
2019 Mental Health System of Care Needs Assessment



Contra Costa County
Behavioral Health Services
December 2019

Executive Summary

Mission, Commitment and Vision

The mission of Contra Costa Health Services (CCHS) is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems.

- We provide high quality services with respect and responsiveness to all.
- We are an integrated system of health care services, community health improvement and environmental protection.
- We anticipate community health needs and change to meet those needs.
- We work in partnership with our patients, cities and diverse communities, as well as other health, education and human service agencies.
- We encourage creative, ethical and tenacious leadership to implement effective health policies and programs.

In 2019 CCHS also launched its Envision Health planning process to understand, think about, deliver and support health in Contra Costa County to collectively address changing realities. CCHS is working with the community and partners in planning for health realities for 10, 20 and even 30 years into the future.

Ensuring, promoting and protecting the health of everyone in Contra Costa, especially our most vulnerable, demands that we be thoughtful, proactive and bold. We cannot afford to be stuck with plans that respond to yesterday's realities. We owe it to our community to step out of our comfort zone, peer into the future and work with both existing and non-traditional partners to create a future system of health that advances the health of all Contra Costa while being responsive to our changing world¹.

The Contra Costa County Behavioral Health Services (BHS) Division, under Contra Costa Health Services; in partnership with consumers, families, staff, and community-based agencies strives to provide welcoming, integrated services for mental health, substance abuse, and other needs that promote wellness, recovery and resiliency; while respecting the complexity and diversity of the people we serve².

BHS is committed to strengthening its ongoing efforts in providing a system of care that works to be integrated, promotes wellness and recovery, be culturally responsive and linguistically appropriate to the communities served. The 2019 Mental Health System of Care Needs Assessment, herein forth referred to as the 2019 Needs Assessment details data and strategies that outline BHS's response to address the service needs and continue work to build a more equitable system of care.

Purpose

The primary purpose of the Needs Assessment is to evaluate the service and workforce needs of the populations BHS is intended to serve as well as identify possible gaps or areas that need strengthening within its system of care and adopt strategies to attend to those needs through the Mental Health Services Act (MHSA)³. BHS conducted a triennial quantitative and qualitative assessment of its system needs to inform and prepare for the implementation of the Fiscal Year 2020-2023 Mental Health Services Act (MHSA) Three Year Program and Expenditure; herein after referred to as the 2020-2023 Three Year Plan.

¹Contra Costa County Health Services Envision Health. <https://cchealth.org/healthservices/envision-health.php>

² Contra Costa County Behavioral Health Services. <https://cchealth.org/bhs/about-us.php>

³ Mental Health Services Act Oversight and Accountability Commission. <http://mhsoac.ca.gov/document/2020-02/mental-health-services-act-revised-january-27-2020>

BHS including contracted community based organizations and other agencies are primarily responsible for providing mental health and alcohol and other drug services to individuals who are considered to have moderate to severe illnesses and are Medi-Cal eligible or living in poverty and are considered to be eligible for services in the public mental health system. Currently, 61% of services are provided by contracted CBOs, with the other 39% being compiled of County operated/ staffed clinics and network providers⁴. Taking into consideration that Mental Health and Alcohol and Other Drug Services have been integrated within recent years under the BHS System of Care, it is important to note that this Needs Assessment is primarily focused on the mental health service delivery.

Method

The following questions were used to analyzing the information presented in this Needs Assessment:

- 1) What populations in Contra Costa County is BHS intended to serve and which populations are being served?
- 2) What is the demographic composition of the Contra Costa County population?
- 3) How is BHS aligning its resources and funding to ensure it is providing a full spectrum of services at the appropriate level; while also working to meet the needs in a culturally and linguistically responsive, wellness-oriented manner?
- 4) How is BHS developing its workforce to address and implement identified service needs?
- 5) Are there service gaps or identifiable needs and how will BHS work to address these needs over the next three years?

Findings

Data analysis supports that BHS is serving most clients/consumers/peers and families requiring services, and moreover serves more eligible clients than most counties in California⁵. This is based upon prevalence estimates and penetration rates of economically under privileged children with serious emotional disturbance and adults with a serious mental illness as compared with other counties. In lieu of this, it is important to continually renew efforts in service delivery by gaging data, evaluating services and gathering client/consumer/peer and family input as methods to strategize on more effective service delivery and improvement.

Significant findings revealed through this Needs Assessment included the following:

- 1) There are significant identifiable gaps in service delivery when considering Asian/Pacific Islander, LatinX/ Hispanic and children ages 0-5 years which show to be underrepresented when considering penetration rates in comparison to other groups within Contra Costa County.
- 2) There continues to be an ongoing need for housing support for those individuals and families affected by mental health and it continues to be the number one need.
- 3) Based on data analysis and stakeholder input, there is a need to strengthen services that can support children, youth and adults who are high acuity or have severe emotional disturbances or severe mental health challenges.
- 4) As a method of prevention and early intervention, suicide prevention, awareness, and training is needed throughout the County, with special consideration for youth and young adults.
- 5) As voiced in the 2016 Needs Assessment, the need for an electronic data management system which facilitates systems evaluation and informative decision making and planning remains.

⁴FY 2018-2019 Medi-Cal Specialty Mental Health External Quality Review. Page 28. <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>

⁵ FY 2018-2019 Medi-Cal Specialty Mental Health External Quality Review. Page 15. <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>

- 6) Workforce analysis and system delivery indicates the need to continue supporting a Loan Repayment Program to address the need for psychiatry time.
- 7) Workforce evaluation also indicated that there are minimal career progression opportunities for the classifications of peers and family partners.
- 8) Staffing for language capacity remains a need, continuing from the 2016 Needs Assessment, specifically for Spanish and Asian/Pacific Islander languages (to be further defined). Workforce staffing also shows that LatinX/ Hispanic and API groups are also under-represented in BHS staffing.

Recommendations

BHS recognizes the importance of developing programs and services that are receptive to the clients/ consumers/peers, families, and community as well as the development of a workforce that can support and respond to the needs of those served. Strengthening program development also involves collecting and analyzing data to better inform on planning practices. Input gathered through this data driven analysis complements the Community Program Planning Process (CPPP), where stakeholders which include clients/ consumers/peers, families, service providers, the workforce and community in general provide input in various methods to prioritize needs. The data collected and used in this Needs Assessment includes quantitative and qualitative data studies collected from various County sources; as well as State and other reports referenced herein. The recommendations made, use both input gathered from the CPPP, as well as data analysis. Details on the recommendations made are further explained throughout the report.

It is recommended that BHS take special consideration to the needs outlined below and focus efforts and planning through its upcoming 2020-2023 MHSA Three Year Plan.

- 1) Strengthen outreach and engagement strategies for identified underserved populations identified as Asian/Pacific Islander, LatinX/ Hispanic, children ages 0-5 years across the county.
- 2) Continue to explore and strengthen methods on how to support all BHS clients/consumers/peers and their families in methods that support culturally responsive and humble practices and provide linguistic access to create more equitable outcomes.
- 3) Continue to strengthen integration efforts with Alcohol and Other Drug (AOD) Services to better serve clients/consumers/peers and families affected by mental health and substance use (or dual diagnosis).
- 4) Provide outreach, education, and link treatment specifically for families with young children between the ages of 0-5 to promote and educate about early childhood mental health and intervene early so that children can have improved mental health outcomes and families can learn how to promote healthy mental health in early childhood.
- 5) As housing continues to be the top need throughout the State, it is essential to fund more Supportive Housing models designed to offer mental health support services for the most vulnerable populations affected by mental health challenges. Specifically, for youth with systems involvement, such as foster care, BHS is working to support the creation of a Short Term Residential Treatment Facility (STRTP) that can assist children with high need serious emotional disturbances, to be able to remain in Contra Costa County versus an out of county placement.
- 6) It is recommended BHS continue to apply for No Place Like Home (NPLH) funding to obtain more funding for permanent supportive housing, as well as continue to retain and recruit more augmented board and cares. Furthermore, BHS should continue its ongoing goal to repurpose the Oak Grove site through NPLH funds, as well as additional MHSA County funds to house and provide on-site treatment for transition aged youth; as well as other populations that are affected by mental health.
- 7) It is recommended that continued support for flexible housing funds continue to provide flexibility in housing support for the various models of housing offered for those affected by mental health.

