



Contra Costa Mental Health

Mental Health Services Act
Community Services and Supports
Implementation Progress Report

Period: January 1, 2007 – December 31, 2007

This report provides progress toward implementation of Contra Costa Mental Health's Community Services and Supports (CSS) Implementation Plan for the period of January 1, 2007 through December 31, 2007. It also includes some information for the current year where appropriate. The report follows the format required in DMH Info Notice 08-08:

<http://www.dmh.cahwnet.gov/DMHDocs/docs/notices08/08-08.pdf>



A. Program/Services Implementation

1. Progress on Work Plans

Workplan #1: Children's Full Service Partnership (FSP)

a) Progress Toward Implementation

The revised timeline for start-up of the Children's FSP – Families Forward -- as discussed in our last progress report was to be first quarter, 2007. During this quarter, we successfully completed contracting for our community partners, hired a Mental Health Program Supervisor and begin program implementation. Community partners are: Familias Unidas (lead agency) and Asian Pacific Psychological Services.

It took until the second quarter of 2007 to find, renovate and move into an office space in Far East County. During this time, enrollment protocols, team development and the building of community contacts and relationships were also ongoing. Outreach and engagement began in June, 2007. The first participants were enrolled September, 2007. Language capacities of staff include: Spanish, Portuguese, Vietnamese and Tagalog.

The collaborative has established a Community Advisory Board which meets quarterly.

Outreach and engagement has included:

- The development of program materials – brochure and flyers
- Phone and face-face meeting with public and private providers in the area
- On-site outreach to such places as: Day laborers at Home Depot, produce packing camps, police agencies, youth service offices, high schools, donut and nail shops and churches.

Outreach and engagement by the end of 2007 included contact with 529 potential clients, resulting in engagement of 98 clients over 265 hours. Additionally, there were 20 community forums/presentations reaching 470 individuals.

Enrollment:

Exhibit 6 has been submitted. In summary, by the end of 2007, 9 clients were actually enrolled against the originally estimated 90 (10%). While this is behind the originally envisioned schedule, it is steadily increasing. For example, by the end of first quarter, 2008, enrollment increased to 32 and by May 22, it had risen to 41.

Reasons for slow early enrollment include:

- Late start-up, difficulties of finding appropriate space to rent in the area
- Very long engagement periods were not resulting in enrollments on a timely basis. The point when engagement turns to enrollment was refined.
- With a full wrap-around approach, it is difficult/very labor intensive to be starting too many new cases at once, which results in slower but steady enrollment.
- Arrangements for housing as part of the range of supports available took longer than other aspects of program development and housing did not become available until the very end of 2007. No families were housed in 2007.

b) Implementation Challenges included:

- The logistics of starting a collaborative effort such as this were complex. MediCal contracting did not allow the collaborative – made up of more than one community-based agency – to bill as a unit for services. This resulted in each organization needing to contract separately with the County, and bill separately for MediCal. Ultimately, this is divisive to the concept of collaboration. Separate paperwork and separate tracking mechanisms needed to be developed and implemented at the same time that the different groups were working to define themselves as a team.
- The first Program Director that was originally hired left in the 2/4, 2007 after only 3-4 months on the job. This “suspended” some start-up progress until a new Director could be hired and trained. The current Program Director was hired in September, 2007 and is working out well.
- The primary target population for this FSP is uninsured families earning up to 300% of the poverty level. However, because Far East County is so isolated, we are finding unserved MediCal-eligible families well. We have gone ahead and enrolled some MediCal families into the program and will continue to review our eligibility policy.

Workplan II: Transition Age Youth FSP

a) Progress Toward Implementation

County contracting with community collaborators for the Transition Age Youth Program (TAY) was completed in the second quarter of 2007. Community partners include: Fred Finch Youth Center (lead agency), the Greater Richmond Interfaith Program (GRIP) and the Latina Center. The county's Homeless Services Program is also a partner on the project.

A TAY Workgroup, formed in late 2006, continues to meet to provide oversight to the development of the program and coordination with existing homeless services for young adults. While some groundwork was laid before contracting with community partners was complete, significant emphasis on outreach, engagement and enrollment did not begin until May, 2007 when there was adequate staff to run full programming. Key achievements of the period include: Pulling the complex collaborative team together, establishing referral mechanisms, housing resources and communications among collaborative members and with key community leaders/agencies. The program is also quite proud of the solid relationships that it has been able to build with its TAYs. Current language capacities include Spanish, Lao, Thai and Turkish.

