
**Cognitive
Behavioral Social
Skills Training
(CBSST) in
Augmented
Board & Cares:
MHSA Final
Innovation Work
Plan**

Contra Costa
Behavioral Health
Services



**Contra Costa Behavioral Health
Cognitive Behavioral Social Skills Training (CBSST) in
Augmented Board & Cares**

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Executive Summary

Many consumers spend years residing at County augmented board and care facilities with little or no mental health treatment provided, and little or no functional improvement taking place. Often this lack of progress results in multiple admissions to the County's Psychiatric Emergency Services and other, more costly, interventions. Cognitive Behavioral Social Skills Training (CBSST) is an emerging practice with demonstrated positive results for persons with severe and persistent mental illness. The CBSST Project proposes to apply this therapeutic practice to the population of individuals that have been placed in augmented board and care facilities. The CBSST Project will create a clinical team, consisting of a licensed clinician and peer support worker, to lead cognitive behavioral social skills training groups at board and care facilities. Adults with serious mental illness will learn and practice skills that will enable them to achieve and consolidate recovery based skills.

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

Project Overview

Primary Problem

a) What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

CCR Title 9, Sect. 3930(c)(2) specifically requires the Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update to describe the reasons that a County's selected primary purpose for a project is "a priority for the County for which there is a need ... to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system." This question asks you to go beyond the selected primary purpose (e.g., "Increase access to mental health services,") to discuss more specifically the nature of the challenge you seek to solve.

b) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

It is the intent to address the state of on-site treatment for consumers at augmented board and care facilities (B&Cs) in Contra Costa County who have been diagnosed with a severe and persistent mental illness (SPMI). Augmented B&Cs are defined as a specialized service that recognizes that the living standard funded by basic public benefits is below successful progress toward wellness for certain clients. Contra Costa County funds to augment, or pay in addition to, the rental amount received by B&Cs from the SSI rental allowance. Excess augmentation funds to subsidize the "rent: on behalf of the client beyond what their SSI pays, and for which the client receives enhanced services. Most consumers placed in B&Cs rarely receive the level of treatment needed once they are placed. On average most will only meet with their case manager (if one has been assigned) every two weeks, and with their clinic psychiatrist approximately every 60 days. The result is that many B& C residents spend their years living in augmented B&Cs with little or no improvement in functional ability.

Augmented board and care facilities should be a major component of a rehabilitation and recovery-oriented mental health system¹. Provision of services in B&C's have been shown to have a lack of policies and procedures, client records, adequate documentation regarding nutrition, sufficient medication oversight, lack of services and client education². Persons with mental illness living in B&Cs are at risk for decompensation and potential harm.

¹Housing for California's Mental Health Clients: Bridging the Gap. (2013, April). Retrieved January 11, 2017, from www.dhcs.ca.gov/dataandstats/reports/Mental%20Health/Housing

²Helping Tennessee's Supportive Living Facilities Offer Board and Care for All. (2011, June). Retrieved January, 2017, from www.sccgov.org/sites/mhd/MentalHealthBoard

c) Describe what led to the development of the idea for your INN project and the reasons that your project is a priority for your county?

The state of B&C housing for consumers in Contra Costa County who have been diagnosed with a severe and persistent mental illness (SPMI) has been a near constant agenda item at Contra Costa County (CCC) Mental Health Commission meetings. Consumers, their families, and clinicians have voiced serious concerns about the lack of care and therapeutic engagement at B&Cs, in which the county spends significant money with no documented indication of positive outcomes.

The challenges of B&C residents include remoteness of the housing to mental health treatment facilities, separation of residents from their families and other potential sources of support, and the lack of mental health training among B&C staff.³ In CCC this has led to placing consumers with multiple SPMI diagnoses under the same roof with a staff (frequently the staff is made up of one person) with virtually no mental health training, and only limited and occasional support from trained clinicians. Yet, despite the lack of evidence that this non-clinical housing model advances recovery, CCC has continued to employ it without change or innovation. Virtually nothing has been done to address the treatment void that currently exists at the B&Cs in which consumers are placed.

Moreover, there is significant anecdotal evidence from Psychiatric Emergency Services (PES) at Contra Costa Regional Medical Center as well as case managers and clinical program managers that B&C residents provide a large share of individuals placed in Section 5150 involuntary holds. This evidence provides further insight into the lack of services around case management and the ability to provide adequate services to the consumers. Case management caseloads can only withstand a limited number of consumers and can't provide the constant one on one treatment commonly needed for this population. Finally, this results in higher costs due to more admissions in PES and inpatient services.

³ Shepherd, G., Macpherson, R., (2011). Residential care. In Thornicroft, G., Szukler, G., Mueser, K.T., Drake, R.E. (eds) *Oxford Textbook of Community Mental Health*, pp 178-187. Oxford University Press. New York.

What has Been Done Elsewhere to Address Your Primary Problem?

“A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach (CCR, Title 9 Sect. 3910 (b)).