- 8) In efforts to address the need for high acuity treatment, further support for Assertive Community Treatment (ACT) to fidelity or Full Service Partnership (FSP) programs which are models that have shown to decrease visits to psychiatric emergency services (PES), hospitalization rates, and length of stay when hospitalized, as well as a decrease in Juvenile Assessment and Consultation Services (JACS) rates for juvenile population. Further work to identify law enforcement and judicial involvement data for adults is needed to gauge this outcome. Funding services for supportive housing and ACT to fidelity models, will also allow for movement of those individuals experiencing mental health challenges that are in locked facilities to have the opportunity to enter treatment as well as assisting with the decreasing PES visits for those individuals served. This effort also assists to address the associated high costs of those individuals which access PES, which allows funding to be utilized for programming.
- 9) Implement support for further suicide prevention efforts county wide to prevent, create awareness and support services and training in relation to suicide.
- 10) Continue to recruit and retain psychiatrists and psychiatric nurse practitioners through the Loan Repayment Program. Efforts made since the 2016 Needs Assessment have led to a decrease in the wait time to the average number of days to access services as well as retaining staff in hard to fill positions.
- 11) Improve capacity to strengthen a career progression for peer partners and family partners to be retained through the Loan Repayment Program to pursue higher education to obtain a behavioral health related degree and retain quality staff with lived experience. Create further Mental Health Specialist Positions within the County system to allow for those in peer and family partner classifications to promote to a higher paid classification, and will permit for movement of others into peer and family partner roles; with consideration to hire individuals with other language capacities.
- 12) Further fund internship programs through partner CBOs with specific consideration for Spanish and Asian/Pacific Islander (to be further identified) language needs which enables further workforce development in efforts to support mental health for underserved communities.
- 13) It is also essential that BHS continue to increase the number of staff with other language capacities, specifically for Spanish and Asian/Pacific Islander languages as well as further recruiting individuals from these communities; as workforce staffing shows these groups are also under-represented. In general, BHS should continue to recruit staff that identify with the culture of those being served; not just considering ethnicity/race, but also considering age, lived mental health and systems involvement experience, sexual identity, gender and when possible individuals which come from the communities being served.
- 14) Lastly, it is recommended that BHS support an internal electronic data management system to better inform BHS and the community, as well as facilitate analysis, oversight, information gathering, and decision making as currently, there are many challenges in obtaining data, one being that information must be pieced together from various sources which often involves a lengthy and difficult process.

I. Community Program Planning Process

The Community Program Planning Process (CPPP) is a method in which input is received by BHS from clients/consumers/peers, families, services providers, the workforce and community in general. Part of the qualitative and quantitative data and input that is used in this report was collected through the CPPP. This information is also analyzed to identify service needs, system gaps, and strategize how programming and planning can be directed to address the identified needs.

Input is received through community forums, in-person interviews, surveys, and through various meeting groups throughout BHS's System of Care. Detailed examples of the CPPP include, but are not limited to:

- Various client/consumer/peer, family, community, and service provider interviews and surveys

conducted through the MHSAs Program Reviews of MHSAs funded programs.

- Community Forums which include hearing from clients/consumers/peers, families, community members, and service providers throughout the community. The forums are offered in partnership with Community Based Organizations (CBOs) and target specific topics. Forum topics to date have been focused on Family Support in Relation to Mental Health, Supporting Mental Health in Youth, Serving Immigrant Communities, Supportive Housing, Suicide Prevention, and Early Childhood Mental Health. These forums provide several avenues for the community to provide input such as small group discussions where input is collected via notes. A public comment portion; as well as written input forms. If an individual prefers to provide input for the public comment period but does not wish to speak in front of a large crowd, they can write their input on a card and a staff member will read their comment. All forum attendees are provided the opportunity to prioritize needs by voting at each forum. On average, 100 people attend a forum, and about 1,000 participants from various regions of the county have participated in Community Forums over the three years between 2017 through 2019. Nine forums were held in total. In 2018, the community forums started being live streamed as another method to address accessibility challenges, giving people the opportunity to participate remotely via a video feed. People viewing the forums could provide input via email.
- Committees and Workgroups such as the Consolidated Planning Advisory Workgroup (CPAW) and its sub-committees of Systems of Care, Membership, Steering and Innovation. Other meeting groups include; Suicide Prevention, Social Inclusion, Reducing Health Disparities (RHD), Children's, Teens, and Young Adults (CTYA) Committee, Adults Committee, Aging and Older Adults Committee, Alcohol and Other Drugs (AOD) Advisory Board, the Behavioral Health Care Partnership (BHCP), the Training Advisory Workgroup (TAW), and the Mental Health Commission (MHC). All meeting groups are open to the community. Ongoing efforts are made to include involvement from clients/consumers/peers, families, and service providers to have various voices present in shaping and integrating services and programs. Meeting groups also serve to dialogue with BHS Staff and Leadership and the overall Health Services Department in evaluating service responsiveness and quality

Client/consumer/peer and family input is also received through the Mental Health Statistics Improvement Project (MHSIP) Forms that are administered semi-annually, as well as specific language access reports generated from the Language Access Line. Any person receiving services through BHS or a contracted CBO also has the right to file a formal grievance. Grievances also serve to inform BHS on its system of care. Workforce needs within BHS are evaluated using internal assessment of positions, staffing capacity challenges in staffing, and through surveys data collected by BHS. BHS has developed all these various practices to identify, address, and inform on service needs while aiming to create more equitable services. Efforts are made to continually work to improve methods, services and systems.

The Community Forums listed, were part of the CPPP conducted in 2019. The forum topics were chosen based on stakeholder groups and input received. One forum was held in each region of the County and the community was informed via distribution of flyers to local CBOs and other agencies, outreach to schools, social media and via email, as well as through the County's internal communications team, which also has connections to local news outlets. Materials were also made available in Spanish and translation services were offered at all forums.

Community Forum focused on Supportive Housing

At the Community Forum focused on Supportive Housing 110 people signed in and 101 people completed a demographic form, with breakdown as follows:

- Gender
 - 66% female
 - 29% male
 - 5% other
- Age
 - 1% Under 16
 - 9% 16-25
 - 67% 26-59
 - 20% Over 60
- Identity (Could select multiple choices)
 - 10% Consumers
 - 22% Family
 - 26% Service Providers
 - 16% CCBHS Staff
 - 15% Other
- 29 Evaluation Forms were received. Scores were on a scale of 1-5 (1 = strongly disagree, 5 = strongly agree):
 - Objectives of the forum were clearly stated – 4.3
 - Forum met objectives – 4.16
 - Breakout sessions – group discussions were effective – 4.41
 - Community input – right topics chosen – 4.04
 - Felt comfortable sharing – 4.44
 - Overall satisfaction with experience – 4.41
 - Overall satisfaction with method of obtaining input – 4.44
 - Overall satisfaction with location – 3.79
 - Overall satisfaction with availability of accommodations – 4.21

A sampling of what attendees felt were the most pressing issues were:

- More funding for housing of all kinds, including housing with on-site services
- Cultural Humility/Awareness
- Navigation/case management services available and offered by people with lived experience/peers
- Transportation
- Life skills training / meaningful activity options for people living with severe mental illness (SMI)

Community Forum focused on Suicide Prevention

At the Community Forum focused on Suicide Prevention, a total of 110 people signed in and 92 of those people completed a demographics form, with breakdown as follows:

- Gender
 - 67% female
 - 29% male
 - 3% other
- Age
 - 8% Under 25
 - 75% 26-59
 - 19% Over 60
- Identity (could select multiple choices)

- 14% Consumers
- 13% Family
- 57% Service Providers
- 17% CCBHS Staff
- 13% Other
- Area of County Identified with (could select multiple):
 - 32% West
 - 70% South/Central
 - 33% East
- Race/ Ethnicity Identified with:
 - 54% White/Caucasian
 - 16% Hispanic/Latino
 - 11% Black/African American
 - 10% Asian/Pacific Islander
 - 13% Other

A sample of what attendees felt were the most pressing issues were:

- Housing (all types including permanent supportive housing)
- Education around suicide prevention
- More language access – printed materials, meetings available in multiple languages
- Mental health resources / education for families and young children
- Lack of cohesive/coordinated resources
- More regionally located resources (especially East county)
- More crisis response support services
- More to combat mental health stigma

Some of the suggestions and comments conveyed that overall it was a positive experience at the forum. The attendees liked the speakers and liked that Spanish translation was made available, as well as food. Some suggested areas for improvement included having better audio quality, the wi-fi was poor and live streaming this event was a challenge. Use more web presence/social media to promote event (like, share, tweet, post).