The TAY FSP has housed almost all of its FSPs in a range of available places including the existing youth shelter, existing transitional housing, and in their own apartments. Family reunification has also been successful on several occasions. See section on Housing for additional information.

Outreach, Engagement and Enrollment

Exhibit 6 Data show that the TAY program made contact with 70 potential clients by the end of 2007, more fully engaging 17 of them and enrolling 14. This is below the originally targeted number of 100 (14%) but doubled to 28 by the end of 1st quarter, 2008 and rose to 35 by May 22, 2008.

b) Implementation Challenges

Implementation challenges have includes:

- As with the Children's FSP, a key start-up challenge has been the need to build working relationships in the midst of rapid start-up. It takes time to establish protocols and communications for a new program being run by a single organization – and the FSPs are blending multiple community-based organizations with the county for broad collaborative efforts.
- One key lead staff person, who was hired early, stayed only a few months. Two other outreach workers that were hired in the Fall of 2007 also did not stay. As of first quarter, 2008, two Personal Service Coordinator positions are still vacant. Reasons for this high start-up turnover seem to be the combination of high expectations for the training and experience of staff, with relatively low pay. Most staff that have left, have gone to higher paying positions.
- The collaborative has also learned that it takes much longer to engage and enroll TAYs than it does adults. They are very mobile. They are very unsure of what they want week to week. Sometimes they disappear for weeks at a time and then show back up. To address this, protocols for engagement, tracking, when to “give up” on engagement, and when to enroll have needed to be refined. This coming and going affects staff caseload capacities as well.
- It has been difficult to hire and retain peer mentors as well. Three of the four peer mentors that were originally hired left in the first few months. They did not have the skill level or training needed to do the job. The collaborative has been taking its time to rehire for those positions – looking for the characteristics and skills that are most needed, and providing

strong support after the hire. The county is looking at ways to address consumer training issues such as this through the Workforce Education and Training component of MHSA – where planning is now underway.

Workplan 3: Adult FSP – Bridges to Home

a) Progress Toward Implementation

Contracting for collaborating partners for the Adult FSP program was completed in the second quarter of 2007. As reported previously, this was later than originally anticipated. The group had been meeting to begin planning implementation before contracting was complete. This was intensified after contracting. Space within an existing Rubicon Programs building (lead contractor) was remodeled for MHSA use and the program formally opened in September, 2007.

As previously reported, a few enrollments were completed prior to the formal opening of the program. These FSPs were housed in the new MHSA-funded transitional residential facility (Pathways) and the previously hired Program Supervisor served as their Personal Services Coordinator.

Enrollment

Exhibit 6 has been submitted. Additional enrollment began in September with a year-end total of 27 enrollments. This is lower than the 130 estimated (21%). However, the number continues to rise with 70 enrollments by the end of the first quarter, 2008 and 92 by May 22, 2008. As with the TAY and the Children's programs, the Adult program has learned that it is difficult to take on too many new clients at once – as the immediate needs of new clients are very intense and consume a great deal of staff time. All have learned that it is better to have a slower but steady rate of enrollment.

Currently, services are available in English, Spanish, Laotian, Thai, Khmu, Mien and Chinese.

Almost all FSPs have been housed in a range of locations including transitional housing, board and care homes and permanent apartments. Permanent housing placements have been very successful with the only departures from apartments to-date being for residential treatment.

The program has also established a co-occurring disorder group, a WRAP (Wellness Action Recovery Planning) group, and opportunities for cultural growth and socialization.

b) Implementation Challenges

Setting a steady pace for engagement and enrollment to best utilize staff capacities while achieving growth in enrollment has been a challenge. Establishing strong communications, clear expectations and working relationships between the County and community agencies is a relatively new activity and has taken some time and effort – but is now working out well.

On the client/program side, community collaborators report several challenges:

- While it is relatively easy to engage and enroll FSPs with the promise of housing, getting those FSPs to take the next steps after housing – toward recovery, increased socialization and increased independence – are more difficult.
- Many FSPs are being placed in housing in Central County (as opposed to West County where the program is located) because it is the nearest safe and drug free housing. This adds geographic complexity to the program.
- With the very high level of care and support provided early in enrollment, it has sometimes been difficult to back off to a lower intensity of ongoing support. Clients would like the high intensity of early enrollment to continue.
- A few adult FSPs are over 65 and have a myriad of health issues that require attention. This has been a challenge in terms of getting them into impacted medical systems of care. This points to the need for an Older Adult FSP in the future as well.

