CPAW AGENDA ITEM
READINESS WORKSHEET

CPAW Meeting Date: 2/2/2017 **Name of Committee**: Innovation

1. Agenda Item Name*: Innovation Project Proposals Process and Update*

2. Desired Outcome: All CPAW members will be informed of current activity on new Innovation Project Proposals

3. Summary:

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 are developed by an ongoing community program planning process that is sponsored by CPAW through its Innovation Committee.

All Innovation Concepts comply with the general requirements of the Mental Health Services Act and comply with the Innovation Regulations approved in 2015. There are three key objectives that need to be applied to the concepts concerning the Innovation Regulations:

- Introduce a mental health practice or approach that is new to the overall mental health system, including but not limited to, Prevention and Early Intervention;
- Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population;
- Apply to the mental health system a promising community driven practice or approach that has been successful in a non-mental health context or setting.

4. Background:

On April 15, 2016 Contra Costa Behavioral Health Services (CCBHS) began the process of developing the Innovation Component of the new MHSA Three Year Plan by inviting concepts, or ideas, to be submitted by any interested stakeholder. All concepts considered needed to be received by June 30, 2016.

A total of 54 concepts were received, reviewed and screened to ensure they met innovation regulation requirements. The Innovation Committee then evaluated and ranked the 13 concepts that met regulatory requirements. The Innovation Committee's recommendations were then provided to the Behavioral Health Services Director, Cynthia Belon, and the Deputy Director, Matthew Luu, for consideration. The Director and Deputy Director selected two concepts to be proposed: Cognitive Behavioral Social Skills Training (CBSST) in Board and Cares, and Center for Recovery & Empowerment (CORE).

Notifications were sent out to all who had submitted concepts on September 20th that reflected the outcomes of the screening process. Groups that were suggested to be part of the project development phase included AOD and Housing and Homeless Services, staff, stakeholders, consumers, and family members. Committees were then tasked with completing the 10-page MHSOAC template for project proposal submission.

The first concept, known as CORE, is an intensive outpatient treatment program for adolescents experiencing both mental health and substance abuse disorders. This project will focus on three levels of care: intensive care, transitional care and continuing care. Upon admission, each consumer would be assigned to a multidisciplinary recovery team consisting of an individual therapist, family therapist, and recovery coach. All adolescents would participate in individual therapy, group therapy, family therapy, "Young People" community twelve-step meetings, and sober events.

The second concept, known as CBSST in Board and Cares, will be to bring mental health care to board and care facilities in which consumers learn and practice skills that will enable them to achieve recovery-based goals. This proposal is for the creation of a clinical team to lead cognitive behavioral social skill training groups at all the board and cares at which CCBHS places consumers.

Project proposals are now in the beginning stages of development. MHSA team member Windy Murphy is supporting both workgroups in order to complete the project proposals. Both Innovation project proposals have been started, and ongoing efforts with the two workgroups are moving towards completion.

5. **CPAW Role:** To be informed and have the opportunity to provide input.

6. **Anticipated Time Needed on Agenda***:* **10** Minutes

7. **Who will report on this item?** Innovation Committee

MHSA Three Year Plan
Proposed Changes for FY 17-20

Addressing Prioritized Needs From the Community Program Planning Process and Needs Assessment Study

CONTRA COSTA
HEALTH SERVICES

Linking to the Community Program Planning Process

CONTRA COSTA
HEALTH SERVICES

1. Supportive Housing

- Special Needs Housing Program (SNHP) funding received November 2016 – Health, Housing and Homeless Division to administer via competitive bid process
- Language added that addresses the “No Place Like Home” statewide initiative that is planned to be implemented during the three year period, and adds a placeholder budget line item for planning supportive housing options

CONTRA COSTA
HEALTH SERVICES

2. Supporting Family Members

- Via Request for Qualifications (RFQ) contract with a local organization to recruit, train and supervise a cadre of volunteers for the purpose of supporting family members of persons experiencing mental illness
- Support to consist of providing education and training, emotional support, assistance with navigating the mental health system, and how to best participate in their loved ones recovery

CONTRA COSTA
HEALTH SERVICES

3. Better Coordination of Care

Two new Innovative Projects to be developed and funded:

- Center for Recovery and Empowerment (CORE) fields a multi-disciplinary team to serve youth with mental health and substance abuse disorders
- Cognitive Behavioral Social Skills Training (CBSST) brings behavioral therapy to consumers housed in board and care facilities

CONTRA COSTA
HEALTH SERVICES

4. Children Needing Intensive Care

Expand Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to provide the full spectrum of community based services via intensive home based services, intensive care coordination, and therapeutic foster care for any child and family who needs it

CONTRA COSTA
HEALTH SERVICES

5. Finding the Right Services

All three adult services clinics to now field Community Support Workers to assist with navigation of services

CONTRA COSTA
HEALTH SERVICES

6. Improved Response to Crisis and Trauma

- Augment the Mental Health Evaluation Team (MHET) to expand capacity of mental health staff to partner with law enforcement in the community
- Train Mental Health First Aid staff to train community organizations and first responders in the basics of mental health issues and be contingency responders in the event of trauma in the community
- Expand the current Crisis Intervention Training for law enforcement officials

CONTRA COSTA
HEALTH SERVICES

7. Support Peer and Family Partner Providers

Better support retention and career progression for Community Support Workers by creating CSW Specialist classification and creating locally administered loan forgiveness program

CONTRA COSTA
HEALTH SERVICES

8. Intervening Early in Psychosis

The County's First Hope Program to add staff to enable the program to now serve transition age youth experiencing a first psychotic break

CONTRA COSTA
HEALTH SERVICES

9. Getting Care in My Culture

Through the statewide Each Mind Matters Initiative the Social Inclusion and Suicide Prevention committees will expand the County's capacity via language specific materials, social media and subject matter consultation with regional and state experts to reach diverse underserved populations, such as Hispanic, African American, Asian Pacific Islander, LGBTQ, Native American and immigrant communities

CONTRA COSTA
HEALTH SERVICES

10. Assistance With Meaningful Activity

CCBHS Vocational Services Program partner with Putnam Clubhouse to utilize flexible funds better support pre-employment efforts

CONTRA COSTA
HEALTH SERVICES

11. Getting To and From Services

The Innovative Project “Overcoming Transportation Barriers” to be fully implemented and funded