- 31 Evaluation Forms were received. Scores were on a scale of 1-5 (1 = strongly disagree, 5 = strongly agree):
 - Objectives of the forum were clearly stated – 4.35
 - The forum met the stated objectives – 4.32
 - Method of obtaining input in small group discussion was effective – 4.26
 - The right topics were chosen – 4.56
 - I felt comfortable providing input – 4.61
 - Overall you were satisfied with your experience – 4.46
 - Overall you were satisfied with the method of obtaining input – 4.42
 - Overall you were satisfied with the location – 4.33
 - Overall you were satisfied with the time frame – 4.14
 - Overall you were satisfied with the length of forum – 4.15
 - Overall you were satisfied with availability of reasonable accommodations – 4.65

Community Forum focused on Early Childhood Mental Health

At the Community Forum focused on Early Childhood Mental Health, a total of 151 people attended. 123 of these individuals were adults and 28 were children who received childcare that was made available. Of the 116 adults, 93 of them completed a demographics form, with breakdown as follows:

- Gender
 - 93% female
 - 6% male
 - 1% other
- Age
 - 5% 16-25
 - 85% 26-59
 - 10% Over 60
- Identity (Could select multiple choices)
 - 5% Consumers
 - 10% Family
 - 54% Service Providers
 - 10% CCBHS Staff
 - 23% Other
- Area of County Identified with (could select multiple):
 - 25% West
 - 37% South/Central
 - 59% East
 - 1 attendee was from Sonoma County
- Race/ Ethnicity Identified with:
 - 39% White/Caucasian
 - 30% Hispanic/Latino
 - 18% Black/African American
 - 11% Asian/Pacific Islander
 - 4% Native American/ Alaskan Native
 - 8% Other

A sample of what attendees felt were the most pressing issues were:

- Training, Support, Education for Families and Teachers
- Trauma Informed Care – including implicit bias, cultural humility, intergenerational trauma, preventing Adverse Childhood Experiences (ACEs), and compassion fatigue
- Access and Quality of Care – including marginal preschools, daycares, long wait lists, inconvenient times, lack of resources
- Prevention and Early Intervention
- Stigma Reduction
- Advertising / Resource Information
- Black Mental Health Issues – including disproportionate preschool expulsion, discipline
- Peer Support

Some of the suggestions and comments conveyed were that there is a need for trainings and events, specifically in relation to culture, such as including African American, Islamic, LGBTQ peers in mental health, emphasizing more cultural humility. Create trauma transformed systems, address racism, cultural

appropriation, impact of politics on mental health. Have more of a partnerships/ collaboration with other health care systems (i.e. Kaiser), K-12 systems, other stakeholders. Funding specifically allocated for children 0-5, bridging gaps for the transition between early childhood (0-5) and school age (6-18), and system navigation support. Attendees stated that they liked learning about new resources / new information, they like the small group discussions and opportunity to give input, the passion of the community, as well as meeting new people, learning about the importance of the 0-5 experience, and hearing from speakers.

93 Evaluation Forms were received. Below are the responses:

Overview of MHSA and forum objectives - clearly stated, forum met stated objectives:	Breakout Sessions – method of obtaining info was effective:	Community Input – right topics were chosen, felt comfortable giving input:	Overall were you satisfied with - your experience, method of obtaining input, location, time frame, length, accommodations:
Strongly Agree: 67% Agree: 25% Neutral: 8%	Strongly Agree: 72% Agree: 21% Neutral: 7%	Strongly Agree: 79% Agree: 14% Neutral: 7%	Strongly Agree: 64% Agree: 30% Neutral: 6% Disagree: < 1%

Additionally, as part of each community forum, participants are asked to prioritize previously identified service needs via applying dot markers. The identified needs were gathered from the previous years' CPPP. This strategy provides a means for evaluating perceived impact over time of implemented strategies to meet prioritized needs. Thus, service needs determined to be unmet in previous years may change in ranking as the BHS system addresses these needs. The needs listed in the 2019-2020 MHSA Three Year Plan are listed in order of priority as determined by forum participants, with a comparison to the 2018-2019 year's rankings.

Current Year's Rank	Previous Year's Rank
1 More housing and homeless services	1
2 More support for family members and loved ones of consumers	3
3 Support for peer and family partner providers	11
4 Improved response to crisis and trauma	4
5 Connecting with the right service providers in your community when you need it	5
6 Outreach to the underserved – provide care in my community, in my culture, in my language	2
7 Increased psychiatry time	12
8 Intervening early in psychosis	8
9 Children and youth in-patient and residential beds	9
10 Getting to and from services	7
11 Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care	6
12 Care for the homebound frail and elderly	13
13 Assistance with meaningful activity	14
14 Serve those who need it the most	10

All the input received through the Community Forums, as well as the input received through the stakeholder

groups is taken into consideration; while also reviewing programming data to see areas where there may be service gaps for strategizing service delivery. County demographics and data is also included in this Needs Assessment to provide a better picture for strategizing.

II. Contra Costa County at a Glance

According to the most recent 2018 U.S. Census Bureau estimates, the population size in Contra Costa County was estimated at 1,150,215⁶. It's estimated that about 9% of people in Contra Costa County are living in poverty⁷ and about 30% of the non-institutionalized residents have public health coverage,⁸ however with the passing of the Affordable Care Act⁹ the numbers of people eligible are foreseen to grow as Medi-Cal eligibility is considered for some cases to be up to 322% Federal Poverty Level (FPL)¹⁰. Information released by the State of California's Department of Finance, projects that population size is expected to grow. Latino/Hispanic and Asian/ Pacific Islander communities will see larger population growth¹¹.

An estimate of current racial/ethnic demographic data is illustrated below in Figure 1. In addition, more than half of the population is 18 or older, with about 30% of the population being children.¹² Further age estimates can be seen in Table 1. About a quarter of Contra Costa County residents are foreign born¹³.

Figure 1: Contra Costa County 2019 Projected Racial/ Ethnic Populations

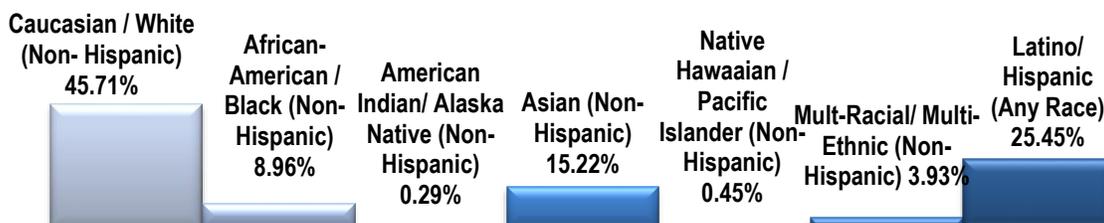


Table 1: Contra Costa County Age Demographic Estimates

Age Estimates	Percentage
*Compiled from 2013-2017 American Community Survey 5-Year Estimates for Age	
Children, Teens, & Young Adults (Ages 0-25)	About 30%
Adults (Ages 26-59)	About 50%
Older Adults (Ages 60+)	About 20%

*Please note: Table 1 illustrates the age estimates in Contra Costa County shown in relation to the BHS System of Care.

