helpful to be able to get around to not only appointments but other activities to improve his independent living skills.
    - Due to OTB's help, my client was able to attend in-person appointments without the fear and anxiety of breaking down on the side of the road or being in an accident. Overall, it has helped the client attend to other basic needs as well, such as getting groceries and going to medical appointments. The client has expressed deep gratitude for OTB's assistance.

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

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA BEHAVIORAL HEALTH
1340 Arnold Dr Suite# 126
Martinez, CA 94553-4639
(925) 313-9579
E-mail: jennifer.bruggeman@cchealth.org

3. **How did the services provided by OTB benefit your client's ability to make it to their future appointments?**
    - Without this financial support, my client would likely have had to continually choose between driving an unsafe vehicle and obtaining necessary in-person care.
    - Client lives a good distance from Bart and bus stops, so it helps cut the travel time drastically.
    - Without this financial support, my client would likely have had to continually choose between driving an unsafe vehicle and obtaining necessary in-person care.

4. **Was the turnaround time fast enough for your client to get the most benefit from the services from OTB?**
    - OTB was incredibly responsive to questions, followed up, and was quick to act.
    - Yes, turnaround was about 2 weeks which I thought was fast.
    - OTB was incredibly responsive to questions, followed up, and was quick to act.

5. **Is there anything you would like to have seen done differently in your experience with OTB?**
    - Understandably, there was some questions the car mechanic had that I could not answer as a case manager/the person not in charge of billing. Since there were four parties involved (client, case manager, OTB, auto shop) it took some additional coordination. Perhaps in the future, if schedules allow, there could be a conference call between some of the parties. However, the auto shop may become more familiar with the process in the future as well.
    - Yes, once order is submitted and approved it should not be changed. My client has a disability that requires a key lock and that was changed to a much cheaper combo lock, I had to purchase out of pocket a new key lock for my client because I wanted him to have a lock he could use.
    - Understandably, there was some questions the car mechanic had that I could not answer as a case manager/the person not in charge of billing. Since there were four parties involved (client, case manager, OTB, auto shop) it took some additional coordination. Perhaps in the future, if schedules allow, there could be a conference call between some of the parties. However, the auto shop may become more familiar with the process in the future as well.

Vignette:

"Rose", 71 year old female, 2021

Rose is a 71 year old female who is a client in the CCBHS Older Adult Clinic. During a home visit, her social learned that Rose, who uses a wheelchair, was having difficulty with transportation. She was unable afford a proper wheelchair and her insurance would not cover this benefit until 2023. In order to perform her daily tasks and errands independently, she had been using a transport wheelchair, which has small wheels and is not intended for daily use. In the past month, she had crashed or fallen off the transport

wheelchair five times, including falling off a bus ramp. The social worker was concerned for her safety and immediately put in the referral. Through the use of Flex Funds, the client was able to obtain a new manual wheelchair which allowed her to maintain optimal health and wellbeing by attending her appointments and performing errands independently.

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

FINAL INNOVATIVE PROJECT REPORTING FORM

FISCAL YEARS: 2016-2021

Agency/Project Name: Partners in Aging

INNOVATIVE PROJECT TYPE:

Community Support Services

INNOVATION:

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

The Partners in Aging Innovation Project was based on the innovative idea to add Community Support Workers (CSWs) and Interns to the IMPACT Program. Our IMPACT Program provides psychotherapy services to older adults, who are 55 and above. The goals were to find out if clients of the IMPACT Program would benefit from these new additions to the treatment team. Community Support Workers are able to provide linkage to community resources, advocacy and in-home and in-community rehab support and coaching. This addition expanded the reach of the IMPACT Program beyond the therapy session. The addition of an Intern expanded the ability to serve additional clients and develop a workforce that has skills and passion for working with older adults.

PROJECT OVERVIEW:

Please provide an overview of the innovative project.

The Partners in Aging Innovation Project began on September 1, 2016 with the hiring of one Community Support Worker (CSW), and one Intern. Every Fall we welcome a new Intern into our program. Most of our Interns have chosen a dual track for the Internship with Older Adult Mental Health. They have split their time between our Intensive Care Management Program and IMPACT. This has given our Interns a breadth of experience by providing services to clients ranging from mild to severe and persistent mental illness. They have also been able to provide services that are clinic based and home or community based. They have provided a wide range of services, including individual therapy, case management, collateral contacts and crisis intervention. Our Interns have also frequently engaged in outreach or research projects, including outreach to West County, and the development of a binder of resources for clients experiencing cognitive decline. Interns always bring a spark of curiosity and passion to our clinic and we are happy to be able to increase the mental health workforce that can specialize in providing services to older adults. We were able to hire one of our Interns as a Permanent Full-Time Mental Health Clinical Specialist in January 2021.