CONTRA COSTA
HEALTH SERVICES

12. Care for Homebound Frail and Elderly

The Innovative Project “Partners in Aging” to be fully implemented and funded

CONTRA COSTA
HEALTH SERVICES

13. Serve Those Who Need it the Most

The Assisted Outpatient Treatment Program to be fully implemented and funded

CONTRA COSTA
HEALTH SERVICES

14. Help Moving to a Lower Level of Care as People Get Better

- Needs Assessment Study has established benchmarks for appropriate resourcing by level of mental health care, ranging from locked facilities to basic services for prevention and health maintenance
- CCBHS priority is to move people from locked facilities to intensive services in the community

CONTRA COSTA
HEALTH SERVICES

15. Improve Program and Fiscal Accountability

- Three Year Plan now includes outcome indicators for both FSP and PEI programs
- In current Three Year Plan all MHSA funded programs to have completed program and fiscal review, to include documenting opportunities for improvement
- In new Three Year Plan all MHSA funded programs to undergo a program and fiscal review, to include addressing opportunities for improvement that were surfaced in initial review

CONTRA COSTA
HEALTH SERVICES

Linking to the Quantitative Needs Assessment Study

CONTRA COSTA
HEALTH SERVICES

Strengthen Outreach Strategies for Underserved Populations

PEI programs are aligned with the new seven PEI categories, with all programs required to provide outreach and engagement to those populations who have been identified as traditionally underserved, and six programs now focusing on improving timely access to mental health services for underserved populations

CONTRA COSTA
HEALTH SERVICES

Recruit Psychiatrists and Staff Representing Underserved Populations

- Establish a loan forgiveness program that reduces student loan debt in exchange for completion of service provided to the County
- Establish graduate student internship positions that serve PEI program clients and link with county operated clinics

CONTRA COSTA
HEALTH SERVICES

Needs Assessment

Contra Costa Behavioral Health Services (CCBHS) conducted a quantitative assessment of public mental health need in preparation for developing the Fiscal Year 2017-20 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan (Three Year Plan). This data driven analysis complements the Community Program Planning Process (CPPP), where interested stakeholders provided input on priority needs and suggested strategies to meet these needs.

Data was obtained to determine whether CCBHS was a) reaching the people it is mandated to serve, b) appropriately allocating its resources to provide a full spectrum of care, and c) experiencing any significant workforce shortfalls.

Benchmarks for the CCBHS target population were established for the county and county regions (East, Central, West) as well as by race/ethnicity, age group and identified gender to determine whether CCBHS was serving more or less than these benchmarks. Benchmarks for appropriate resourcing by level of mental health care, ranging from locked facilities to basic services for prevention and health maintenance, were also established to determine whether the level of funding CCBHS spent on each level met recommended standards. Finally, all CCBHS position classifications were reviewed to determine whether any significant shortfalls existed between authorized versus filled positions, staffing demographics, and bi-lingual staff.

Data analysis supports that CCBHS is serving the number of clients that approximate the estimated number of individuals requiring services, and serves more eligible clients than the majority of counties in California. This is based upon prevalence estimates and penetration rates of low income children with serious emotional disturbance and adults with a serious mental illness as compared with other counties. In addition, regions and sub-populations within Contra Costa County are generally appropriately represented, with the exception of Asian/Pacific Islanders, Latina/os, children ages 0-5 years, and adults ages 60 and over as being somewhat underrepresented in each region when compared to other sub-populations within Contra Costa County.

Fiscal Year 2015-16 expenditure data indicate services were available at every level of care as defined by the Level of Care Utilization System (LOCUS/CALOCUS). However, compared to benchmarks, CCBHS over spends on the most acute level of in-patient care (Level 6), and is below the benchmark in expenditures related to programs providing high intensity community-based services (Levels 4 and 5).

Workforce analysis indicates a significant shortage of psychiatry time, both in county positions as well as contract psychiatrists. Compounding the issue of filling vacant psychiatrist positions is that Contra Costa County reimburses psychiatrists at a lower rate than neighboring counties. Latina/o and Asian/Pacific Islander populations are under-represented among county staff when compared to the county population. Finally, CCBHS has incrementally increased the number of bilingual staff each year, and has made available as needed phone, in-person and video interpretation services.

This quantitative needs assessment suggests attention in the following areas:

- Strengthen outreach and engagement strategies for identified underserved populations across the county.
- Improve capacity to assist consumers move from locked facilities to community based services.
- Explore strategies to recruit and retain psychiatrists and staff representing underserved populations.

The Community Program Planning Process

Each year CCBHS utilizes a community program planning process to 1) identify issues related to mental illness that result from a lack of mental health services and supports, 2) analyze mental health needs, and 3) identify priorities and strategies to meet these mental health needs.

CPAW. CCBHS continues to seek counsel from its ongoing stakeholder body, entitled the Consolidated Planning Advisory Workgroup (CPAW). Over the years CPAW members, consisting of consumers, family members, service providers and representative community members, have provided input to the Behavioral Health Services Director as each Three Year Plan and Yearly Update has been developed and implemented. CPAW has recommended that the Three Year Plan provide a comprehensive approach that links MHSA funded services and supports to prioritized needs, evaluates their effectiveness and fidelity to the intent of the Act, and informs future use of MHSA funds. CPAW has also recommended that each year's Community Program Planning Process build upon and further what was learned in previous years. Thus the Three Year Plan can provide direction for continually improving not only MHSA funded services, but also influencing the County's entire Behavioral Health Services Division.

Community Forums. CPAW has been the central planning and implementation resource for fielding each year's Community Program Planning Process. Last year's venue was to engage consumers and family members who participate in MHSA funded Prevention and Early Intervention programs that provide outreach and engagement to underserved populations in their respective communities. This year's venue was to bring together via three community forums consumers, family members, service providers and interested community members by Contra Costa County region (West, Central, and East).