⁶ United States Census Bureau Quick Facts Contra Costa County, California: <https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia/AGE135218#AGE135218>

⁷ United States Census Bureau Quick Facts Contra Costa County, California: <https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia/RHI325218#RHI325218>

⁸ United States Census Bureau Information: Summary Statistics for the U.S., States, and Selected Geographies: 2017: https://data.census.gov/cedsci/table?q=contra%20costa%20county%20data&hidePreview=false&table=DP03&tid=ACSDP1Y2018.DP03&g=0500000US06013&vintage=2018&layer=county&cid=DP02_0001E&lastDisplayedRow=124

⁹ HealthCare.Gov Affordable Care Act: <https://www.healthcare.gov/glossary/affordable-care-act/>

¹⁰ Covered California Program Eligibility by Federal Poverty Level for 2020: <https://www.coveredca.com/pdfs/fpl-chart.pdf>

¹¹ State of California Department of Finance Projections: <http://www.dof.ca.gov/Forecasting/Demographics/projections/>

¹² Unites States Census Bureau American Fact Finder: <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

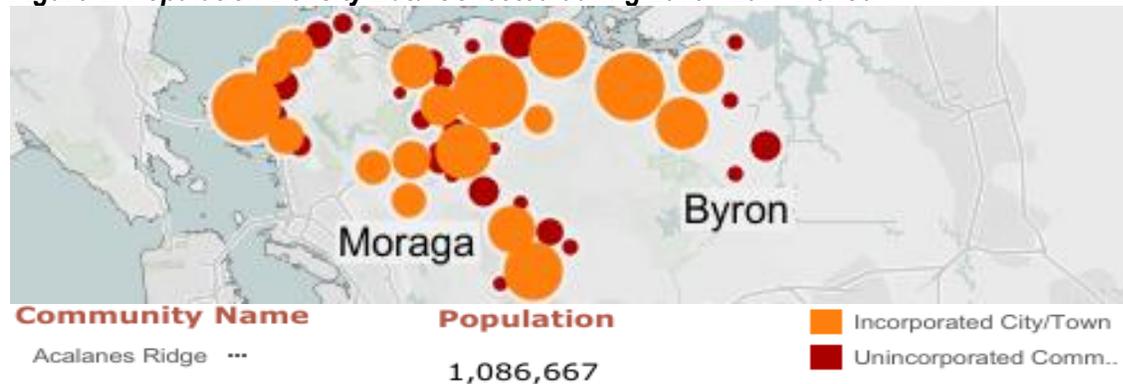
¹³ United States Census Bureau Quick Facts Contra Costa County, California: <https://www.census.gov/quickfacts/fact/table/contracostacountycalifornia/RHI325218#RHI325218>

In considering geographical make up, Contra Costa County is primarily identified by three geographically dispersed regions with each area having unique sub-populations. These three regions are West, Central and East County.

- West County: includes the cities of El Cerrito, Richmond, San Pablo, Pinole, and Hercules, and the unincorporated communities of Kensington, El Sobrante, North Richmond, Rodeo, Crockett, and Port Costa
- Central County: includes the cities of Lafayette, Moraga, Orinda, Walnut Creek, Pleasant Hill, Concord, Clayton, Martinez, Danville and San Ramon and the unincorporated areas of Canyon, Pacheco, Vine Hill, Clyde, the Pleasant Hill BART station, Saranap, Alamo, Blackhawk, and Tassajara
- East County: includes the cities of Pittsburg, Antioch, Oakley, and Brentwood, and the unincorporated communities of Bay Point, Bethel Island, Knightsen, Discovery Bay, and Byron

A general county overview of population density by region is provided in Figure 2¹⁴.

Figure 2: Population Density Data Collected during 2015 - 2017 Period



III. Data Analysis, Gaps and Opportunities

Though we do not have all the answers and some of the challenges lie outside of the purview of the BHS System of Care, it is necessary to look at the voiced service needs; internal and external data that is available, as well as associated behavioral health factors.

Along with the CPPP, another indicator to BHS of the need for public behavioral health services is gauging the population being served by BHS, contracted network providers, and CBO partners.

In Figure 3, the bar in blue is the Contra Costa County Mental Health Plan or mental health services provided by BHS and contracted partners. The percentage of overall penetration rates for BHS show to be higher when compared to the average penetration rates of other large counties and the state average penetration rates¹⁵.

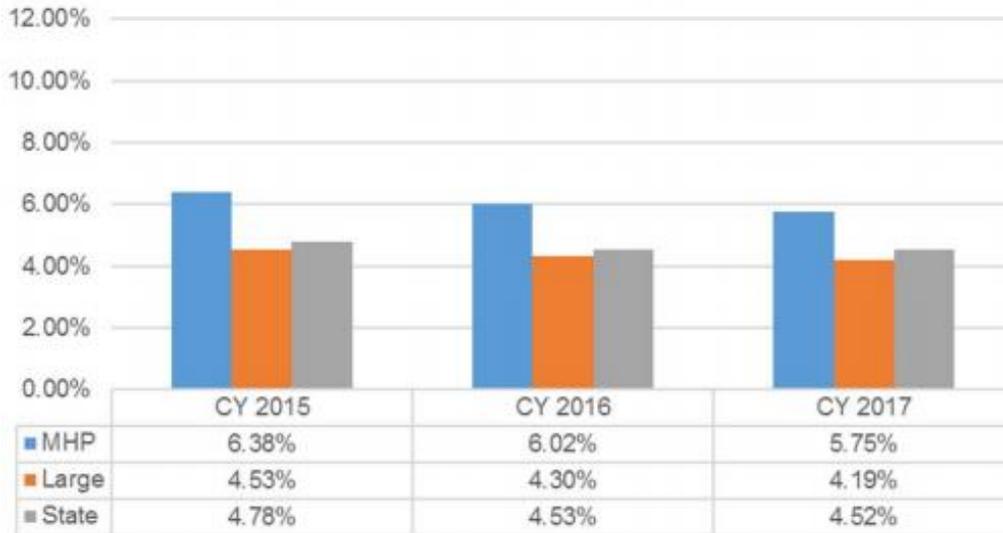
The penetration rates are the proportion of people being served by BHS in comparison to the total Medi-Cal eligible population within Contra Costa County. BHS calculates penetration rates by dividing the number of Medi-Cal eligible clients who accessed mental health services through BHS by the total number of Medi-Cal eligible clients in the County. The following formula was used to calculate penetration rates:

¹⁴Contra Costa County Conservation and Development Demographics: <https://www.contracosta.ca.gov/5342/Demographics>

¹⁵ FY 2018-2019 Medi-Cal Specialty Mental Health External Quality Review. Page 15. <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>

Penetration Rate = $\frac{\text{Number of Medi-Cal eligible clients who accessed mental health services from BHS}}{\text{Total number of Medi-Cal eligible clients in Contra Costa County}}$

Figure 3: Overall Penetration Rates Contra Costa Mental Health Plan (MHP)



Racial and Ethnic Data

The following table provides details on penetration rates of the Medi-Cal eligible population served by race/ethnicity for calendar year 2017 under the most recent 2018-2019 EQRO¹⁶.

Table 1 provides details on beneficiaries served by race/ethnicity.