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

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

In fiscal year 2016-2017 the CSW and Intern provided services to 25 to 30 clients. During fiscal year 2017-2018 the CSW and Intern provided services to 38 clients. During fiscal year 2018-2019 the CSWs and Intern served 32 clients. During fiscal year 2019-2020 our CSWs and Intern served 27 clients. Our CSWs and Interns served 27 clients during the 2020-2021 fiscal year. Throughout the Partners in Aging project most of these clients received multiple services.

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

When our original CSW left the Partners in Aging Program in January 2019 we lost the frequent communication that she was having with the CSWs at Psychiatric Emergency Services (PES). We did not receive referrals from PES during this reporting period. The lack of referrals from PES was also impacted by the switch in the IMPACT program to seeing clients with mild to moderate symptoms in November 2017.

Our Intern served a caseload of approximately 5 IMPACT clients during FY 20/21. He completed intakes and provided psychotherapy. He was able to develop rapport with a range of clients and make progress towards therapeutic goals. Prior to terminating with his clients he provided them with community referrals, and made recommendations for the next Intern regarding next steps for treatment, or discharge from IMPACT.

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

PROJECT CHANGES: ☐No changes

Please explain whether any changes were made to the Innovative Project during the course of the project and the reasons for the changes, if applicable.

The IMPACT Program has gone through several changes during the course of the Partners in Aging Project. As referenced above, in November 2017 the IMPACT Program switched from providing Specialty Mental Health services for adults 55+ with moderate to severe depression, anxiety and PTSD to provide services to adults 55+ with mild to moderate depression, anxiety and PTSD through the Federally Qualified Health Center system. In January 2021 the IMPACT Program returned to providing services to older adults 55+ with moderate to severe depression, anxiety and PTSD through Specialty Mental Health. Our clinicians had been located at Concord Health Center 2, Pittsburg Health Center and West County Health Center. In January 2021 the clinicians were brought back to the Behavioral Health Adult System of Care. Our clinicians are now located at Older Adult Mental Health in Concord, Pittsburg Adult Mental Health and West County Adult Mental Health, and they serve clients who have Medi-Cal or Medicare/Medi-Cal benefits.

These changes in the IMPACT Program affected the Partners in Aging Project in several ways. From November 2017 to January 2021 the CSWs were primarily unable to bill Medi-Cal for the services provided to IMPACT clients. In the Federally Qualified Health Center (FQHC) billing system services can only be billed that occur at the FQHC, and by a Licensed Clinical Social Worker or Licensed Psychologist. We were assured that the inability of the CSWs to bill during this time period would not affect the assessment of the ability to sustain the project at the end of the Innovation funding. In addition, as stated above the change to provide services to clients experiencing mild to moderate symptoms reduced the need to remain in contact with Psychiatric Emergency Services for client referrals.

Due to the ongoing pandemic our IMPACT clinicians and Intern provide telehealth services by phone or Zoom to their clients as well as in-person services. This has made IMPACT therapy services more available for clients who have difficulty attending sessions in person. It has also allowed clients to more easily be matched with a therapist who speaks their native language. It has also changed the role of the CSW as they are spending less of their time transporting clients to their IMPACT appointments and are focused on linking the clients to other resources in the community and providing telephone support.

There were several changes that were made at the start of the project due to changes within the health care system. Originally we had planned that our Intern would be administering the Screening, Brief Intervention and Referral to Treatment (SBIRT) in the health centers. This is now completed by health center staff. Also, we had planned for the Intern and CSW to be stationed at PES at times and this was not possible due to space issues at PES. There was also less focus on linkage to Alcohol and Other Drugs Services (AODS) as this need did not come up as often as was anticipated. Our CSWs and Student Interns have frequently attended the monthly Alcohol and Other Drugs Case Conference to understand the substance use issues our client population is struggling with.

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

OUTCOMES:
Please provide summarized information on any data collected during the project, including demographic info, if available.

Demographic data for the Partners in Aging Project will be provided in a separate report submitted by the MHSA Team.