Over 300 individuals attended these three forums (October 6 in San Pablo, November 3 in Pleasant Hill, December 1 in Bay Point), and self-identified as one or more of the following:

- 23% - a consumer of mental health services
- 32% - a family member of a consumer of services
- 39% - a provider of mental health services
- 14% - an interested member of the community

Discussions. Participants actively discussed in small groups ten topical issues that were developed by consumer, family member and service provider representatives before the forums. Highlights of the discussions include:

- **What should services in my culture look like?**
  - Diversity is important, and cultural differences should be understood and respected in a non-judgmental way – need to be culturally humble. A diverse mental health workforce sends a message to non-dominant cultures that difference is honored.
  - We are getting more immigrants who need more support in understanding our laws.
  - Many of our immigrants come from war torn countries and suffer from post-traumatic stress disorder. Care providers need to understand how specific cultures deal with this disorder, as a common tendency is to hide mental illness.
  - Suggest using non-traditional means to gain trust and acceptance, such as music, art, multi-media, and gardening.
  - Suggest developing a cadre of paid and volunteer care providers of the same culture to go to people's homes, as people need to develop trust, and are often fearful of being subjected to legal action.
  - Youth, especially those with a non-heterosexual gender identity, are prone to bullying and are vulnerable to suicidal behavior.
  - For African and Hispanic Americans mental health care should be family centered and/or faith based.
  - Clinicians should understand the ramifications of assigning a mental illness diagnosis.
  - We need more clinicians who speak multiple languages – we are losing them to neighboring counties because of pay disparity.
  - The County should be current with race/ethnicity trends, where Latina/os are moving to the West and African Americans are moving to the Eastern part of the County.
  - Organizations, such as the Native American Health Center, should be educating mental health providers about the various Native American cultures.
  - Medication prescribers need to be sensitive to potential ethnic specific reactions.
  - We need to ensure that translated materials and language interpreters are sensitive to and being understood by the people needing this accommodation.

- **How can I get housing that I can afford?**

- The housing market is way too high to enable low income people to afford rents. We need rent control.
- Section 8 housing is too difficult to navigate to be a resource.
- Affordable housing often means unsafe housing.
- People need access to the internet and help navigating the application process.
- People searching for housing often need some form of stable short-term housing. Sometimes they may need to get help cleaning up and resting at these places so they can be presentable for interviews.
- The east end of the County has the fastest growing population of people not being able to afford housing, and has the least resources to help with this problem.
- Suggest a clearinghouse to assist individuals and their families to find affordable housing. Need to do a better job of sharing housing opportunity information. Need a one stop shopping approach, with a single application.
- More shelter beds needed, especially in the wintertime when it is full.
- Public dollars should go to non-profits with supportive housing expertise, rather than banks and developers.
- More shared housing capacity should be developed, such as elders pooling resources, and families with mental health experience taking in individuals into their homes. Cities should permit "mother-in-law" units.
- Re-purpose abandoned or foreclosed structures for affordable housing.
- Increase the number of board and care homes.
- Advocate for the Board of Supervisors to spend more dollars for housing.
- Flexible funding needed to pay for credit checks, first/last month's rent, moving in and out, and other expenses to enable individuals to obtain housing.
- Organizations should partner to help people get and keep housing.

- **What should care look like for persons with serious mental illness who live in supportive housing?**
  - Services should be provided on site, or have a multi-disciplinary mobile team come to the sites. Mental health, substance abuse and primary health issues should be addressed holistically and in a coordinated fashion.
  - Include life skills support, such as budgeting and money management, cooking, cleaning, home maintenance and conflict resolution skills in order for individuals to keep their residence.
  - Care providers should partner with property managers to deal with behavior issues that might threaten an individual keeping their residency.

- For augmented board and cares specific attention should be given to medication regimens, if professional staff are not located on site.
- Family members living off site should be welcomed and included, as appropriate, and emphasis and rules should be supportive of family reunification.
- Support groups, such as twelve step, should be encouraged.
- Daily meaningful activities, such as self-care regimens, hobby groups, parenting classes, field trips, gardening, site maintenance, pre-vocational activities, before and after school programs and social/cultural activities should be built in, whether at the site or arranged.
- Case management should not drop off when a consumer is placed, but should complement on-site services.
- Housing problems, such as bad food and bed bugs, can trigger mental health problems.
- Before being discharged from psychiatric hospitals persons should have dedicated attention to preparation for living in a less restricted environment, even if it means prolonging their stay to acquire these skills and coping mechanisms.
- It is important not to place supported living residences in high crime and drug environments.
- Each supportive living arrangement should build into all of their activities the goal of improving a consumers living situation, to include moving out to better, more independent housing.
- All of the above would require many more dollars allocated than is currently being budgeted.

- **What does help getting to and from services look like?**
  - Services are too spread out in the County to be accessible. Many countywide services are located in central county, where public transportation is not available to the east and west ends of the County.
  - Using BART/buses can be daunting. Coaching to use public transportation independently would be helpful, to include coping with fears, safety concerns, and responding appropriately to bullying and discrimination.
  - Becoming eligible for discount passes can be difficult. Assistance in becoming eligible would be helpful, as well as the funding to be able to afford vouchers.
  - Suggest a shuttle service that stops at common safe stops, and coordinates with people who live in close proximity to each other, and when people have health/mental health appointments.
  - Assist individuals connect with each other so they can ride together.

- Coordinate appointment scheduling around public transportation schedules.
- Explore voucher system with Uber/Lyft as a means of ride sharing door to door. Expand their business model to include minors.
- Continue moving mental health care out to common safe spots, such as schools, colleges, health centers, so that care is brought closer to where consumers live.
- Assist individuals connect with each other so they can ride together.
- Coordinate appointment scheduling around public transportation schedules.
- Explore voucher system with Uber/Lyft as a means of ride sharing door to door. Expand their business model to include minors.
- Continue moving mental health care out to common safe spots, such as schools, colleges, health centers, so that care is brought closer to where consumers live.
- Expand volunteer services so that drivers can transport consumers.
- Advocate with transit authorities for more accessible public transportation routes and provide more benches and shelters.
- Use smart phones to assist with linking to directions and public transportation availability.

- **Helping family members navigate mental health, medical, and alcohol and drug services – what should that look like?**
  - These services are housed separately, have different eligibility requirements, have different treatment approaches, are poorly coordinated both within themselves and with the education, social services and criminal justice systems, and often have differing, lengthy waiting periods before treatment happens. This is overwhelming for family members.
  - Care providers should work together to provide a more coordinated, whole person team approach that considers and responds to all co-occurring disorders that affect a person simultaneously, to include mental illness, developmental disabilities, health issues, and drug and alcohol problems.
  - Funding streams for these resources should be coordinated such that eligibility does not interfere with or prevent appropriate response and treatment by care providers.
  - Family members of consumers should be included as part of the treatment team, with assistance provided for them to become powerful natural supports in the recovery of their loved ones.
  - Resources should be allocated to establish paid staff to 1) support family members access and navigate current treatment systems, 2) develop family members with lived experience to act as subject matter experts in a volunteer capacity to educate and support other family members in understanding and

best participating in the different systems of care, 3) provide outreach and education to the community to reduce stigma and discrimination pertaining to mental illness, and 4) partner with other organizations to increase community involvement and support in the care of persons with mental illness.
    - Support and education groups for families specific to different cultures and languages need to be increased throughout the County.
    - Family supports need to be developed in and by the various communities in the County, and need to be culturally and linguistically accessible to the families served, irrespective of their ability to pay.
    - Provide a single place of contact in each region of the county for family members to obtain assistance with mobilizing treatment resources for their loved ones.