The Commission expects a County to show evidence that they have made a good-faith effort to establish that the approach contained within their proposed project either has not been demonstrated to be effective in mental health or is meaningfully adapted from an approach that has been demonstrated to be effective. Describe the efforts have you made to investigate existing models or approaches close to what you're proposing (e.g., literature reviews, internet searches, or direct inquiries to/with other counties). Have you identified gaps in the literature or existing practice that your project would seek to address?

- a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?**
- b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?**

Existing models were investigated, as well as literature reviews, internet searches and inquiries with other counties and private treatment programs were conducted. Results indicate that this approach has not been applied in B&Cs. For example, Cognitive Behavioral Therapy (CBT) has been offered in various settings such as prisons or schools, but the population being served and the therapy method being used has varied. CBT is a psychosocial intervention and a combination of basic principles from behavioral and cognitive psychology.

The first setting in which an example of a CBT model exists is within the Department of Corrections. This traditional cognitive-behavioral approach used with the correctional populations has been designed as either cognitive-restructuring, coping-skills, or problem-solving therapies. The cognitive-restructuring approach views problem behaviors as a consequence of maladaptive or dysfunctional thought processes, including cognitive distortions, social misperceptions, and faulty logic. Most cognitive-behavioral programs developed for criminal offenders tend to be of the type of therapy that focuses on cognitive deficits and distortions⁵.

A meta-analysis of 69 studies covering both behavioral and cognitive-behavioral programs determined that the cognitive-behavioral programs were more effective in reducing re-offending than other behavioral approach programs⁶. The mean reduction in re-offending was about 30 percent for treated offenders. Other analyses of correctional treatment concluded that cognitive-behavioral methods are critical aspects of effective correctional treatment⁷. Yet another study similarly determined that the most effective interventions are those that use cognitive-behavioral techniques to improve cognitive functioning⁸. This study is still specific to the population and the grounds of the institution.

Another application of this successful evidence based practice model was a review on CBT used for depression in veterans. Major depressive disorder is one of the most common psychiatric diagnoses among veterans and active duty military, and is linked with impairment.

CBT has shown to be very effective, with over 75% of veterans treated for depression showing noticeable improvement following CBT. This treatment is at least as effective as medications.

Limitations of CBT in these examples do exist. CBT is not helpful for all conditions and as a rule, the more specific the problem, the more likely CBT may help. This is because it is a practical therapy which focuses on particular problems and aims to overcome them. CBT is sometimes used alone and sometimes used in addition to medication, depending on the type and severity of the condition being treated. This type of therapy, along with other possible treatments that a consumer in B&C's may receive, can lead to a better overall chance of improvement in such behavioral markers and reduction in hospitalizations.

⁴Residential Care Options. (n.d.). Retrieved January 19, 2017, from <https://www.caregiver.org/residential-care-options>

⁵Milkman, H., & Wanberg, K. (2007, May). Cognitive-Behavioral Treatment. Retrieved February 10, 2017, from www.nicic.org

⁶Pearson, F., D. Lipton, C. Cleland, and D. Yee. 2002. The effects of behavioral/ cognitive-behavioral programs on recidivism. *Crime and Delinquency* 48(3): 476–496.

⁷Andrews, D., I. Zinger, R. Hoge, J. Bonta, P. Gendreau, and F. Cullen. 1990. Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology* 28: 369–404.

⁸Gendreau, P., and D.A. Andrews. 1990. Tertiary prevention: What the metaanalysis of the offender treatment literature tells us about “what works.” *Canadian Journal of Criminology* 32: 173–184.

⁹Mental Health. (n.d.). Retrieved February 13, 2017, from <http://www.mentalhealth.va.gov/depression/cbt-d.asp>

The Proposed Project

Describe the Innovative Project you are proposing. Note that the “project” might consist of a process (e.g. figuring out how to bring stakeholders together; or adaptation of an administrative/management strategy from outside of the Mental Health field), the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

- a) **Provide a brief narrative overview description of the proposed project.**
- b) **Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).**
- c) **Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.**

The proposed project will involve having a team designed of one Mental Health Clinical Specialist (MHCS) and one Community Support Worker (CSW) whose primary responsibility will be to lead CBSST groups at B&Cs that house CCC consumers. CBSST is a combination of cognitive behavioral therapy (CBT) social skills training (SST) and problem solving therapy (PST). This differs from traditional CBT because it not only includes the general concepts of CBT, which focus on the relationships between thoughts, but works with improving communication skills through SST and basic problem-solving skills through (PST). This intervention will be new to the public mental health system and currently has only been implemented in private hospitals or universities.

Additionally, the groups that will be implemented in the B&Cs are designed to assist consumers in improving their ability to recognize and change inaccurate beliefs, as well as improve communication and problem solving skills. The clinical team will also be a new provided element to the project and framework of the group environment. The goal will be to build a clinical infrastructure to support the consolidation of the skills consumers learn through the CBSST work.

The clinical team will check in with consumer/residents between group meetings to consolidate skills acquisition and address obstacles that may emerge. They will also collaborate with clinic/agency case managers to ensure that consumer/residents are supported in sustaining the skills they develop in the CBSST program. The clinical team will also work with B&C staff to resolve conflicts they may have with consumer/residents before those conflicts become a crisis, improve B&C staff understanding of mental health issues, and develop long-term problem resolving plans at each B&C. Additionally, the CBSST team will train county clinicians and peer providers in this model.