We began utilizing the PEARLS (Program to Encourage Active and Rewarding LiveS) Questionnaire in approximately August 2017 with Partners in Aging clients. The PEARLS is administered when the client begins receiving a service from our Partners in Aging Intern or CSW, every 6 months, and at closing. The PEARLS Questionnaire includes the Patient Health Questionnaire-9 (PHQ-9), and also includes questions on general health, social activities, physical activities and pleasant activities. This questionnaire was developed by researchers at the University of Washington to be used in their community-based, evidence-based treatment program designed to reduce depression in physically impaired and socially isolated people. We worked collaboratively with the Business Intelligence Team to develop a report that would show differences in PEARLS scores over time. At the time of writing this report, the Business Intelligence Team is working to fix this report. The changes in billing systems described above have made it complicated to create a report to show the outcomes of the Partners in Aging Project. We do not have updated data.

Preliminary results of the PEARLS data indicated that all participants showed a decrease in depressive symptoms as measured by the PHQ-9. These decreases ranged an average of 1 point for clients with mild and moderate depression to 5 points for clients with severe depression, which was about 25% of the clients. Clients with severe depression were shown to improve in their overall evaluation of their physical health. Clients with mild to moderate depression were shown to improve their social connections and activities.

PROJECT EVALUATION:
Please provide quantitative and qualitative data regarding evaluation during the course of the project.

- *What was 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.*
- *How did the project evaluation reflect cultural competency?*

In addition to the data from the PEARLS (described above) we have also used PHQ-9 scores, chart

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

review, Monthly Service Summaries, and qualitative interviews with our staff to evaluate the Partners in Aging Project. The PHQ-9 are administered frequently by the IMPACT clinicians. We have requested a report from the Business Intelligence Team to track PHQ-9 scores over time. Building this report was put on hold due to urgent demands on the Business Intelligence Team due to the COVID-19 pandemic.

The PEARLS results described above as well as information from the other sources indicate that the Partners in Aging Program had a positive impact on our IMPACT clients. The preliminary PEARLS results showed different trends depending on the level of severity of the client. It is notable that clients with the most severe depression benefited the most in terms of the reduction in depressive symptoms. This indicates that the current focus of the IMPACT and Partners in Aging Programs on serving clients with moderate to severe depression is likely to lead to significant benefits for the clients served as we go forward. The addition of CSWs to our IMPACT Program has greatly increased the scope of the services that our clients receive and has improved quality of life in countless ways for many clients.

We consistently see the incredible benefits of the collaborative relationship between our CSW, Intern and IMPACT clinicians. Our CSWs provide a different perspective on client functioning based on their experiences with clients in the community. This has had a positive impact on client functioning, progress towards treatment goals, and maintaining client safety. The CSWs have become an essential part of our IMPACT Program!

Unfortunately, we were not able to evaluate this data to see any variation in outcomes related to demographic data due to limitations of the report. As described above the PEARLS was administered at the beginning of Partners in Aging services, every 6 months and at closing. The PEARLS includes the PHQ-9, which assesses depression, and questions that assess general health, social activities, physical activities, and pleasant activities.

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

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.

Our goal is to secure funding to continue to have two Community Support Workers in the Partners in

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

Aging Program. These CSWs have become vital to the functioning of all of our Older Adult Mental Health programs and can continue to support IMPACT as well as our Intensive Care Management Program. We have converted one of these position to a Permanent CSW II position that is now funded under MHSA CSS funding. We are advocating to have the second CSW II position funded. We are collaborating with the MHSA Team and Behavioral Health Administration to have this position created and funded. All MHSA funding for these positions is supplemented by the Medi-Cal billing that our CSWs and Intern complete for billable services. The funding for our Intern will be transitioned to MHSA WET Funds. Our current CSW II has spent approximately 48% to 50% of her time providing direct billable services to Medi-Cal beneficiaries in January, February and March of 2022.

We have attended the Innovations Committee Stakeholder Meeting to advocate for the continuation of the Partners in Aging Program. We have also met with the MHSA Team several times to discuss strategies to continue funding for the Partners in Aging Project, and to advocate for continued funding. We have the support of the Adult and Older Adult Program Chief, Jan Cobaleda-Kegler, Psy.D., to continue this project, and hope to receive approval to create and fill the second CSW II position. We also plan to provide a presentation to the Consolidated Planning and Advisory Workgroup (CPAW) in the near future on the Partners in Aging Project.