- **What should emotional support for family members look like?**
    - The biggest support comes from families who have been through similar experiences and who understand what a family is going through.
    - Mental illness affects the entire family, so emotional support should be for everyone, including the siblings.
    - Families often see disturbing behavior and don't recognize that there is a mental illness going on. Early education and awareness is key to de-stigmatizing, learning coping mechanisms and getting loved ones the help they need. When first encountering mental illness they don't know what to do.
    - Learning self-care is empowering.
    - Most helpful is respite care for parents to have a break.
    - Help in understanding, accessing and navigating services is a tremendous emotional support.
    - It is important for people providing emotional support to families to be culturally humble and honor a family's personal beliefs.
    - NAMI has perfected how to support family members and should be funded to expand this support to paid staff. Operating with only volunteers, NAMI has been limited in what they can do; especially providing family support in the east, west and southern portions of the county.
    - Providing NAMI funding would enable expanding outreach to families of youth and adults in the criminal justice system.
    - Recommend providing psychotherapy for family members who have a loved one experiencing mental illness.

- **How should public mental health partner with the community when violence and trauma occur?**

- Schools can identify children traumatized and at risk, but teachers and staff are not equipped to adequately care for the child and their family. Via wraparound funding behavioral health should partner with education on site and in the homes to provide needed mental health services.
- Children under five and kids with special needs are particularly vulnerable, and are often overlooked.
- Persons who are homeless are in continuous trauma.
- There appears to be a recent increase in violence toward immigrants, Muslims and persons who identify themselves as lesbian, gay, bi-sexual, transgender or who question their sexual identity or gender. There is increased fear among these individuals.
- Mental health care should be extended to teachers, police, church staff, and other community organization first responders, as they are dealing with trauma as well. Working closely with the police is especially helpful.
- Care should be brought to the community by staff who are trusted and culturally and linguistically responsive. Non-labeling and confidentiality are most important.
- Care providers who are not properly trained, ill-suited, or abuse the power of their position can do more damage than the trauma itself.
- Relationships and trust should be established with community first responders before violence occurs, through training, workshops and community events.
- First responders need better information regarding what mental health resources are present in their community, and how to access and navigate them.
- The key role of drugs and alcohol leading to violence need to be recognized and included as part of the mental health care.
- Attention should be focused on the perpetrators, in order to break the cycle of violence.
- Some sort of infrastructure needs to be built such that mental health professionals can respond quickly when community trauma occurs.
- Service should be provided immaterial of whether the family has insurance.
- Mental health professionals should be aware and prepared to address learned desensitization, stigma of discussing feelings regarding experienced violence, and distrust of authority figures.
- All behavioral health staff should stay current with the latest in trauma informed response and care.
- Ending up in the County's psychiatric in-patient ward does not help the person, and often signals a failure to prevent hospitalization.

- **How do we care for young people who have both mental health and alcohol and drug problems?**
    - Currently there is no coordinated outpatient mental health and alcohol/drug treatment services for adolescents, and very limited in-patient treatment. This often leads to juvenile hall.
    - We should be providing all levels of care in one place, from intensive to continuing care.
    - First responders, such as mental health probation liaisons, delinquency boards, faith based groups and teachers trained to recognize symptoms can act as referral sources.
    - Should engage the whole family. Part of the therapy is education regarding addiction as being a "family disease". Also, there is the reality of relapse when returning a youth to a family that is still using and abusing drugs and alcohol.
    - Successful graduates of treatment are ideal to act as peer mentors.
    - Best practices should be determined by the culture the youth is a part of.
    - Mental health and substance use disorder professionals need to be cross trained in each other's disciplines, as well as how to work together as team.
    - Medi-Cal eligibility should not be a barrier, as the need in this age group is overwhelming and cuts across all levels of society.
    - Mental health providers should be able to bill Medi-Cal for substance use disorder treatment the same as they do for mental health disorders.
    - There should be a substance use disorder professional co-located at each regional mental health clinic.
    - School district administrators should be partnered with to establish as part of the district's educational plan curricula regarding mental health/substance use disorders and the neuropsychiatry of addiction.
    - Marketing and education efforts should utilize more social media modes than current the method of flyers and other hard copy materials.

- **How do we help people who get better move to lower levels of care?**
    - There should be discussion of and planning for use of less acute levels of service right from the beginning, so that consumers are prepared to demonstrate higher levels of self-care as they move to lower levels of professional care.
    - Systems of care should be as flexible and non-judgmental as possible to reduce resistance (stigma and embarrassment) when higher levels are needed due to external factors. These setbacks, when properly handled, enable greater learning and better use of lower levels of care when the person is ready.

- All of our various programs need to do a better job of coordinating care and "warm hand offs" with each other.
- Mentoring plays an important role in people's success. A single mentor with lived experience reinforcing the goal of self-sufficiency and supporting movement to different levels helps.
- As many levels of care in one place helps. Permanent supportive housing, with many levels of care on site, is a good model.
- Make sure that there is a lower level of care to go to and utilize. For example, returning to a gang as the only means for social connectivity is not helpful.
- Emphasizing spirituality as part of the healing process at all levels facilitates a deeper and unified approach to wellness, and assists in seeing a level of care as a milestone, and not an end in itself.
- Incorporating meaningful activity at all levels focuses on strengths, and can be built upon as one navigates care.
- Varying levels of employment, from volunteering, to subsidized employment, to competitive jobs in the community can support recovery.
- Recommend utilizing today's tools of apps and social media to facilitate incorporation of self-care into daily health and mental health habits.
- Teaching life and social skills at all levels also is key to the recovery process.
- Inclusion and involvement of the family and other natural supports are important.
- The current model of state and federal reimbursements need to be addressed in order to incentivize counties to facilitate appropriate movement of consumers to lower cost treatment based upon their recovery progress, and not on the need of the system to save money. Current Medi-Cal billing makes this difficult.