Workplan 4: Systems Development – Older Adults

i. Older Adults – Systems Development

a) Progress Toward Implementation

The Older Adult Systems Development Program was originally scheduled to start in the last quarter of 2007. This was delayed slightly due to changes to the program format. Because of budget cuts, our partner in the original program – Contra Costa Health Services’ Division of Hospitals and Clinics – was not able to meet its earlier funding agreements for this program.

To address this significant change in funding and partnership, the Older Adult Stakeholder’s Workgroup was reconvened for three meetings. After discussing options and reviewing different program models, the Workgroup decided to adapt the clinic-based assessment and care part of the original plan to follow the “best practice” Impact Model originally based out of the University of Washington. These changes were submitted to DMH and were recently approved.

In the last quarter of 2007, CCMH staff were trained in Washington on the Impact model and began meeting with Clinic staff to coordinate elements of the program. A Program Manager was also hired in the first quarter of 2008.

At this point, the start date is expected to be further delayed because of complications in hiring the needed staff. With major budget reductions hitting many non-MHSA portions of the CCMH, any newly hired staff for MHSA would be highly susceptible to being “bumped” out of their positions by staff with more seniority who lose their positions due to reductions. Because of this, hiring will not take place until the cuts are clear. This will be toward the end of the second quarter of 2008.

First clients are anticipated to be enrolled in the program in the summer of 2008.

b) Implementation Challenges

As mentioned above, it is difficult to implement a new program in an environment of budget cuts. Even if those cuts do not directly affect the program, there are partners whose commitments are affected.

Workplan 5: Housing

Housing was presented as a separate program in our Plan. Therefore, is being reported on separately here.

a) Progress Toward Implementation

Operating Funds for Housing

The rental apartment housing program for Full Services Partners has been one of the strongest aspects of our new programs to-date. In August, 2007, a contract was completed with Shelter, Inc. to manage the master-lease program. Shelter Inc is an experience provider for this type of service and start-up has gone well. Everyone who is ready for independent housing has received it. Those who are not ready for independent housing have been placed in a range of transitional and board and care sites. Three transitional living sites have strong dual diagnosis capabilities.

Two adult FSPs who were placed in independent apartments left housing to enter residential treatment programs.

Exhibit 6 has been submitted. By the March, 2008, 10 TAY FSPs and 18 adult FSPs had received permanent housing. This is approximately 18% of expected utilization but is comparable to enrollment curves for the TAY and Adult FSP programs.

Housing funds are also used for about 30 beds to shelter individuals in the adult shelter who are in the engagement phase with MHSA.

One Time Housing Development Funds

Our relationship with the Contra Costa Department of Conservation and Development, Redevelopment Division (formerly Community Development Department) continues to develop. In 2007, we signed an MOU with them for technical assistance and oversight of our one-time housing projects as well as the upcoming MHSA Housing Program.

As previously reported, with support from Community Development, an RFP for one-time dollars to develop new housing was issued in 2006. We are pleased to report that \$1,558,206 in one-time funds was awarded in 2007. A full description of these awards is included as Attachment 1.

*(*Attachments include in final only, not DRAFT)* In summary:

- Villa Vasconcellos in Walnut Creek (developed by Resources for Community Development) was allocated \$700,000 in 2007 toward construction of a senior housing complex. Construction was completed in January 2008 and 3 units were occupied by Full Service Partners in February.
- Virginia Street apartments in Richmond were rehabilitated by Rubicon Programs using \$564,000 in MHSA funds. That project is currently under renovation and will provide 6 2-bedroom apartments for leasing July 1, 2008.
- Lilly Mae Jones Plaza, to be constructed in Richmond, was awarded approximately \$294,000 towards construction of 26 1, 2 and 3 bedroom apartments with 2 units allocated for our Full Service Partners.

One Time Funds for Youth Housing

A modular transitional housing unit for TAY FSPs was originally scheduled to be available in 2007. However, the contracting process for the unit as well as plans for installation delayed this. It is currently expected to be available in the Fall of 2008.