As stated above, the approach that is proposed will exclusively be placed in augmented B&Cs and involve groups being co-facilitated by a clinician and peer provider. This approach is identified as making a change to an existing practice (CBSST) by placing an effective evidence-based approach to a new setting. B&Cs lack a more comprehensive support system, to include therapeutic engagement and care. They don't provide the tools in which a consumer will ultimately need in order to progress toward self-sufficiency in their community. With this innovative approach consumers will learn to identify inaccurate beliefs, communication deficits, and address potential sources of conflict that interfere with recovery.

Innovative Component

Describe the key elements or approach (es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.

b) If you are applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?

Contra Costa County stakeholders have voiced serious concerns about the lack of care and therapeutic engagement at B&Cs. CCBHS proposes “increasing the quality of services, including better outcomes” by creating a more service-enriched housing model for people with serious mental illness. This proposal is innovative because of the new and different way in which CBSST will be integrated within the B&Cs.

CBSST is itself an innovative approach to the existing practices of cognitive behavioral therapy (CBT), social skills training (SST), and problem-solving training (PST) by combining them in one treatment protocol. All three elements are evidence-based practices for SPMI diagnoses. The CBT module is designed to assist consumers in identifying inaccurate beliefs (e.g. “I will never accomplish anything, so why try?”) that stand in the way of efforts to achieve positive goals. The SST module is designed to address communication deficits (e.g. inappropriate and/or aggressive expression) that can lead to eviction, involuntary hospitalization, and a host of other roadblocks to recovery. The PST module helps consumers address potential sources of conflict (interactions with roommates, board and care staff, and within interpersonal relationships) in a manner that can lead to achieving recovery goals¹⁰. Addressing these problems where they are most likely to occur (in the community, where the consumers actually live their lives) and often short circuit recovery goals would be an enormous step forward in providing a service-enriched housing model of service.

¹⁰Granholm, E.L., McQuaid, J.R., Holden, J.L. (2016) *Cognitive-behavioral skills training for schizophrenia: a practical treatment guide*. Guilford Publications: New York.

Learning Goals / Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.

- a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?**
- b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?**

There is no maximum number of learning goals required, but we suggest at least two. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

CCBHS's intention will be to address the current state of augmented B&Cs as they apply to seriously mentally ill consumers. This will be done by placing evidence-based psychosocial interventions in a consumer's place of residence with hopes to produce skills that will help consumers live full and productive lives after they leave their B&C homes. This project fully intends to address the following learning goals as they apply to the overall achievement of the project.

- 1) Will the modality of CBSST have an effect on the consumer's mental stability and growth?

Key element:

- CBSST which combines cognitive behavioral therapy (CBT) and social skills training (SST) to target functional disability schizophrenia
- A flexible intervention that teaches cognitive skills, social skills, and problem-solving skills to help consumers achieve their living, learning, socializing and working goals¹¹

- 2) Will the intervention lead to a higher overall functionality and quality of life?

Key element:

- CBT involves learning to catch, check and change unhelpful thoughts that interfere with successful goal-directed skill performance in the community

- CBSST training groups for consumers with a peer component and licensed clinical specialist
- Build a clinical infrastructure to support the consolidation of the skills consumers learn through the CBSST work

3) Will the intervention reduce 5150 involuntary holds within the Crisis Services Unit?
The CBSST Team will:

Key element:

- Check in with consumer/residents between group meetings to consolidate skills acquisition and address obstacles that may occur
- Collaborate with clinic/agency case managers to ensure that consumers/residents are supported in sustaining the skills they develop in the CBSST program
- Work with B&C staff to resolve conflicts they may have with consumer/residents before those conflicts become a crisis
- Improve B&C staff understanding of mental health issues, and develop long-term problem solving plans at each B&C.

4) Will a consumer have fewer evictions or avoid evictions completely?

Key element:

- The PST module helps consumers address potential sources of conflict
- The SST module is designed to address communication deficits that can lead to eviction, involuntary hospitalization, and a host of other roadblocks to recovery

Granholt, E. (2016). *Cognitive Behavioral Social Skills Training for Schizophrenia* [CBSST Workshop Practical Syllabus]. VA San Diego Healthcare System University of California, San Diego, Department of Psychiatry, San Diego.

Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

LEARNING GOAL #1 – *Some tools will be able to measure more than one learning goal*

- Recovery Markers Questionnaire (RMQ) will be given to all group participants
- Public Health Questionnaire (PHQ-9) will be given to all group participants
- Clinic and agency case managers will be asked to fill out the Level of Care Utilization System (LOCUS)

LEARNING GOAL #2

- Client's families will provide ongoing feedback about their relationships with client
- Client's will be given the opportunity to submit anonymous feedback on CBSST therapy

LEARNING GOAL #3

- 5150s will be tracked for pre/post data
- Length of hospital stay pre/post data

LEARNING GOAL #4

- Client transferring from B&C to Institute of Mental Disease (IMD)

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your “sample size”) required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:

a) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired? Data sources will be mental health consumers and their families, B&C staff, peer providers, mental health clinical specialists and other relevant providers. Recruitment will be obtained through referral and hiring practices within the county.

b) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples. Results from self-reporting measures will include surveying personal growth, global functional ability, participation in constructive activities such

as school, employment, etc. Also, measures that evaluate levels of depression and suicide risk will be gathered. Clinic and agency case managers will gather data on consumer risk of harm, functional status, medical/addictive/psychiatric co-morbidity, recovery environment, treatment and recovery history and engagement.

c) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)? Data collection will involve consumer and staff survey completion.

d) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)? Methods will be administered through consumer groups and through treatment teams by way of surveys/measurement tools for pre and post intervention. Tools will be utilized to gather pre and post outcome results.

e) What is the preliminary plan for how the data will be entered and analyzed? During the development of this new project an Access database will be created to capture relevant data. Project service providers will enter this data, with headquarters staff support time budgeted for analysis and refinement of data entry. Once the information has been beta tested it will be incorporated into the County's electronic health record system, utilizing ongoing and ad hoc scripts for data management.

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

This Innovative Project will be county operated and thus will not be contracted out.

Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

- a) **Adoption by County Board of Supervisors. Please present evidence to demonstrate that your County Board of Supervisors has approved the proposed project. Evidence may include explicit approval as a stand-alone proposal or as part of a Three-Year Plan or Annual Update; or inclusion of funding authority in your departmental budget. If your project has not been reviewed in one of these ways by your Board of Supervisors, please explain how and when you expect to obtain approval prior to your intended start date.**
- b) **Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA). Welfare and Institutions Code (WIC) 5847(b)(8) specifies that each Three-Year Plan and Annual Update must include “Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.”**
- c) **Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA. WIC 5847(b)(9) specifies that each Three-Year Plan and Annual Update must include “Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.” Of particular concern to the Commission is evidence that the County has satisfied any fiscal accountability reporting requirements to DHCS and the MHSOAC, such as submission of required Annual Revenue and Expenditure Reports or an explanation as to when any outstanding ARERs will be completed and filed.**
- d) **Documentation that the source of INN funds is 5% of the County’s PEI allocation and 5% of the CSS allocation.**

Answer: Appropriate authorization, certifications and evidence of MHSA compliance is attached.

Community Program Planning

Please describe the County’s Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County’s community.

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSa requirements for INN Projects.

Contra Costa County's approved Mental Health Services Act Three Year Program and Expenditure Plan was developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education social service agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations and other important interests. Focus groups conducted as part of the Community Program Planning (CPPP) process were specifically designed to include representation from unserved and underserved populations, reflect the diversity of the demographics of the County, and outreach to clients with serious mental illness and/or serious emotional disturbance and their family members. Additionally, as referenced in the Three Year Plan, the County's ongoing MHSa stakeholder advisory group, Consolidated Planning and Advisory Workgroup (CPAW), has an Innovation sub-committee charged with assisting in the development of new Innovation projects as well as reviewing existing project and project outcomes. The innovation sub-committee meets on a monthly basis and provides recommendations to the CPAW and ultimately the Behavioral Health Director. Cognitive Behavioral Social Skills Training (CBSST) in Augmented Board & Cares addresses priority needs identified during the current and past CPPPs and was included in the concept in the Innovation chapter of the Three Year Plan. The Adult and Children sub-committees of CPAW also provided stakeholder input on the concept of CBSST proposal ensuring that the perspectives of County and community-based providers, as well as representatives from the various age groups were equally addressed within the proposal. The innovation sub-committee reviewed the concept, and assisted in the development of the CBSST program description.

CPAW also has an ongoing Membership sub-committee who analyzes the work group's needs for full stakeholder representation on CPAW and its sub-committees. The Membership sub-committee recruits for characteristics and affiliations that are under-represented or missing from CPAW.

Primary Purpose

Select one of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need)).

- a) Increase access to mental health services to underserved groups**
- b) Increase the quality of mental health services, including measurable outcomes**
- c) Promote interagency collaboration related to mental health services, supports, or outcomes**
- d) Increase access to mental health services**

Answer: Increase the quality of services, including better outcomes

MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

- a) Introduces a new mental health practice or approach.
- b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.
- c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

Answer: Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to adaptation for a new setting, population or community.

Population (if applicable)

a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number? Approximately 80 consumers a year per team would be served. Upon the project reaching full maturity three teams would serve approximately 240 consumers per year.

b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report. This project will be for male and female adults, age 18 and above. Race/ethnicities will likely be 25% Latino, 25% African American, 40% Caucasian, with 10% Asian Pacific Islander and all other race/ethnicities. Preferred languages of English and Spanish (Contra Costa County's threshold language) would be utilized.

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

Adults ages 18 and above with severe persistent mental illness.

MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your INN Project, please explain why.

a) Community Collaboration

The primary purpose of the Innovation project is to improve the quality of services in augmented B&Cs; this includes primary health care, behavioral health care and behavioral health & homeless program. By working together to implement the project, these partners will improve the overall health and welfare of adult mental health consumers. One of the tasks of the clinical team will be to identify appropriate community resources and supports and assist in the linkage to the identified community resources.

b) Cultural Competency

All goals listed in Article 2, Section 3200.100 Cultural Competence have been incorporated into the protocol and procedures of this proposed project in order to ensure equal access to services of equal quality is provided, without disparities to person with non-dominant racial/ethnic, cultural, and linguistic differences. This will be accomplished by yearly mandatory trainings and certification on cultural competency for all staff involved in this project, as well as a number of voluntary trainings and forums specific to expanding service provider sensitivity, knowledge base and expertise in adapting effective treatment and peer support approaches to the numerous non-dominant cultures In the County, such as inner city African American and Latino populations, urban Native Americans, non-English speaking immigrant populations, and individuals who identify as lesbian, gay, bi-sexual, transgender, or who question their sexual identity.

c) Client & Family Driven

CBSST will involve adults, and as appropriate, their families, in determining the appropriate treatment goals for each client. It will also involve them in the design and implementation of services, resource development, and evaluation of services. By teaching consumers wellness, recovery and self-management skills, peer support workers will be encouraging and assisting consumers to participate actively in their health care.

d) **Wellness, Recovery, and Resilience-Focused** One of the primary goals of the project is to promote the wellness and recovery of adult mental health consumers by teaching them life, wellness, recovery and self-management skills as well as linking them to community-based supports and resources. The project will track changes in consumer's crisis service utilization, suicide risk, levels of depression and quality of life.

e) Integrated Service Experience for Clients and Families

CCBHS and many of its community partners offer integrated services at their program sites. By improving access to services for underserved groups CBSST will assist consumers in linking with existing integrated services. The long-term goals of the learning provided by the project are to: 1) decrease the health disparities experienced by mental health consumers and 2) promote their mental health recovery by decreasing relapses as well as increasing self-reliance and active participations in their wellness.

Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project?

Yes, consumers who are seriously mentally ill are the identified target population to receive services from this project.

If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

The CBSST project will be designed to be sustainable after innovation funding ends by utilizing Federal Financial Participation and realignment funding for Medi-Cal eligible consumers. The objective is to transfer the therapy and training responsibilities to the current adult clinical programs. The idea will be to work with consumers until they sustain the skills developed through the CBSST program and continue to support their transition to independent living in permanent housing.

INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) **Explain how you plan to ensure that the Project evaluation is culturally competent.** *Note: this is not a required element of the initial INN Project Plan description but is a mandatory component of the INN Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.*

b) **Explain how you plan to ensure that the Project evaluation is culturally competent.** *Note: this is not a required element of the initial INN Project Plan description but is a mandatory component of the INN Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups*

It is the intent for all innovation projects to go through a process that utilizes stakeholder involvement by implementing a Consolidated Planning Advisory Workgroup (CPAW) in order to ensure that local stakeholders are an ongoing integral part of all planning and evaluation of MHSA funded services and supports. Additionally, this group has a sub-committee charged with assisting in the development of new innovation projects as well as reviewing existing projects and project outcomes. In this process cultural competence has been incorporated in the protocol and procedures of this proposed project in order to ensure equal access to services of equal quality. To ensure that the project evaluation is culturally competent there will be a yearly mandatory training and certification on cultural competency for all staff involved in this projects, as well as a number of voluntary trainings and forums specific to expanding service provider sensitivity, knowledge base and expertise in adapting effect treatment and peer support approaches to the numerous non-dominant cultures in the County. CPAW membership composition mandates representation by individuals who reflect the diversity of the County's regions, micro-communities, racial/ethnic groups and self-identified gender and sexual preferences.

c) **Explain how you plan to ensure meaningful stakeholder participation in the evaluation.**

Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group, or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must contribute in some meaningful way to project evaluation, such as evaluation planning, implementation and analysis.

Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weigh in at different stages of the evaluation.

CCBHS has set up a meaningful stakeholder involvement process by implementing a Consolidated Planning Advisory Workgroup (CPAW) and 10 ongoing topic/age related committees in order to ensure that local stakeholders are an integral part of all planning and evaluation of MHSA funded services and supports. Additionally, this group has a sub-committee charged with assisting in the development of new innovation projects as well as reviewing existing projects and project outcomes

Deciding Whether and How to Continue the Project Without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

This project is critical for mental health consumers living in B&Cs and if successful will be supported to continue after innovation funding has ended. In order to ensure this, services that are provided to Medi-Cal eligible consumers be funded by a combination of realignment and Federal Financial Participation dollars.

Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

- a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?**
- b) How will program participants or other stakeholders be involved in communication efforts?**

All innovation projects are vetted through the Innovation and age-related committees and routinely invited to participate in project updates and evaluations. These results are then reported to the Consolidated Planning and Advisory Workgroup (CPAW) for stakeholder comment and recommendations. Oversight is ensured in the process of implementation and meant to enhance successful practices.