- **What community mental health needs and strategies would you like to discuss that have not been mentioned?**
  - Pre-employment services need to be expanded so that people have the whole range of activities that can prepare them for employment, to include volunteer experiences and internships. These services are particularly lacking for transitional age youth. Suggest partnering with the Career Resource Centers throughout the county.
  - Aging felons are coming out of prison after experiencing many years of trauma and do not have any place to go or any support system.
  - Young people experiencing a first psychotic break can receive effective treatment that enables recovery. This county needs funding to establish a first break program.
  - NAMI should receive financial support to support and educate families of persons with mental health issues.

- The hearing impaired need mental health services.
- Many immigrants and undocumented persons are now fearful and distrustful of the system. We need to provide safe spaces for them to get the care they need.
- We need a substance use detoxification program in each region of the county that includes mental health treatment.
- We cannot get any psychiatry time in our part of the county.
- Would like one stop centers that are inclusive and inviting, such as senior centers and the Family Justice Center.
- People need to have services and supports in their native language.
- Children with special needs, such as learning and developmental disabilities have a hard time getting mental health services.
- Money management, or benefits counseling is no longer offered and is sorely need for consumers so that they can access and navigate financial benefits, manage their money, and not get taken advantage of.
- Faith based spiritual work should be included as part of the recovery process.
- Foster youth mental health services are lacking.
- Youth need safe places to go where they see other youth that look like them and mental health discussions are normalized to reduce stigma and discrimination.
- Expand the SPIRIT program to support internships outside of behavioral health settings. Consider internships before as well as after the classroom training.
- More adequate psychiatric emergency facilities are needed.
- Children out of county placements are a hardship for the family.
- Parents of adult children with serious mental illness could use respite care.

As part of the event participants were then asked to prioritize via applying dot markers the following identified needs from previous years' community program planning processes. This provides a means for evaluating perceived impact over time of implemented strategies to meet prioritized needs. Needs are listed in order of priority as determined by forum participants, with previous Three Year Plan rankings provided for comparison.

1. **More housing and homeless Services.** (Previous rank: 1) The chronic lack of affordable housing make this a critical factor that affects the mental health and well-being of all individuals with limited means. However, it is especially deleterious for an individual and his/her family who are also struggling with a serious mental illness. A range of strategies that would increase housing availability include increasing transitional beds, housing vouchers, supportive housing services, permanent housing units with mental health supports, staff

assistance to locate and secure housing in the community, and coordination of effort between Health, Housing and Homeless Services and CCBHS.

2. **More support for family members and loved ones of consumers.** (Previous rank: 11) Critical to successful treatment is the need for service providers to partner with family members and significant others of loved ones experiencing mental illness. Stakeholders continued to underscore the need to provide families and significant others with education and training, emotional support, and assistance with navigating the system.

3. **Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care.** (Previous rank: 3) Integrating mental health, primary care, drug and alcohol, homeless services and employment services through a coordinated, multi-disciplinary team approach has been proven effective for those consumers fortunate to have this available. Often cited by consumers and their families was the experience of being left on their own to find and coordinate services, and to understand and navigate the myriad of eligibility and paperwork issues that characterize different service systems. Also cited was the difficulty of coordinating education, social services and the criminal justice systems to act in concert with the behavioral health system.

4. **Children and youth in-patient and residential beds.** (Previous rank: 6) In-patient beds and residential services for children needing intensive psychiatric care are not available in the county, and are difficult to find outside the county. This creates a significant hardship on families who can and should be part of the treatment plan, and inappropriately strains care providers of more temporary (such as psychiatric emergency services) or less acute levels of treatment (such as Children's' clinics) to respond to needs they are ill equipped to address. Additional funding outside the Mental Health Services Fund would be needed to add this resource to the County, as in-patient psychiatric hospitalization is outside the scope of MHSA.

5. **Finding the right services when you need it.** (Previous rank: 8) Mental health and its allied providers, such as primary care, alcohol and other drug services, housing and homeless services, vocational services, educational settings, social services and the criminal justice system provide a complexity of eligibility and paperwork requirements that can be defeating. Just knowing what and where services are can be a challenge. Easy access to friendly, knowledgeable individuals who can ensure connection to appropriate services is critical.

6. **Improved response to crisis and trauma.** (Previous rank: 4) Response to crisis situations occurring in the community needs to be improved for both adults and children. Crisis response now primarily consists of psychiatric emergency services located at the Contra Costa Regional Medical Center (CCRMC). There are few more appropriate and less costly alternatives.

7. **Support for peer and family partner providers.** (Previous rank: 7) CCBHS was acknowledged for hiring individuals who bring lived experience as consumers and/or family members of consumers. Their contributions have clearly assisted the County to move toward a more client and family member directed, recovery focused system of care. However, these individuals have noted the high incidence of turnover among their colleagues due to exacerbation of mental health issues brought on by work stressors, and lack of support for career progression. Individuals in recovery who are employed need ongoing supports that assist with career progression, and normalizes respites due to relapses.

8. **Intervening early in psychosis.** (Previous rank: 5) Teenagers and young adults experiencing a first psychotic episode are at risk for becoming lifelong consumers of the public mental health system. Evidence based practices are now available that can successfully address this population by applying an intensive multi-disciplinary, family based approach. A proposed strategy is to expand the target population now served by Project First Hope from youth at risk for experiencing a psychotic episode to include those who have experienced a "first break".

9. **Getting care in my community, in my culture, in my language.** (Previous rank: 9) Focus groups underscored that mental health stigma and non-dominant culture differences continue to provide barriers to seeking and sustaining mental health care. Emphasis should continue on recruiting and retaining cultural and linguistically competent service providers (especially psychiatrists), training and technical assistance emphasis on treating the whole person, and the importance of providing on-going staff training on cultural specific treatment modalities. Also, culture-specific service providers providing outreach and engagement should assist their consumers navigate all levels of service that is provided in the behavioral health system. Transition age youth, to include lesbian, gay, bi-sexual, transgender and questioning youth, who live in at-risk environments feel particularly vulnerable to physical harassment and bullying. Stakeholders

continued to emphasize MHSA's role in funding access to all levels of service for those individuals who are poor and not Medi-Cal eligible.