MHSA Housing Program Development

In August 2007, we also issued an RFP for a consultant to work with us and Community Development on development of the MHSA Housing Program. This contract was awarded in late 2007 to Debbie Raucher. Other 2008 progress includes issuance of a Notice of Funding Availability (NOFA) for the MHSA Housing Program. We established a Housing page on our MHSA website. In April 2008, we held a technical assistance meeting for prospective applicants. This TA meeting was co-led by CCMH/Community Development and California Housing Finance Agency (CalHFA). Approximately 20 developers and service providers attended. We are handling applications for the program on an over-the-counter basis and are continuing to provide technical assistance as needed.

b) Implementation Challenges

There have been no real implementation challenges with the Housing program. In fact, it has gone well and is a strong part of the overall FSP effort.

Workplan 6: Systems Development Strategies

SD Strategy 1: Office for Consumer Empowerment Expansion

a) Progress Toward Implementation

The expansion of the County's Office for Consumer Empowerment to support an expanded SPIRIT vocational training program was due to occur in late 2006. Per our last progress report, this was delayed due to our primary emphasis on getting the Full Service Partnerships off the ground at that point. Additionally, the full-time OCE Coordinator also left her position during this period. Start-up was then estimated to occur in the summer of 2007.

An Interim OCE Coordinator took some leadership responsibility for the OCE program. Additionally, we contacted out the SPIRIT Training Program to Mental Health Consumer Concerns (MHCC) -- a local consumer-led mental health organization. CCMH is working closely with MHCC during the first round of training to assure a smooth transition.

Prior to this sub-contracting, however, county OCE staff did start a round of SPIRIT training in May of 2007. A total of 40 individuals enrolled in the program (100% of expected) and a total of 26 of them moved on to the final work/internship phase in May of 2008. This is the largest "class" to move into internships ever. The stipend for participation in the work-study program (funded by MHSA), as well as increasing improvements to the curriculum are to be credited for this. As previously reported, the SPIRIT Training Program has affiliated with and co-located with nearby

Contra Costa College which is offering full college credit for participation in the program. Participation in this program will also be a step toward a Psycho-Social Rehabilitation Certificate (PSR) that will be developed using Workforce Education and Training dollars.

One 2007/2008 SPIRIT training participant has been offered a full-time, benefited position with the Department of Rehabilitation.

Additional consumer supports in the form of stipends, travel costs and translation for Consumer Involvement Steering Committee meetings have been implemented.

ii. SD Strategy 2: Planning for Future Systems Development

a) Progress Toward Implementation

A Transportation Needs Assessment was begun in 2007 with key informant interviews and one focus group with family members of consumers. An immediate program opportunity came up to include mental health consumers in an existing taxi voucher program run by the Contra Costa Department of Employment and Human Services. Plans to pilot this in Full Service Partnerships were put on hold, however, when county-wide planning for budget cuts began. Hopefully, negotiations for this will be able to be resumed in Fall of 2008.

Planning for co-occurring disorders has also been postponed until Fall 2008 at the soonest due to the number of other activities taking place.

b) Challenges

The sheer number of new programs being rolled out simultaneously by CCMH under MHSA is a challenge to our organization and roll-out of some new efforts has needed to be staged over time.

iii. SD Strategy 3: Peer Benefits Advocates

a) Progress Toward Implementation

Implementation of this element of the MHSA program has been further delayed and has not yet begun. As reported in our previous progress report, the hiring of these new positions was envisioned to occur by the end of September, 2007. However, there was no physical space to put the new hires until additional workspace was built out and became available in March, 2008. This postponed hiring until summer of 2008 – which will be further delayed due to impending budget cuts. This will be described further in the next progress report.

iv. SD Strategy 4: Expansion of Family Partner Program

a) Progress Toward Implementation

Per our last progress report, 4 new Bilingual Family Partners were to be hired in the first half of 2007. However, we did not receive enough viable applicants to fill all four positions. Two have

now been filled and we are hopeful that the remaining positions will be filled by the end of June, 2008.

Of the two Family Partners who were hired, one is bi-lingual in Spanish and is working with the Juvenile Justice Team. The other is working at our residential treatment center for women.

The lack of applicants is probably due to the relatively low entry-level pay in the county system, along with the challenge of finding bilingual individuals. As a reminder, these positions were recently converted from contract to fully-benefited staff positions. While the pay is relatively low, it was thought that the benefits would be an added asset.

v. SD Strategy 5: Wellness Services

a) Progress Toward Implementation

As stated in our previous progress report, the Wellness Nurse targeted for hiring in late 2006 was postponed because two additional, non-MHSA wellness nurses became available from elsewhere. The decision was made to focus on settling those two nurses into their positions before hiring the additional MHSA-funded nurse. This occurred during 2007. With these two nurses, we were able to start wellness services.