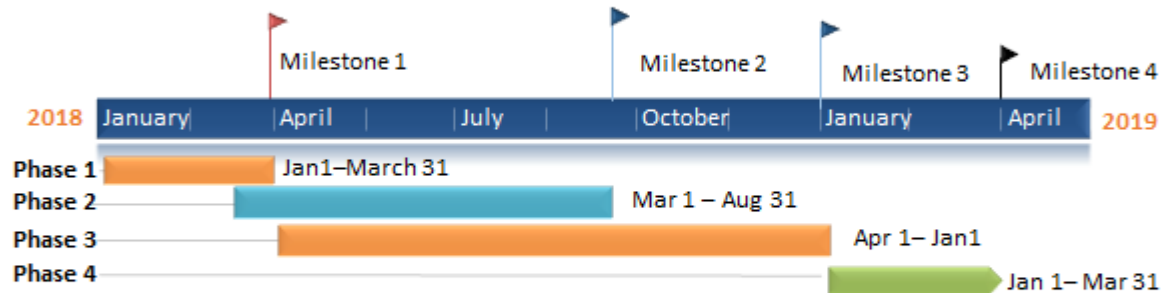
- c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.**

- CBSST in Augmented Board & Cares
- CBSST for Severe and Mentally Illness
- Treatment in residential programs
- Contra Costa County Innovation Project

Timeline

- a) Specify the total timeframe (duration) of the INN Project: 5 Years _____ Months
- b) Specify the expected start date and end date of your INN Project:
1/1/2018 Start Date 12/31/2022 End Date
Note: Please allow processing time for approval following official submission of the INN Project Description.
- c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for
 - i. Development and refinement of the new or changed approach;
 - ii. Evaluation of the INN Project;
 - iii. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
 - iv. Communication of results and lessons learned.

CBSST (Cognitive Behavioral Social Skills Training)



The total duration of the Innovation Project is 5 years to accomplish the following: feasibility & start-up, operationalizing learning goals and development, evaluation and recommendations, testing and implementing, communication of results and looking forward and sustaining.

Start-up Phase (3 Months)

Phase 1)

- Evaluate County policies and protocols to adapt project's day-to-day processes
- Define intervention within modified protocol
- Research augmented board and care sites to determine initial locations for groups & trainings
- Secure an office location for CBSST positions
- Create CBSST positions, recruit and hire staff
- Train staff in CBSST positions
- Purchase equipment and project supplies (computer, furniture, cell phones, etc.)
- Purchase vehicles
- Define a baseline of indicators to determine impact
- Conduct information sharing & receive input from various stakeholder groups

Learning and Developing (6 Months)

Phase 2)

- Finalize a plan for eligibility criteria into the enrollment of the CBSST training and therapy
- Educate & inform the community regarding the new CBSST project
- Provide outreach to the target populations to be served
- Develop a curriculum for board & care staff to be trained on CBSST model
- Identify measurement tools
- Refine intended policies and protocols to correct/adjust changes as needed
- Continue to conduct periodic information sharing & receive input various stakeholder groups

Testing and Implementing (9 Months)

Phase 3)

- Serve initial cohort of consumers
- Compile results; evaluate indicators related to all learning goals
- Compare and analyze data captured
- Assess and adjust indicators of success related to all learning goals
- Continue to conduct periodic information sharing & receive input from various stakeholder groups

Looking Forward and Sustaining (3 Months)

Phase 4)

- Complete first CBSST Annual Report for dissemination
- Provide first annual report for CBSST project to various stakeholder groups and the state
- Develop/implement plan to share lessons learned with stakeholders
- Continue to collect data and continuously assess indicators of success related to all learning goals and adjust/revise services tools as needed
- Produce annual updated reports and final report on outcomes related to learning goals
- Continue to conduct periodic information sharing & receive input from various stakeholder groups

INN Project Budget and Source of Expenditures

The next three sections identify how the MHSAs funds are being utilized:

BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

BUDGET CONTEXT (If MHSAs funds are being leveraged with other funding sources)

A. Budget Narrative:

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “\$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total \$15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, “Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time...”). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

FY 17/18 – Half Year

1. Personnel

- a) 1.0 FTE Community Support Worker Level II; **(\$20,666 or 19.29 per hour)** - the primary responsibility of the CSW will be to co-lead CBSST groups at B&Cs that house consumers
- b) 1.0 FTE Mental Health Clinical Specialist; **(\$36,039)** - the primary responsibilities will be to lead CBSST groups at B&Cs that house consumers as well as collaborate with clinics and agencies that provide services for consumers
- c) 1/6th Administrative Service Assistant III (ASAIII); **(\$6,639)** – staff responsible for overall project implementation.
- a) 1/6th Mental Health Project Manager; **(\$7,841)** – provide staff support to innovation project for oversight and evaluation.

2. Operating Expenses:

- a) For county operated programs CCBHS Finance apportions a percentage cost for direct and indirect operating costs to each county FTE staff position assigned to the program.

3. Non-recurring Expenses:

- a) 2 County Vehicles (\$84,000) - County vehicles will be used to travel regionally to B&Cs and clinics for CBSST groups and trainings.