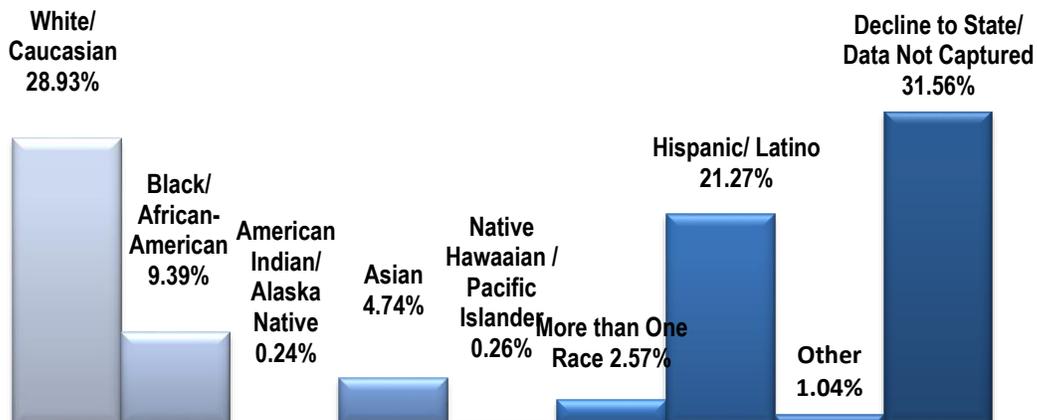
Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Contra Costa MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	52,576	19.0%	4,361	27.5%
Latino/Hispanic	98,653	35.7%	4,083	25.7%
African-American	40,123	14.5%	3,173	20.0%
Asian/Pacific Islander	32,424	11.7%	815	5.1%
Native American	775	0.3%	86	0.5%
Other	51,572	18.7%	3,365	21.2%
Total	276,122	100%	15,883	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

¹⁶ FY 2018-2019 Medi-Cal Specialty Mental Health External Quality Review. Page 14. <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>

Aside from this population, roughly 33,298 individuals were also served through CBOs under MHSAs funded programs that do not require Medi-Cal eligibility. Most of these CBOs fall under the MHSAs component of Prevention and Early Intervention (PEI). Figure 4 illustrates racial/ethnic demographic data for those individuals served through these CBOs.

Figure 4: BHS MHSAs Funded Community Based Organizations Racial/ Ethnic Data
2018-2019 Fiscal Year Racial/ Ethnic Demographic Data



In examining the data captured above, it seems there are areas where penetration rates are low for specific ethnic/racial groups in comparison to others. Specifically, penetration rates for the Latino/Hispanic and Asian/Pacific Islander communities seem to be disproportionately lower when taking into consideration the group percentage estimates of enrollees for these two racial/ethnic groups as well as the County population.

There can be several factors, linked to this such as needing more culturally responsive services as well as language staffing capacity to meet the needs for these specific racial/ethnic groups. However, another possible factor that may be affecting the low penetration rates for some communities may be due to the current political climate and immigrant ousting. Contra Costa County Health Services is aware that immigrant communities decreased accessing services due to the current political climate¹⁷. This has also been communicated through Program Reviews of some MHSAs funded programs as well as the MHSAs Community Forum focused on Serving Immigrant Communities¹⁸ where program participants, staff and community members voiced concerns in accessing County services.

A method in which can be addressed is to support workforce development for staff with specific Spanish or Asian/Pacific Islander (API) languages. Due to API languages being many; it is recommended that focus studies be conducted, and further language data analysis be completed to identify language needs under the API category. Another area that could be explored is to provide more support to these communities through CBOs partners who do not require Medi-Cal eligibility and serve these groups, which may assist in working to address some of the fear expressed by these communities.

Some indication of API languages can be identified through the reports submitted by MHSAs funded CBOs. The table displayed below summarized the data in the reports. After Spanish being a primary threshold

¹⁷ <https://cchealth.org/insurance/pdf/Public-Charge-Comment-12-7-18.pdf>

¹⁸ <https://www.youtube.com/watch?v=rFWIjW0Tla0&feature=youtu.be>

language, Tagalog and Farsi were listed more frequently, followed by Mandarin, Arabic, and Portuguese, Russian, Mien/Lao, Nepali, Chamorro, Bengali, and American Sign Language (ASL). Furthermore, in analyzing internal County data, the five top languages where interpreter services were accessed during the 2018-2019 year in order of utilization were Spanish, Vietnamese, Farsi, American Sign Language, and Cantonese.

Table 2. FY 2018-2019 Primary Language Spoken for MHSA CBO Client Data

Primary Language Spoken	Numbers Served
English	20,471
Spanish	6,181
Other	642
Decline to State or Data Not Captured	6,004

Capturing data to further support language needs and conducting focus groups will be a focus area of the Reducing Health Disparities Meeting Group. This will allow BHS to gain a better understanding of specific language needs, specifically for underserved communities both in County operated services and CBO partners.

Age

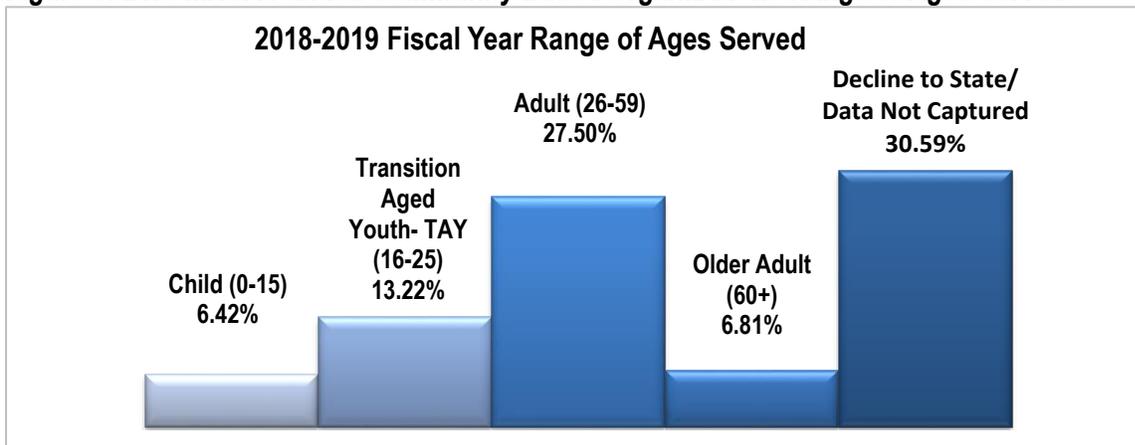
A limitation on capturing age within the County system is that there was a recently implemented electronic health record (EHR) and our internal Information Technology (IT) office which creates and assists in report developing from internal data collection systems is currently under strain with many requests for data reports that need to be created and tied to the newly implemented EHR.

The following figures and tables represent MHSA CBO service data. Figure 5 represents data in relation to age. PEI programs under the MHSA are mandated to provide more than half of funding supports to children. However, when reviewing data, it seems there is a need to strengthen services for children. A challenge faced was obtaining specific data to understand the children’s ages, specifically children under 12. A recommendation would be to try to capture more specific data that breaks up the category of children into further subsets as the age group of 0-15 is a vast range with children’s needs being very different in certain ages. This work to identify subsets of this age group shall be a focus of the RHD Meeting Group. Children between the ages of 0-5 continue to be a focus as identified continued from the 2016 Needs Assessment¹⁹.

As a response to the continued voice need to support families and provide training on mental health and efforts to reduce stigma, it is recommended that specific programming for early childhood mental health and families with young children between ages 0-5 have specific targeted educational programs and training services for families and service providers of young children. This further supports efforts of prevent and intervene early in children experiencing mental health challenges.

¹⁹ <https://cchealth.org/mentalhealth/mhsa/pdf/2016-ccbhs-needs-assessment.pdf>. Page 15.

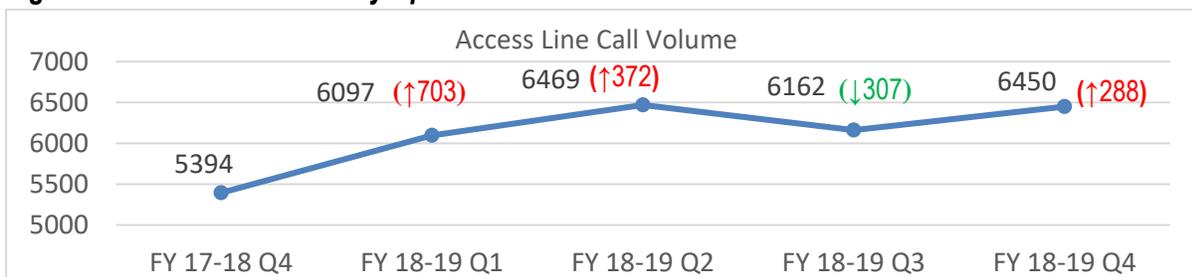
Figure 5: BHS MHSA Funded Community Based Organizations Range of Ages Served



Access Line Calls

Another method to gauge needs, is to consider the Access Line calls, which is the line people call to request services or appointments. During fiscal year 2018 – 2019, over 25,000 calls were received.²⁰ Figure 6 provides a snippet of data over a year period indicated the call volumes are rising.