A Wellness Group was formed made up of doctors, nurses and clerical staff to formulate the Wellness Program. The existing Wellness Nurses are working in outpatient clinics and on transition teams to incorporate non-medical wellness oriented activities into consumer care plans. This includes education about the need for exercise, dietary issues, how medication affects overall health and general healthy lifestyles.

We are in the process of establishing tracking mechanisms for the activities of the Wellness Program. We can report that in the first quarter of 2008, CCMH's Transition Team Nurses provided wellness-related services to 150 unique clients. Of these clients, 35% were from Central County, 31% were from East County, and 30% were from West County. (The remaining 4% were unknown.) More data will be available in the next reporting period.

Hiring for the Wellness Coordinator position is expected to occur in the 3rd quarter of 2008 after budget cuts are implemented.

vi. SD Strategy 6: Transformation Training

a) Progress Toward Implementation

In June 2007, we hired a Training and Ethnic Services Project Manager. Since that time, the Project Manager has:

- ✓ Worked with community-based agencies to co-sponsor trainings in the community about mental health and the recovery model;
- ✓ Co-sponsored a recovery training program – with the Office for Consumer Empowerment – to train all new FSP contractors;

- ✓ Developed an ad hoc training workgroup comprised of County staff and Contract providers to host specialized trainings, including Assessing & Managing Suicide Risk, and other topics;
- ✓ Obtained approval as a Continuing Education Provider: The Mental Health Division has become an official provider of CEUs on behalf of the following licensure boards: Board of Behavioral Sciences, Board of Registered Nursing, Board of Psychology and the California Association of Alcoholism and Drug Abuse Counselors (CAADAC).

We have also focused training on the new FSP Programs, with a current focus on the Children’s FSP, Families Forward. Through the California Institute for Mental Health (CiMH), children’s mental health staff and contractors are participating in an intensive Wraparound Training program focusing on developing and maintaining fidelity to adhere to the true “wraparound” model. This involves training all levels of staff and developing internal resources for the agency to have a group of trainers/coaches to train new staff. There is also an extensive evaluation component to the project.

Other Strategies:

Communication Advisory Workgroup

In 2007 we developed a Communication Advisory Workgroup to brainstorm communication methods and resources for all MHSA-related programs and services. The workgroup is comprised of county and contracted staff and met several times during 2007. The group developed a one-page “Did You Know” document that is published every two months to update the public on MHSA activities in Contra Costa, and also developed an MHSA logo, “Go Beyond” which is used to identify the County’s MHSA Programs and strategies:



B. Successful Strategies toward Title 9, Section 3320 Standards

i. Community Collaboration

As highlighted earlier in this report, Contra Costa County made a strong move toward extensive community collaboration in contracting out the majority of Full Service Partnership operations to community-based collaborations. Some of these community-based agencies have worked with Contra Costa Mental Health before, and others have not. County partners include agencies serving predominantly Latino, Asian/Pacific Islander and African American communities – as well as youth, substance abusers and the homeless. Additionally, Contra Costa County is working side-by-side with these community-based agencies for a seamless public/private collaborative effort. Providers in the Health Services’ Homeless Program also work closely with the teams.

The success is in the operation of the collaboratives themselves. Community partners are able to do outreach and provide services in a culturally and linguistically appropriate manner. The County is able to verify and authorize program eligibility, and create linkages for needed County supports and services.

ii. Cultural Competence

Adult Full Service Partnership staff report the following as an example of how improved cultural competence can make it possible to reach consumers who might otherwise not be reached:

- *A non-English speaking adult female -- Pacific Islander -- was living with an abusive husband and experiencing serious mental health problems. Her community does not tend to deal aggressively with mental illness. And her husband was isolating her in their home. At some point, she left her husband and was living in her car.*

Through repeated outreach contacts in her own language, the Bridges to Home FSP program was able to enroll her in the program, place her in permanent housing, and qualify her for SSI. She is now receiving mental health treatment and beginning to think about the next steps in her life.