FY 18/19 – Full year, 1 team plus 3% cola

1. Personnel

- a) 1.0 FTE Community Support Worker Level II; **(\$42,572)** - the primary responsibility of the CSW will be to co-lead CBSST groups at B&Cs that house consumers.
- b) 1.0 FTE Mental Health Clinical Specialist; **(\$74,240)** - the primary responsibilities will be to lead CBSST groups at B&Cs that house consumers as well as collaborate with clinics and agencies that that provide services for consumers.
- c) 1/6th Administrative Service Assistant III (ASAIII); **(\$13,676)** – staff responsible for overall project implementation.
- d) 1/6th Mental Health Project Manager; **(\$16,153)** – assists with providing staff support to innovation project for oversight and evaluation.

FY 19/20 – Full year, 2 teams plus 3% COLA

1. Personnel

- a) 2.0 FTE Community Support Worker Level II; **(\$87,698)** - the primary responsibility of the CSW will be to co-lead CBSST groups at B&Cs that house consumers.
- b) 2.0 FTE Mental Health Clinical Specialist; **(\$152,934)** - primary responsibilities will be to lead CBSST groups at B&Cs that house consumers as well as collaborate with clinics and agencies that that provide services for consumers.
- c) 1/6th Administrative Service Assistant III (ASAIII); **(\$14,087)** – staff responsible for overall project implementation.
- d) 1/6th Mental Health Project Manager; **(\$16,637)** – provides staff support to innovation project for oversight and evaluation.

FY 20/21 – Full year, 2 teams plus 3% COLA

1. Personnel

- a) 2.0 FTE Community Support Worker Level II; **(\$90,328)** - the primary responsibility of the CSW will be to co-lead CBSST groups at B&Cs that house consumers.
- b) 2.0 FTE Mental Health Clinical Specialist; **(\$157,522)** - the primary responsibilities will be to lead CBSST groups at B&Cs that house consumers as well as collaborate with clinics and agencies that that provide services for consumers.

- c) 1/6th Administrative Service Assistant III (ASAIII); **(\$14,510)** – staff responsible for overall project implementation.
- d) 1/6th Mental Health Project Manager; **(\$17,137)** – assists with providing staff support to innovation project for oversight and evaluation.

FY 21/22 – Full year, 3 teams plus 3% COLA

Personnel

- a) 3.0 FTE Community Support Worker Level II; **(\$139,554)** - the primary responsibility of the CSW will be to co-lead CBSST groups at B&Cs that house consumers.
- b) 3.0 FTE Mental Health Clinical Specialist; **(\$243,372)** - primary responsibilities will be to lead CBSST groups at B&Cs that house consumers as well as collaborate with clinics and agencies that that provide services for consumers.
- c) 1/6th Administrative Service Assistant III (ASAIII); **(\$14,946)** – staff responsible for overall project implementation.
- d) 1/6th Mental Health Project Manager; **(\$17,651)** – assists with providing staff support to innovation project for oversight and evaluation.

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
1.	Salaries	71,185	146,642	271,256	279,392	415,309	1,183,782
2.	Direct Costs	27,051	56,483	103,859	106,974	168,647	463,014
3.	Indirect Costs	4,747	9,774	18,092	18,635	27,703	78,951
4.	Total Personnel Costs	102,983	212,898	393,207	405,001	611,659	1,725,747
OPERATING COSTs							
5.	Direct Costs	13,527	28,241	51,930	53,487	84,324	231,509
6.	Indirect Costs	2,375	4,887	9,046	9,317	13,852	39,477
7.	Total Operating Costs	15,902	33,128	60,976	62,804	98,176	270,986

NON RECURRING COSTS (equipment, technology)		FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
8.							
9.							
10.	Total Non-recurring costs	84,000					
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
11.	Direct Costs						
12.	Indirect Costs						
13.	Total Consultant Costs						

OTHER EXPENDITURES (please explain in budget narrative)		FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
14.							
15.							
16.	Total Other expenditures						

BUDGET TOTALS							
Personnel (line 1)		71,185	146,641	271,255	279,392	415,309	1,183,782
Direct Costs (add lines 2, 5 and 11 from above)		40,578	84,724	155,789	160,461	252,971	694,523
Indirect Costs (add lines 3, 6 and 12 from above)		7,122	14,661	27,138	27,952	41,555	118,428
Non-recurring costs (line 10)		84,000					84,000
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		202,885	246,026	454,182	467,805	709,835	2,080,733

C. Expenditures By Funding Source and FISCAL YEAR (FY)

Administration:

A.	Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
1.	Innovative MHSAs Funds	11,088	22,841	23,526	24,232	24,959	106,646
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	11,088	22,841	23,526	24,232	24,959	106,646

Evaluation:

B.	Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:	FY17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
1.	Innovative MHSAs Funds	13,095	26,976	27,785	28,619	29,478	125,953
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	13,095	26,976	27,785	28,619	29,478	125,953

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	Total
1.	Innovative MHSAs Funds	202,885	246,026	253,418	261,018	283,853	1,247,200
2.	Federal Financial Participation			100,382	103,394	212,991	416,767
3.	1991 Realignment			100,382	103,394	212,991	416,767
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	202,885	246,026	454,182	467,805	709,835	2,080,733

*If "Other funding" is included, please explain.