Figure 6: Contra Costa County April 2017 - June 2019 Estimated Access Line Call Volume



Psychiatric Emergency Services

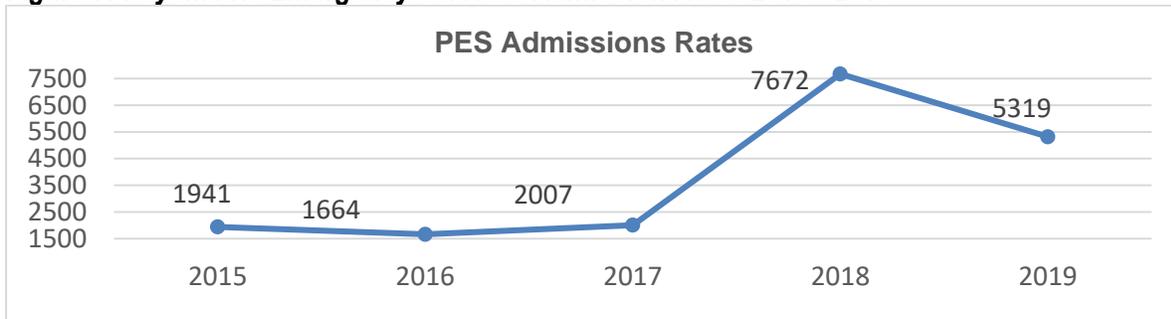
Psychiatric Emergency Services (PES) Admissions in Contra Costa have also increased since 2015²¹. Unfortunately, high hospitalization rates also have high cost which puts an overall strain on the System of Care and programming for services and programming delivered in the community. Figure 7 shows PES Admission rates since 2015.

²⁰ Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

²¹ Fiscal Year 2018-2019 Medi-Cal Specialty Mental Health External Quality Review: <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>.

Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

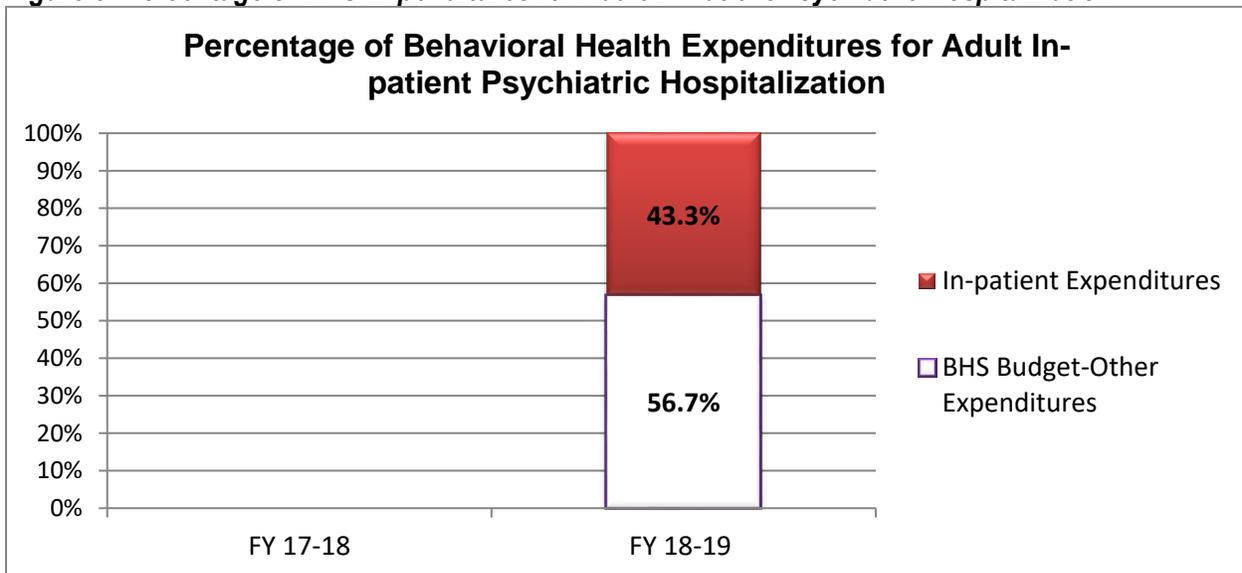
Figure 7: Psychiatric Emergency Services Admission Rates 2015 - 2019



*Please note only data for first half of 2019 was available at the time this report was completed.

The percent of BHS expenditures for in-patient psychiatric hospitalizations versus total adult system of care mental health program costs over time are outlined in Figure 8. It is evident that the costs for those hospitalized, almost meets the same percentage of costs for all other BHS budget expenditures in the adult system of care. The more that high cost services are utilized, the less funding is afforded for community programming. As a method to address the need for high cost, hospitalization services, BHS should explore and implement further methods that support high acuity clients.

Figure 8: Percentage of BHS Expenditures for Adult In-Patient Psychiatric Hospitalization



The total number of specialty mental health services provided by BHS is another indicator of service need. The specialty mental health services have also increased during the fiscal year 2018-2019²², as illustrated in the following figure.

²² Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

Figure 9: Total Number of Specialty Mental Health Services Provided FY 2018 – 2019

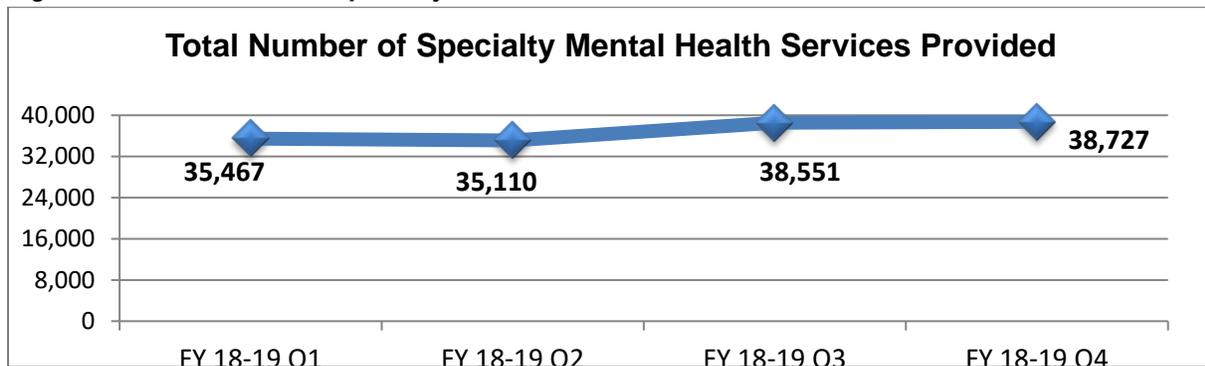


Figure 10 shows estimates which represent the percent of persons in Contra Costa who are seriously mentally ill and living in poverty²³.

Figure 10: Seriously Mentally Ill People Living in Poverty in County FY 2018 – 2019 EQRO



Community services and supports such as full-service partnership programs have demonstrated to be effective when providing Assertive Community Treatment (ACT) to fidelity. A review of clients/ consumers/ peers receiving ACT services showed to have a decrease of over 50% of PES visits, over 31% decrease in the number of admissions, and over a 20% decrease in the number of hospitalization days for those that were hospitalized²⁴. These results, not only support client/consumers/peers and families through their journey of wellness and recovery, but the results also support the entire System of Care in general, as there is a direct correlation in PES Admissions and those individuals that received ACT services.