- *A gay young transgender female (21) was living on the street and working the street to make a living. The Program heard about her from a referring social service agency. After several weeks of engagement, she entered the TAY FSP Program. She is now in transitional housing, taking medications, in therapy at and engaged with the LGBTQ-focused Pacific Center in nearby Berkeley. Her mother, whose religious beliefs had prevented her from supporting her child, is back in the young woman's life.*

iii. Client/Family Driven Mental Health System

All Full Service Partners are working with their care providers to develop client-driven care plans as soon after their entry into the program as possible. This commitment to a client-driven program is embedded throughout our programs.

- *One youth with Major Depression and significant health issues is parenting two small children. ILSP had done multiple referrals over the five years they have known her but she has been resistant to support and has been homeless repeatedly. We were in contact with her for three months before she would consistently engage with the team. She was supported through the housing application process and going with her to gather all necessary documentation. She has developed a Plan that truly reflects her wants and needs and is now in stable housing, thinking about getting some vocational training and looking at careers. She is open to working with team members on parenting issues and has increasingly sought the team for support. She is demonstrating more follow through than seen since she emancipated from foster care.*

iv. Wellness/Recovery/Resiliency Focus

All clients in the Bridges to Home adult FSP are being supported to develop WRAP (Wellness Action Recovery Plans). An example of how useful these plans are was reported as:

- *Recently, a Full Service Partner with schizophrenia and a 30-year history of substance abuse put a gun to his head. Staff were able to talk him down by pulling out his WRAP plan and reviewing the steps that he had already identified that he could take if he started to fall apart. The man recognized that he had identified these steps himself and was able to pick a starting*

place to begin on the list. He decided to go back onto his medication and has not had a repeat suicide gesture since that day.

v. Integrated Service Experience

Many families in the Children’s Full Service Partnership are already involved in multiple systems. The ability to manage these complicated relationships – each with complicated demands – further challenges the abilities of some parents to cope. Full Partnership support to navigate these systems is critical to stability and success for many. For example:

- *B is a 15-year-old young man who has experienced a tumultuous childhood due to mother’s own troubles with drug abuse. B’s life has been full of unpredictability and instability. At the time that B became enrolled in Families Forward and became a Full Service Partner he was at the Juvenile Hall. Mother was homeless and living at the Rescue Mission.*

At the beginning stages of wraparound, staff gathering information and identified needs based on the family’s voice and choice. There were many demands placed on the family from a variety of agencies. Staff identified and communicated with both natural and professional supports to gain a thorough understanding of the family. Regularly scheduled meeting with team players help keep all on the same page and help the family navigate through the chaos.

Through the Families Forward program and Shelter Inc., the family was found housing. Staff worked closely with the school district to get B placed at a nonpublic school that caters to his academic and behavioral needs. Mother is doing her best to stay on track. With support from staff, she now manages all her treatment appointments and participates actively in treatment of her children. She is very resourceful and becoming a great advocate for her children.

3. Wrap Around and Inpatient Services

- a. Contra Costa County has implemented SB 163 Wraparound.
- b. MHSA FSP funding for short-term acute inpatient services: We are currently developing a protocol and method for tracking the dollar amount for any short-term acute inpatient services for enrolled FSPs.

B. Efforts to Address Disparities

1. Current Successful Strategies to Address Disparities

One of the most important avenues to reducing disparities in access to care is to hire staff that are reflective of traditionally underserved communities. By collaborating with a range of community-based agencies, including specifically Latino and Asian/Pacific Islander-focused agencies, it has been possible to hire and support community residents into outreach and service coordination positions. As noted earlier in this report, the language capacities of our FSP staff are very broad and the diversity of our enrolled FSPs reflects this. While data for December 31, 2007 are not

available, we do have cumulative data as of March 31, 2008 which show the diversity of our FSP enrollment to-date. This includes:

Race/Ethnicity	Adult FSPs	Children FSPs	TAY FSPs
White	29	6	10
African American	40	3	16
Native American	1	0	1
Mexican Amer/Chicano	7	18	3
Latin American	1	7	1
Other Spanish	1	0	0
Chinese	1	0	1
Vietnamese	0	2	0
Laotian	4	0	0
Filipino	2	0	0
Other Asian/SE Asian	3	0	1
Other Non-White	3	0	1
Mixed/Unknown	9	0	2
TOTAL	101*	36	36*

*Data includes 11 adult and 4 TAY FSPs who disenrolled before May 1, 2008.