10. **Assistance with meaningful activity.** (Previous rank: 2) Stakeholders underscored the value of engaging in meaningful activity as an essential element of a treatment plan. Youth in high risk environments who are transitioning to adulthood were consistently noted as a high priority. For pre-vocational activities, suggested strategies include providing career guidance, assistance with eliminating barriers to employment, and assistance with educational, training and volunteer activities that improve job readiness. Stakeholders highlighted the need for better linkage to existing employment services, such as job seeking, placement and job retention assistance. For daily living skills, suggested strategies include assistance with money and benefits management, and improving health, nutrition, transportation, cooking, cleaning and home maintenance skill sets.

11. **Getting to and from services.** (Previous rank: 10) The cost of transportation and the County's geographical challenges make access to services a continuing priority. Flexible financial assistance with both public and private transportation, training on how to use public transportation, driving individuals to and from appointments, and bringing services to where individuals are located, are all strategies needing strengthening and coordinating.

12. **Care for homebound frail and elderly.** (Previous rank: 14) Services for older adults continue to struggle with providing effective treatment for those individuals who are homebound and suffer from multiple physical and mental impairments. Often these individuals cycle through psychiatric emergency care without resolution.

13. **Serve those who need it the most.** (Previous rank: 12) Through MHSA funding the County has developed designated programs for individuals with serious mental illness who have been deemed to be in need of a full spectrum of services. These are described in the full service partnership category of the Community Services and Supports component. In spite of these programs, stakeholders report that a number of individuals who have been most debilitated by the effects of mental illness continue to cycle through the most costly levels of care without success.

14. **Help with moving to a lower level of care as people get better.** (Previous rank: 13) Levels of care range from in-patient hospitalization to intensive case

management to therapy and medication to self-care recovery services. Stakeholders (both care providers and receivers) consistently cited the difficulty in moving from one level of care to another. Consumers often cited the disincentive to getting better, as it meant loss of care altogether. Consumers and their families indicated that this system inattention to level of care movement often interfered with the important work of minimizing or eliminating the level of psychotropic medications needed to maintain recovery and wellness. Often a "meds only" service response was not responsive to appropriate lower levels of medication and/or psychosocial support alternatives. Care providers indicated that they faced the choice of either ending service or justifying continuance of a more intensive level of care than was needed. Continuity of care from a more intensive to a less intensive level and vice-versa need to be improved.

15. **Better communication, program and fiscal accountability to enable stakeholder participation.** (Previous rank: 15) The stakeholder community has requested CCBHS to provide more transparent and ongoing program and fiscal information and decision-making in order to better understand what is working well, what needs to improve, and what needs to change in order to address identified priority needs. This would enable a better working partnership in planning, implementation and evaluation between consumers, their families, service providers, and administration.

Summary. The community program planning process identifies current and ongoing mental health service needs, and provides direction for MHSA funded programs to address these needs. It also informs planning and evaluation efforts that can influence how and where MHSA resources can be directed in the future.

The full complement of MHSA funded programs and plan elements described in this document are the result of current as well as previous community program planning processes. Thus, this year's planning process builds upon previous ones. It is important to note that stakeholders did not restrict their input to only MHSA funded services, but addressed the entire health and behavioral health system. The MHSA Three Year Program and Expenditure Plan operates within the laws and regulations provided for the use of the Mental Health Services Act Fund. Thus, the Three Year Plan contained herein does not address all of the prioritized needs identified in the community program planning process, but does provide a framework for improving existing services and implementing additional programs as funding permits.

MHSA Monthly Budget Report

Fiscal Year 2016-17

July 2016 through December 2016

Summary

	Approved MHSA Budget	Expenditures	Projected Expenditures
• CSS	31,568,631	$ 11,567,306	$ 29,931,517
• PEI	8,037,813	3,300,089	8,028,827
• INN	2,019,494	714,033	1,953,902
• WET	638,871	171,335	549,080
• CF/TN	849,936	417,613	256,197
Total	**43,114,745**	**$ 16,170,375**	**$ 40,719,522**

- Approved MHSA Budget means the funds set aside, or budgeted, for a particular line item prior to the start of the fiscal year.
- Expenditures means the funds actually spent in the fiscal year by the end of the month for which the report was made.
- Projected Expenditures means the funds that are estimated to be spent by the end of the fiscal year.

Disclosures:

1) Cost centers are used to track expenditures. MHSA cost centers are: 5713, 5714, 5715, 5721, 5722, 5723, 5724, 5725, 5727, 5735, 5753, 5764, 5868, 5899, and 5957. MHSA program plan elements include expenditures from multiple MHSA cost centers. Therefore, expenditures reported in the County's Expenditure Detail Report may not tie exactly to the MHSA program plan elements.

2) Various projected expenditures are based on rolling average of actual expenses.

3) Actual expenditures for the quarter ending September 30, 2015 are not reflective of the projected annual expenditures due to lags in receiving invoices from Community Based Ogranizations (CBOs) and Contracted Agencies Therefore, projected expenditures are the same as the approved MHSA Budget for the first quarter.

CSS Summary

	Approved MHSA Budget	Expenditures	Projected Expenditures
• Full Service Partnerships			
– Children	$ 2,885,820	$ 1,119,566	$ 2,753,395
– Transition Age Youth	2,085,642	420,698	1,957,964
– Adults	5,062,092	1,641,214	3,690,168
– Adult Clinic FSP Support	1,788,059	559,576	1,507,311
– Recovery Centers	875,000	377,280	870,708
– Hope House	2,088,741	668,175	2,038,149
– Housing Services	4,886,309	1,781,768	7,155,154
Full Service Partnerships Sub-Total	**$ 19,671,663**	**$ 6,568,276**	**$ 19,972,849**
• General System Development			
– Older Adults	$ 3,560,079	$ 1,559,182	$ 3,253,804
– Children's Wraparound	2,161,975	761,267	1,462,375
– Assessment and Recovery Center - Miller Wellness Center	500,000	158,389	295,752
– Liaison Staff	513,693	61,624	98,951
– Clinic Support	1,201,636	585,264	1,148,309
– Forensic Team	493,973	141,129	265,824
– Quality Assurance	1,176,672	595,887	1,246,126
– Administrative Support	2,288,940	1,136,287	2,187,526
General System Development Sub-Total	**$ 11,896,968**	**$ 4,999,029**	**$ 9,958,668**
	$ 31,568,631	**$ 11,567,306**	**$ 29,931,517**