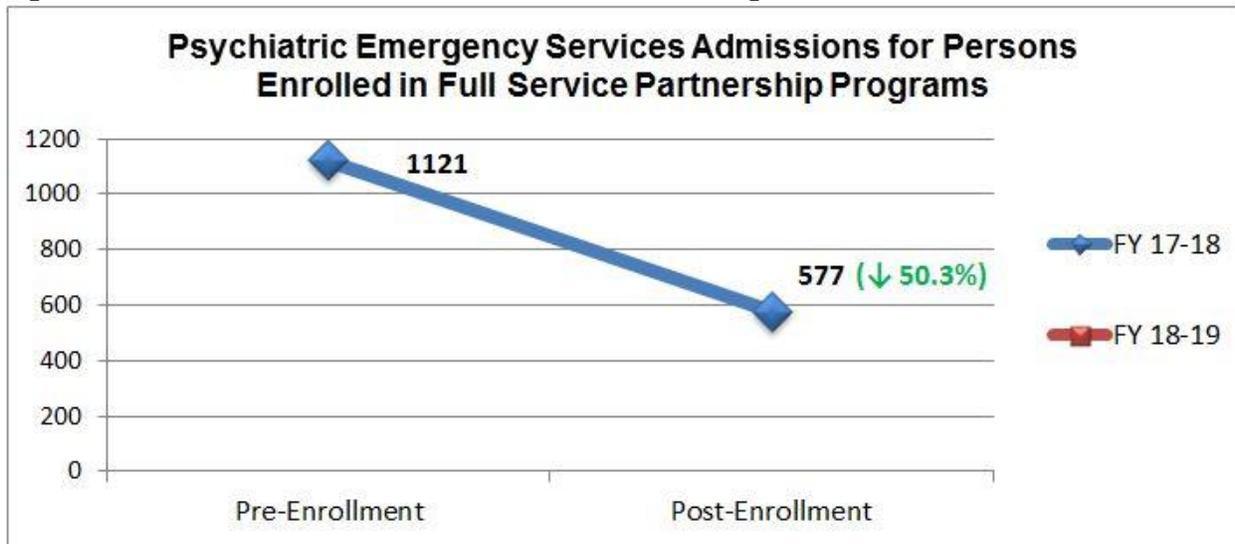
Through Full-Service Partnership (FSP) Programs which provide ACT level treatment to fidelity, BHS and CBO partners assist clients in avoiding in-patient psychiatric hospitalization and recover to lower levels of care. Figure 11 shows the reduction of Psychiatric Emergency Service (PES) admissions for persons enrolled in FSP program from fiscal years 2017-2018 to fiscal years 2018-2019²⁵.

²³ Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

²⁴ <https://cchealth.org/mentalhealth/mhsa/pdf/Plan-Update-FY-2019-2020.pdf>. Page 36.

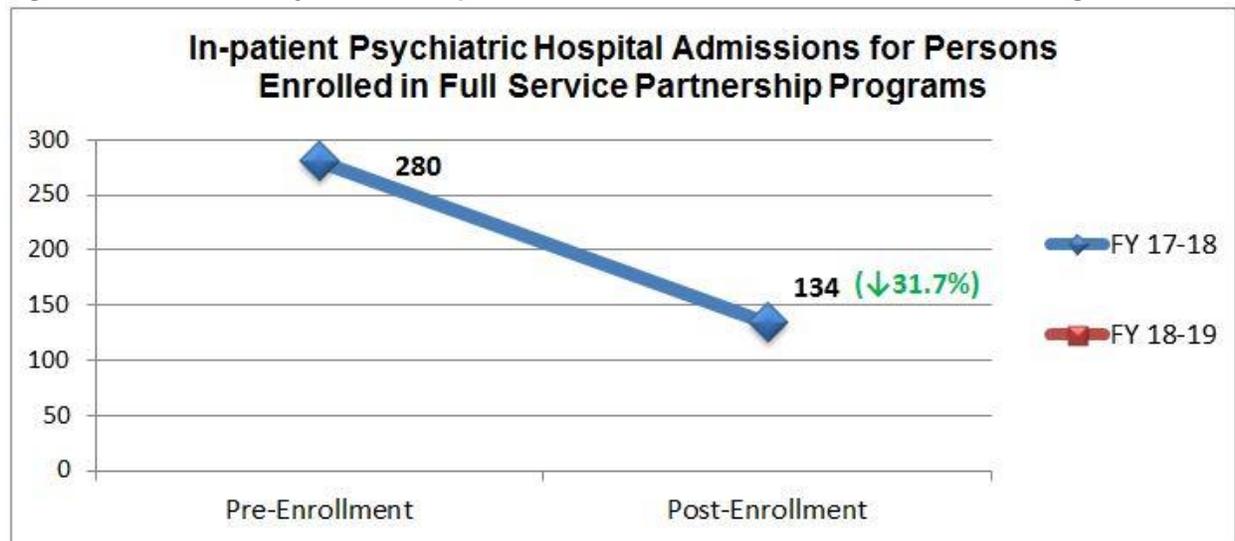
²⁵ Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

Figure 11: PES Admissions for Persons Enrolled in FSP Programs



The next figure shows a reduction of in-patient psychiatric hospital admissions for persons enrolled in Full-Service Partnership Programs from fiscal years 2017-2018 to fiscal years 2018-2019²⁶.

Figure 12: In-Patient Psychiatric Hospital Admissions for Persons Enrolled in FSP Programs



There are promising outcomes displayed in FSP programs providing ACT to fidelity treatment.

In general, mental health services provided within the County system continue to increase. In fiscal year 2016-2017²⁷ the number of individuals that received services within the County system were 13,223 in

²⁶ Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

²⁷ Fiscal Year 2016-2017 Medi-Cal Specialty Mental Health External Quality Review MHP Final Report: <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2016-2017.pdf>. Page 13.

comparison to the most recent External Quality Review in 2018-2019²⁸ which showed an increase to 16,777 individuals served. In BHS's partner CBOs, there has also been a rise in the numbers of individuals served which has increased from over 25,000 individuals served in fiscal year 2017-2018²⁹ in comparison to over 33,000 served during fiscal year 2018-2019³⁰.

Workforce and Staffing Challenges

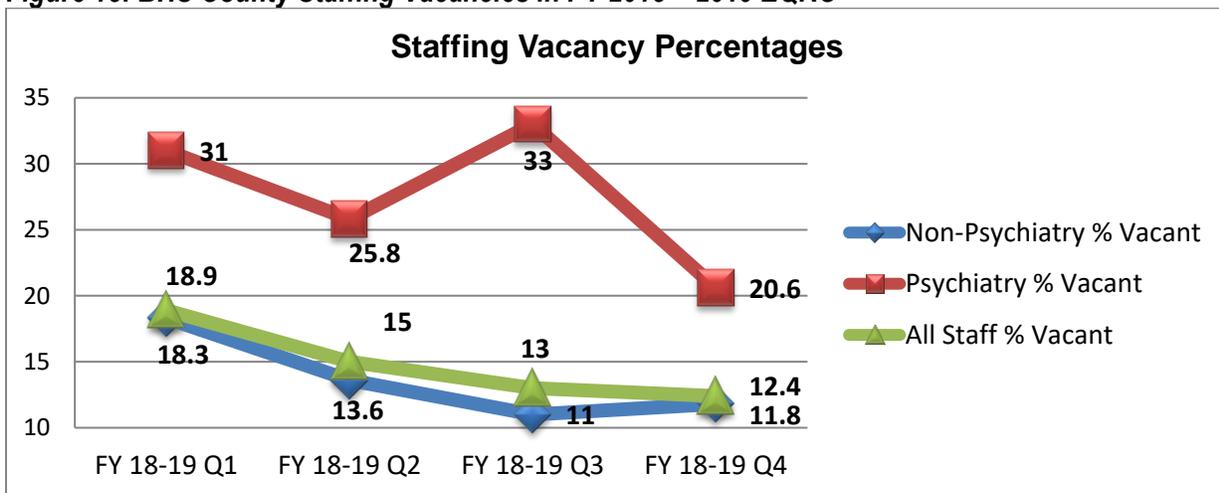
Another factor, when considering the delivery of services is the staff needed to provide the services. Contra Costa County continues to face a challenge, as wages in this County fall behind in comparison to its neighboring counties³¹ as well as competing with other local health employers, such as John Muir and Kaiser.

Although staffing vacancies are in decline, BHS must continue to develop a workforce to respond to the need of those served. Table 3 and Figure 13 shows the staffing vacancies, along with the decrease of staffing within BHS³².