Data also show that 24 or 14% of FSPs have reported a non-English language as their preferred language. Of those preferring a non-English language, 54% preferred Spanish and 25% preferred an Asian language (Chinese, Laotian, Vietnamese, Mandarin, Ilocano, Mien). The remaining 5 (21%) speak other languages.

An example from our Children’s Full Service Partnership shows how system navigation assistance and explanation of medical options allowed a “crisis” to be de-escalated, allowing a child to stay with his family and get proper medical/psychiatric care:

- *A Pacific Islander child in middle school had a psychotic episode at school. The police became involved and the child was in danger of being detained. The parents did not speak English and could not communicate with the police. With the assistance of the FSP Service Coordinator, the family was able to communicate with the police. The family was also able to understand what type of care their child needed and, for the first time, agreed to medication for their child. The child is at home with his family, is in school, and is doing well.*

2. Challenges Faced in Implementing Strategies to Address Disparities

As discussed earlier in this report, CCMH is developing new working relationships with ethnically-specific community-based agencies. While we are clear that those relationships will lead to reducing barriers to care for those who are traditionally unserved or underserved, the learning curve to develop smooth collaborative operations across agencies is steep. This has slowed down the roll-out of our new programs. But we continue to make progress.

3. Native American Involvement

As reported earlier, no Native American organizations or tribal communities have been funded to provide services under MHSA to-date. With a small Native American population and little in-county organization, this has been difficult.

However, we are pleased to report that through our process of community engagement for PEI planning, we were able to work with the Native American Health Center in Oakland (Alameda County). Staff from the Native American Health Center organized a PEI focus group/social event for Native Americans in Contra Costa County. The event was quite successful with more than 20 residents attending. We are hopeful that this will be the start of a continuing dialog and participation in ongoing efforts.

4. System Improvements to Reduce Disparities

As describe in our earlier Progress Report, the Contra Costa Health Services Department has a broad, department-wide initiative to reduce health disparities and Mental Health is an active participant and has its own internal reducing disparities work group as well. Accomplishments of these groups in 2007 include:

- 1) We have produced a comprehensive new policy that specifically states Contra Costa Health Service's commitment to reducing health and healthcare disparities for residents of Contra Costa County. This new policy is included here as an Attachment 2. (**Attachments include in final only, not DRAFT.*)
- 2) We have updated Health Service's policy on provision of Service Excellence. This includes clear articulation of our commitment to providing high quality services with respect and responsiveness to all and to reduce health disparities.
- 3) We have updated the official policy for providing linguistic access to limited English proficient persons (LEP) and deaf/hearing impaired clients in the Mental Health Division. While this was not formally approved until 4/08, the majority of the work was done in 2007.

C. Stakeholder Involvement

The CSS Stakeholder Advisory Committee was formed in 2005 at the end of the CSS Stakeholder process. The Committee is a subset of Stakeholder Planners from all four age-groups that worked on the original Plan. Originally, it was designed to advise the roll-out of CSS-funded activities for one year. The group ended up staying in place through three meetings in 2007. As we begin to look toward an integrated planning process, we are considering how to formulate stakeholder input going forward and are reassessing the role of this group in the process.

The MHSA Steering Committee, made up of key staff throughout Health Services has also continued to meet throughout 2007 and into 2008. They meet monthly to review progress of the roll-out and to address and resolve operational issues.

Two other groups have remained active to oversee the activities of CSS. They are the Consumer Involvement Steering Committee – which meets bi-monthly, and the Family Involvement Steering Committee, which meet monthly.

A sub-group of the Family Involvement Steering Committee is also now also participating on a new project – with the Greater Richmond Interfaith Program. GRIP has initiated a social justice action project focused on mental health. The two groups are now meeting together to define and initiate that project.

We also formed an additional Stakeholder Workgroup for PEI planning in late 2007. That group has two subcommittees – one for ages 0-25 and one for ages 26+. This group was trained on PEI in January, 2008 and has continued their work through the first half of 2008. As stated earlier, toward the end of the year, we will begin to address the roles of all of these Stakeholder groups and how they can best support integrated planning and implementation in the future.

D. Public Review and Hearing

1. Stakeholder Review and Comment Period

2. Methods of Distribution

3. Summary and Analysis of Feedback

**To be added after public input*

Attachments: (**Attachments include in final only, not DRAFT*)

Attachment 1: Approved One-Time Housing Expenditures

Attachment 2: Reducing Health Disparities Policy