CSS - FSP Children's

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Personal Service Coordinators - Seneca	$ 562,915	$ 189,030		$ 562,915
• Multi-dimensional Family Therapy – Lincoln Center	874,417	219,947		874,417
• Multi-systemic Therapy – COFY	650,000	395,452		650,000
• Children's Clinic Staff – County Staff	798,488	315,138	1	666,063
Total	**$ 2,885,820**	**$ 1,119,566**		**$ 2,753,395**

Note:

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

CSS - FSP Transition Age Youth

- Fred Finch Youth Center
- Youth Homes
- Other Costs

	Approved MHSA Budget	Expenditures		Projected Expenditures
	$ 1,400,642	$ 308,851	1	$ 1,272,341
	665,000	111,377	1	673,016
	20,000	470		12,606
Total	**$ 2,085,642**	**$ 420,698**		**$ 1,957,964**

CSS - FSP Adults – Agency Contracts

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Assisted Outpatient Treatment	$ 2,250,000	$ 550,665	1	$ 1,510,102
• Rubicon	$ 928,813	$ 27,485	2	$ 27,485
• Anka	768,690	206,444	1	695,735
• Familias Unidas (Desarrollo Familiar)	207,096	61,443	1	217,688
• Hume Center	907,493	687,135		1,138,586
• Crestwood Behavioral Hlth	-	41,905		100,572
• Resource Development Associates	-	66,138	3	-
Total	**$ 5,062,092**	**$ 1,641,214**		**$ 3,690,168**

Note:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.
2) Rubicon's contract ends in FY15-16. Partial expenditure from FY15-16 posted in FY16-17 due to delayed billing.
3) RDA's expenditures will be moved to General System Development- Administrative Support.

CSS - Supporting FSPs

	Approved MHSA Budget	Expenditures	Projected Expenditures
• Adult Clinic Support - FSP support, rapid access, wellness nurses	$ 1,788,059	$ 559,576	$ 1,507,311
• Recovery Centers – Recovery Innovations	875,000	377,280	870,708
• Hope House - Crisis Residential Program	2,088,741	668,175 [1]	2,038,149
Total	**$ 4,751,800**	**$ 1,605,030**	**$ 4,416,168**

Note:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.

CSS - Supporting FSPs
Housing Services

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Supportive Housing – Shelter, Inc	$ 1,663,668	$ 1,025,181		$ 2,030,447
• Supportive Housing – Bonita House (proposed)	220,000	-	1	-
• Augmented Board & Care – Crestwood	411,653	298,171		567,391
• Augmented Board & Care – Divines	4,850	960	3	3,546
• Augmented Board & Care – Modesto Residential	90,000	34,020	3	102,060
• Augmented Board & Care – Oak Hills	21,120	8,158		16,768
• Augmented Board & Care – Pleasant Hill Manor	30,000	(12,653)	4	83,861
• Augmented Board & Care – United Family Care	271,560	209,475		453,840
• Augmented Board & Care – Williams	30,000	14,555		31,409
• Augmented Board & Care – Woodhaven	13,500	3,750		9,000
• Shelter Beds – County Operated	1,672,000	-	2	1,691,254
• Housing Coordination Team – County Staff	457,958	197,504		2,160,285
• Other Costs	-	2,646	5	5,293
Total	**$ 4,886,309**	**$ 1,781,768**		**$ 7,155,154**

Note:

1) Bonita House is still in planning phase.

2) Shelter Beds expenditures will be recorded at year end.

3) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.

4) The negative expenditure is reversal of prior year expenditure accrual. This amount will be net to zero when actual prior year expenditure is posted.

5) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

CSS - General System Development Services

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Older Adult Clinic - Intensive Care Mgmt , IMPACT	$ 3,560,079	$ 1,559,182	1	$ 3,253,804
• Wraparound Support – Children's Clinic	2,161,975	761,267	1	1,462,375
• Assessment and Recovery Center (MWC)	500,000	158,389	1	295,752
• Liaison Staff - Regional Medical Center	513,693	61,624	1	98,951
• Money Management – Adult Clinics	617,465	305,067	1	587,913
• Transportation Support – Adult Clinics	213,693	67,437	1	134,875
• Evidence Based Practices – Children's Clinics	370,478	212,760	1	425,520
• Forensic Team – County Operated	493,973	141,129	1	265,824
Total	**$ 8,431,356**	**$ 3,266,855**		**$ 6,525,015**

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

CSS - General System Development
Administrative Support

	Approved MHSA Budget	Expenditures [1]	Projected Expenditures
• Quality Assurance			
– Utilization Review	199,329	105,734	211,467
– Medication Monitoring	631,460	347,095	730,194
– Clinical Quality Management	345,884	143,058	304,465
– Clerical Support			
Quality Assurance Total	**$ 1,176,672**	**$ 595,887**	**$ 1,246,126**
• Administrative Support			
– Project and Program Managers	$ 757,210	$ 401,400	$ 667,086
– Clinical Coordinators	213,902	57,467	114,934
– Planner/Evaluators	260,400	171,386	376,191
– Family Service Coordinator	105,205	38,030	76,061
– Administrative/Fiscal Analysts	424,212	291,888	528,808
– Clerical Supervisor	-	-	-
– Clerical Support	390,310	100,551	200,880
– Community Planning Process - Consultant Contracts	100,000	-	100,000
– Other Costs	37,703	75,565	123,566
Administrative Support Total	**$ 2,288,940**	**$ 1,136,287**	**$ 2,187,526**
Total	**$ 3,465,612**	**$ 1,732,174**	**$ 3,433,653**

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

PEI Summary

	Approved MHSA Budget	Expenditures [1]	Projected Expenditures
• Prevention – Outreach and Engagement			
– Reducing Risk of Developing a Serious Mental Illness			
• Underserved Communities	$ 1,476,176	$ 419,049	$ 1,444,479
• Supporting Youth	1,550,954	595,998	1,641,877
• Supporting Families	585,434	230,033	601,181
• Supporting Adults , Older Adults	736,435	305,206	645,887
– Preventing Relapse of Individuals in Recovery	533,400	224,238	549,402
– Reducing Stigma and Discrimination	692,987	190,098	365,030
– Preventing Suicide	416,343	191,537	434,179
Prevention Sub-Total	$ 5,991,728	$ 2,156,159	$ 5,682,036
• Early Intervention – Project First Hope	$ 1,685,607	$ 1,036,831 [1]	$ 2,133,539
• Administrative Support	360,478	107,099 [1]	213,252
Total	**$ 8,037,813**	**$ 3,300,089**	**$ 8,028,827**

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

PEI – Outreach and Engagement
Underserved Communities

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Asian Community Mental Health	$ 130,000	$ -	1	$ 130,514
• Center for Human Development	133,000	63,437	1	128,879
• Jewish Family & Children's Services	159,679	50,348	1	156,154
• La Clinica de la Raza	256,750	89,173	1	264,453
• Lao Family Community Development	169,926	87,842	1	140,813
• Native American Health Center	213,422	58,752	1	193,797
• Rainbow Community Center	220,505	69,497	1	225,423
• Tides Center - BBK	192,894	-	1,2	204,447
Total	**$ 1,476,176**	**$ 419,049**		**$ 1,444,479**

Note:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.
2) Tides Center replaced YMCA contract.