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

ATTACHMENT 1- Three Year Program and Expenditure Plan Signed Letter

D. 7



Contra
Costa
County

To: Board of Supervisors
From: William Walker, M.D., Health Services Director
Date: June 13, 2017

Subject: Mental Health Services Act (Proposition 63): Three Year Program and Expenditure Plan for Fiscal Year 2017/20

RECOMMENDATION(S):

ACCEPT the recommendation of the Behavioral Health Services Director to adopt the Mental Health Services Act Three Year Program and Expenditure Plan for Fiscal Years 2017/20.

AUTHORIZE the Chair of the Board of Supervisors to sign the attached letter to the Mental Health Services Oversight and Accountability Commission (MHSOAC) to inform the MHSOAC of the Board's approval of the adoption of this Plan.

FISCAL IMPACT:

Adoption of the Mental Health Services Act Three Year Program and Expenditure Plan, Fiscal Year 2017/20 assures continued MHSA funding for Fiscal Year 2017/18 in the amount of \$51,574,742.

BACKGROUND: Proposition 63 was passed by California voters in the November 2004 election. Now known as the Mental Health Services Act (MHSA), the legislation provides public mental healthfunding by imposing an additional one percent tax on individual taxable income in excess of one million.

APPROVE OTHER
 RECOMMENDATION OF CNTY ADMINISTRATOR RECOMMENDATION OF BOARD COMMITTEE

Action of Board On: 06/13/2017 APPROVED AS RECOMMENDED OTHER

Clerks Notes:

VOTE OF SUPERVISORS

AYE: John Gioia, District I Supervisor
Candace Andersen, District II Supervisor
Diane Burgis, District III Supervisor
Karen Mitchoff, District IV Supervisor
Federal D. Glover, District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: June 13, 2017

David J. Twa, County Administrator and Clerk of the Board of Supervisors

By: June McHuen, Deputy

Contact: Cynthia Belon,
925-957-5201

cc: T Scott, M Wilhelm, Warren Hayes

BACKGROUND: (CONT'D)

million dollars. There are a total of five MHSA components which have been enacted out over time by the State with the goal of creating a better program of mental health services and supports in California's public mental health systems. The five components include: Community Services and Supports; Prevention and Early Intervention; Workforce Education and Training; Capital Facilities and Technology; and Innovation. There are multiple programs operated within each component. This is a state mandated program under Welfare & Institutions Code.

ATTACHMENTS

Plan Summary

MHSA 3 Year Plan 2017-20

Letter to MHSOAC

ATTACHMENT 2 - Signed Letter to Mental Health Services OAC

WILLIAM B. WALKER, M.D.
Health Services Director
CYNTHIA BELON, L.C.S.W.
Behavioral Health Services Director



**CONTRA COSTA
BEHAVIORAL HEALTH
SERVICES
ADMINISTRATION**
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5201
Fax 925/957-5156

June 13, 2017

Mental Health Services Oversight and Accountability Commission
1300 17th St., Suite 1000
Sacramento, CA 95811
E-mail: mhsoac@mhsoac.ca.gov

Dear Mental Health Services Oversight and Accountability Commission:

Enclosed you will find the Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for Fiscal Year 2017/2020, to include the proposed Innovation Projects, "Center for Recovery and Empowerment (CORE)" and "Cognitive Behavioral Social Skills Training (CBSST)", as required. The Draft MHSA Three Year Program and Expenditure Plan for FY 2017/2020 was posted for the required 30 day public review and comment period from March 17, 2017 through April 19, 2017, with a public hearing on May 3, 2017. The MHSA Three Year Program and Expenditure Plan for FY 2017/2020 was adopted by the Contra Costa County Board of Supervisors on June 13, 2017.

Please note that we will be seeking Mental Health Services Oversight and Accountability Commission (MHSOAC) approval for the aforementioned new Innovation projects during the upcoming fiscal year. The descriptions contained herein are meant to inform our stakeholders in regards to our intentions for FY 2017/2020, and only include the budget for the first several months of project implementation (estimated start January 2018). These descriptions are not intended to seek and receive approval from the MHSOAC. Detailed project descriptions and multi-year budgets will be submitted to the MHSOAC in a separate document, and will constitute Contra Costa County's official request for approval.

As required, we have enclosed one hard copy with original signature, and one electronic copy that is a single document in PDF format, for submission.

If you have any questions on this request, please contact: Cynthia Belon, LCSW, Behavioral Health Services Director, 925-957-5201, or Cynthia.Belon@hcd.eccounty.us.

Thank you.

Sincerely,

Federal D. Glover, District V
Chair of the Contra Costa County Board of Supervisors

Enclosure: Contra Costa County Adopted MHSA Three Year Program and Expenditure Plan for FY 2017/2020 +



• Contra Costa Emergency Medical Services • Contra Costa Environmental Health • Contra Costa Health Plan • Contra Costa Hazardous Materials Programs •
• Contra Costa Behavioral Health • Contra Costa Public Health • Contra Costa Regional Medical Center • Contra Costa Health Centers