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

The Partners in Aging Project learning goals are described below.

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

   Yes. Our CSWs successfully provided services to approximately 22 IMPACT clients to improve their access to IMPACT services during FY 20/21.

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, completing housing applications, maintaining benefits, 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

Contra Costa Behavioral Health Services
1340 Arnold Dr., Ste. 200
Martinez, CA 94553-4639
E-mail: jennifer.bruggeman@cchealth.org

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 CSWs 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 continued to participate in Health Coaching services through April 2021.

7) Does social isolation decrease?

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

clients and have become important sources of support, which has also reduced social isolation.

8) Does quality of life increase?

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

9) Do older adults have improved depression scores?

   Yes, over the 17/18 fiscal year on average 75.8% of IMPACT clients experienced an improvement in depressive symptoms based on their PHQ-9 scores, and 51.6% of these clients experienced a significant improvement (5 points or more). We have requested a new report to evaluate the PHQ-9 scores over time. When IMPACT started using the Ambulatory Medicine documentation tools, and the Federally Qualified Health Center model of billing in November 2017, they gradually stopped using a PHQ-9 tracker since this data was entered in ccLink. We are hoping that this report can separate the clients who received Partners in Aging services from the other IMPACT clients to see if there is a difference in the change in the scores over time between these two groups. The development of this new report was put on hold due to the Business Intelligence Team's need to respond to urgent requests related to the COVID-19 pandemic.

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

Summary: The Partners in Aging Project has achieved its learning goals. We have shown that adding an Interns and CSWs to the IMPACT Program has a positive effect on our clients. Clients engage with peer support workers and greatly benefit from these connections, including developing life skills, meeting self-management goals, linkage community resources, decreasing social isolation, improving quality of life, and reducing depression. The goal related to the SBIRT was no longer relevant to the Partners in Aging Project since this is administered to all patients at the Health Centers. The goal related to reduced recidivism at PES was met with the one client that was referred to us from PES. It is difficult to extrapolate from this one client.

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. <u>Please attach any relevant presentations, brochures or other marketing materials.</u>

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

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.

We have provided several vignettes to illustrate the positive effects of the Partners in Aging Project.

Our CSW assisted a 71-year-old female patient with multiple health issues including blindness and s/p double organ transplants. She worked to assist this client find an IHSS caregiver. She called IHSS and requested a list of caregivers on registry. Due to the absence of a caregiver and blindness this client had trouble going to see her doctors. The CSW provided transportation support so that she could get her medical care. Shelby also picked up her medications after she had a minor surgery. This client benefitted greatly from the support of our CSW, which contributed significantly to her mental health treatment.

Our CSW has been helping a 61-year-old male, who is diagnosed with PTSD, obtain food and pick up his prescriptions. She found a pharmacy service that can mail his prescriptions to him and has been working with the clinician, the client and his Primary Care Provider to work to resolve this. She also took him to the DMV to get an id card after his wallet was stolen.

Our CSW worked with a 56-year-old divorced Caucasian female with a history of Post-Traumatic Stress Disorder, Generalized Anxiety Disorder (severe), Major Depressive Disorder (moderate), fear and low self-esteem. She was going through a very difficult phase in her life which was triggering her and causing her mood dysregulation and severe depression. Around the time she came to see us, the main reason for her distress was her nearly becoming homeless but with the help of our CSW she ended up finding a room for rent in a home with other roommates and was very happy with this. She desperately needed to get her own place and live independently, but her credit status as well as her finances were in poor shape. Our CSW was able to help her link with financial counseling services in

Contra Costa County which included support in filling out multiple forms. She has maintained this residence for over a year. The CSW also helped the client complete job applications countless times after she lost her job. The CSW supported client on multiple occasions, was consistent and always available, in person and by phone. The CSW worked with her to build her Wellness Recovery Action Plan (WRAP). She has been learning to recognize when she is not feeling well and learning to utilize her wellness tools as well as reaching out for help when needed. The CSW continues to work with her on building hope, practicing positive thinking and building self-esteem. Our CSW's care for this client provided great mental health support, in that she became less anxious, less depressed, and more emotionally regulated. These changes greatly contributed to client's stability and increased her hopefulness that she could overcome her financial difficulties to eventually become more independent and have her own living arrangement. She has now been hired at a new job. The support provided by the CSW was invaluable to support us in complementing her mental health treatment.