PEI – Outreach and Engagement
Supporting Youth

		Approved MHSA Budget		Expenditures		Projected Expenditures
• James Morehouse Project (West CC YMCA)		$ 94,200		$ 33,950	1	$ 97,026
• Project New Leaf (Martinez USD)		170,000		38,169	1	151,546
• People Who Care		203,594		57,732	1	209,701
• RYSE		460,427		188,604	1	474,240
• STAND! Against Domestic Violence		122,733		46,502		126,415
• Families Experiencing Juvenile Justice System		500,000		231,041		582,950
	Total	**$ 1,550,954**		**$ 595,998**		**$ 1,641,877**

Note:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.

PEI – Outreach and Engagement
Supporting Families

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Child Abuse Prevention Council	$ 118,828	$ 33,475	1	$ 122,826
• Contra Costa Interfaith Housing	64,526	26,680	1	66,462
• Counseling Options Parenting Education (Triple P)	225,000	70,627	1	231,750
• First Five	75,000	75,000	2	75,000
• Latina Center	102,080	24,250	1	105,142
Total	**$ 585,434**	**$ 230,033**		**$ 601,181**

Note:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.
2) $75,000 is prior fiscal year expenditure posted in current fiscal year due to delayed billing.

PEI – Outreach and Engagement
Supporting Adults and Older Adults

	Approved MHSA Budget	Expenditures		Projected Expenditures
• MH Clinicians in Concord Health Center	$ 246,986	$ 130,323	1	$ 260,645
• Lifelong Medical Care	118,970	43,531	2	122,538
• Senior Peer Counseling Program	370,479	131,352	1	262,704
Total	**$ 736,435**	**$ 305,206**		**$ 645,887**

Note:

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

2) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.

PEI

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Preventing Relapse				
– Putnam Clubhouse	$ 533,400	$ 224,238	1	$ 549,402
• Reducing Stigma				
– Office of Consumer Empowerment	692,987	190,098	1	365,030
• Preventing Suicide				
– Contra Costa Crisis Center	292,850	125,265	1	301,636
– MH Clinician Supporting PES, Adult Clinics	123,493	66,272	1	132,544
	$ 416,343	$ 191,537		$ 434,179
• Early Intervention				
– Project First Hope	$ 1,685,607	$ 1,036,831	1	$ 2,133,539
• Administrative Support	360,478	107,099	1	213,252
Total	**$ 3,688,815**	**$ 1,749,803**		**$ 3,695,402**

Note:

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

INN

		Approved MHSA Budget	Expenditures		Projected Expenditures
• Supporting LGBTQ Youth – Rainbow Community Center		$ 420,187	$ 200,198		$ 600,593
• Women Embracing Life Learning – County Operated		194,652	134,563	1	269,127
• Trauma Recovery Project – County Operated		123,492	-	1	107,520
• Reluctant to Rescue – Community Violence Solutions		126,000	-	2	-
	Sub-Total	$ 864,331	$ 334,761		$ 977,240
• Wellness Coaches - County Operated		$ 277,445	$ 211,614	1	$ 480,144
• Vocational Services for Unserved (proposed)		251,982	-		-
• Partners in Aging - County Operated		251,982	17,761	1	98,796
• Overcoming Transportation Barriers (proposed)		251,982	-		-
• Other Costs		-	9,445	1	116,821
	Sub-Total	$ 1,033,390	$ 238,821		$ 695,760
• Administrative Support		121,773	140,451	1	280,901
	Total	**$ 2,019,494**	**$ 714,033**		**$ 1,953,902**

Note:

1) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

2) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.

WET

	Approved MHSA Budget	Expenditures		Projected Expenditures
• Workforce Staffing Support				
– Administrative Support	$ 197,800	$ 25,481	4	$ 109,049
• Training and Technical Assistance				
– Staff Training – Various Vendors	59,500	2,063	1	8,875
– SPIRIT – TBD	23,500	-	1	-
– Family to Family – NAMI Contra Costa	20,000	5,904	1	20,000
– Law Enforcement – Various Vendors	5,000	2,400	1	10,000
• Mental Health Career Pathway Programs				
– High School Academy – Contra Costa USD	3,000	-	2	-
• Residency, Internship Programs				
– Graduate Level Internships – County Operated	199,382	75,171	4	181,317
– Graduate Level Internships – Contract Agencies	100,000	8,032	1	134,500
• Financial Incentive Programs				
– Bachelor, Masters Degree Scholarships	-	-	3	-
• Other Costs	30,689	52,284	4	85,338
Total	**$ 638,871**	**$ 171,335**		**$ 549,080**

Notes:

1) This is not reflective of the projected annual expenditures due to lags in receiving invoices from CBOs and Contracted Agencies.
2) High School Academy is the planning phase.
3) The Bachelor, Masters Degree Scholarships is in the planning phase.
4) Certain County-operated MHSA programs are staffed by individuals assigned to various departments (cost centers). Since this report is based on specific program elements, expenditures for these programs should be considered reasonable estimates. Although this may give the appearance that a specific program is underfunded or overfunded, the total expenditures reported accurately reflects all MHSA-related program costs.

Capital Facilities/Information Technology

	Approved MHSA Budget	Expenditures	Projected Expenditures
• Electronic Mental Health Records System	849,936	417,613 [1]	256,197
Total	**$ 849,936**	**$ 417,613**	**$ 256,197**

Note

1) This amount represents full contract cost from July to December for both MH and MHSA. Non-MHSA share of cost will be moved to MH.