Table 3. FY 2018-2019 Authorized and Vacant Staffing Numbers

	Authorized	Vacant
Non-Psychiatrists	518	61
Psychiatrists	40	8.25
Total All Staff	558	69.25

Figure 13: BHS County Staffing Vacancies in FY 2018 – 2019 EQRO



Methods and strategies to address vacancy in hard to fill or retain positions have included the Loan Repayment Program (LRP) that was utilized to recruit and retain hard to fill position such as psychiatrist, as well as psychiatrists with specific language need. BHS will continue this effort, while also expanding to

²⁸ Fiscal Year 2018-2019 Medi-Cal Specialty Mental Health External Quality Review: <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf><https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>. Page 14.

²⁹ Three Year PEI Evaluation Report: <https://cchealth.org/mentalhealth/mhsa/pdf/PEI-evaluation-report-2015-2018.pdf>. Page 4.

³⁰ Cultural Competence Plan Update 2019-2020: <https://cchealth.org/bhs/pdf/2019-2020-ccp-update.pdf>. Page 13.

³¹ Data from Contra Costa County Employment Opportunities and its neighboring Counties:

<https://www.governmentjobs.com/careers/contracosta/classspecs>

<https://jobapscloud.com/alameda/auditor/ClassSpecs.asp>

<https://www.marincountyhr.org/>

<http://www.solanocounty.com/depts/hr/classifications.asp>

³² Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

other classifications, specifically for peer and family partner classifications. This also increased access to services.

In reviewing the length of time it took for someone to get a first appointment for mental health care in the County operated clinics, the number of days from initial request to offered appointment for all services, and the percent of offered appointments that meet the State standard of 10 business days has been met. This has been to continued efforts by BHS to staff the system, especially for psychiatric positions, which were significantly understaffed prior to the Loan Repayment Program (LRP) implemented from the 2016 Needs Assessment. In gaging this effort implemented form the previous Needs Assessment, there were significant improvements to system delivery as outlined in Figures 14 and 15 through these efforts³³.

Figure 14: Average Number of Days to Offered Appointment for All Services FY 2018 - 2019



The following figure illustrates the number of days from initial request to offered appointment for a psychiatrist and the percent of offered appointments that meet the State standard of 15 business days. The days have significantly been decreasing and are close to meeting the State standard. Continuing the LRP would continue to improve these numbers.

Figure 15: Average Number of Days to Offered Psychiatric Appointment FY 2018 - 2019



³³ Contra Costa County Behavioral Health Services Director's Report Presentation. <https://cchealth.org/mentalhealth/mhc/pdf/2020-0108-agenda.pdf>

Further staffing demographics within BHS were collected in June 2019. The data showed that BHS County workforce is roughly 73% female and 27% male. Racial/ ethnic data is captured in the following table. Although BHS data language capacity is captured, accessing this data has proved challenging as not all those who may speak other languages utilize their languages or self-report³⁴.

Table 4. BHS County Racial/Ethnic Staffing Estimates as of June 2019

Racial/Ethnic Data Estimates	Staff Employed
LatinX/Hispanic	14%
Caucasian/ White	38%
African- American/ Black	14.5%
Asian	5%
Native American/ American Indian	0.5%
Pacific Islander	2%
2 or More Races/ Ethnicities	5%
Data Not Captured/ Data Not Reported	21%

In reviewing this information, it is recommended that reporting for language capacity of all staff and utilization of language be reviewed. This would help align language capacity resources with services, as well as indicate the need for staffing for specific language needs as well as identified staffing in regions of the County.

Workforce evaluation also has revealed that this County’s classification of peer providers which include Community Support Workers (CSWs) and Family Partners which are lower paid than most classifications also have minimal opportunities for career progression. Due to this, BHS shall define an LRP to support the classifications of peer providers and family partners that wish to continue higher education to obtain a behavioral health related degree. Although, this plan was included in the 2017-2020 MHSA Three Year Plan³⁵, a specific LRP needs to be developed for this group which is catered specifically for those individuals in peer and family partner classifications, keeping in mind that the goal to include these individuals is to improve service delivery and continue to include the perspective of lived experience. The goal is to implement the program during the 2020-2023 MHSA Three Year Plan; while also including this opportunity for BHS’s CBO partners, whom also have peer and family partners which provide mental health support services to the community.

Additionally, more Mental Health Clinical Specialist positions be added to allow for progression of the 60+ peer and family partners working within BHS’s system of care. This shall be a method to address career progression and turnover rates while allowing BHS to retain quality staff with lived experience wishing to continue higher education in a behavior health related field and degree path.

Furthermore, Contra Costa County acknowledges that in reviewing the 2016 Needs Assessment, API and LatinX/Hispanic communities continue to be underserved populations. Planning to address these specific needs through workforce development should be implemented. Although interpretation services are available, it is recommended that BHS identify practices to further develop and recruit for the language need of Spanish and API languages (to be further identified). Workforce staffing also show these

³⁴ Cultural Competence Plan Update 2019-2020: <https://cchealth.org/bhs/pdf/2019-2020-ccp-update.pdf>. Pages 23-24.

³⁵ <https://cchealth.org/mentalhealth/mhsa/pdf/Plan-Update-FY-2019-2020.pdf>. Page 73.

LatinX/Hispanic and API groups are also under-represented in BHS staffing. Recruitment from these communities with specific language capacity could also help address the disparity in language access.

As most of the populations that are intended to be served through the public mental health system are socio-economically underprivileged people Medi-Cal eligible individuals; it is important to consider that many of these are also people of color. More than half of the people being served by the entire Health Services Department are people who have self-identified as an ethnicity or race other than white/ Caucasian³⁶. The MHSA was intended to include culturally appropriate services and supports; and when considering communities of color and mental health supports, it may not fit within traditional Westernized practices. It is important to continue ongoing system evaluation to ensure services are being delivered in methods that honor the cultures of those being served³⁷.

Information Technology System Needs

A main limitation that has continued from the 2016 Needs Assessment is the current capacity of BHS to obtain data³⁸. Although the Electronic Health Record has been implemented, there is a need to build capacity for electronic data management that will result in a more effective method to gauge system performance, as well as provide more clarity on system needs. Currently, data is pulled by various staff from various avenues, which makes data compilation challenging and timely. BHS should work to implement a centralized data collection system that can serve to inform decision making.

IV. Other Behavioral Health Factors

Through the community input provided, it is also necessary to look at other behavioral health factors that affect individuals.

Suicide

It is also essential to look at suicide information in Contra Costa County. Between the years of 2012 – 2018, there were over 700 deaths by suicide in this County³⁹. Of those that died by suicide, the largest age group was people over the age of forty, however numbers for this group have been declining over the years while the number of children up to middle aged adults ages 0 - 39 continues to rise⁴⁰.

During the six-year period, close to 600 were men, in comparison to under 200 women. However, the highest suicide attempts were made by women. In reviewing data, most men attempted suicide in more lethal forms which resulted in a completed suicide, versus women having higher attempts via poisoning with lower completion rates. The ages of individuals that died by suicide ranged from 11 years of age to 93; with racial/ ethnic compositions reflecting the following: 63% were Caucasian/White, 15% were LatinX/Hispanic; 11% were Asian/Pacific Islander, and 7% were African American/ Black⁴¹.

³⁶ FY 2018-2019 Medi-Cal Specialty Mental Health External Quality Review. Page 14. <https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2018-2019.pdf>

³⁷ California Behavioral Health Directors Association (CBHDA) Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services.

³⁸ 2016 Contra Costa Mental Health System of Care Needs Assessment. Pages 39-40. <https://cchealth.org/mentalhealth/mhsa/pdf/2016-ccbhs-needs-assessment.pdf>

³⁹ American Foundation for Suicide Prevention: <https://afsp.org/about-suicide/suicide-statistics/>

⁴⁰ Contra Costa County Coroner's Office data 2011-2018. Information presented in Contra Costa County Suicide Data Deaths, Attempts, Ideation and Lifeline 2012 – 2018 Presentation: https://www.youtube.com/watch?v=35928Nwwd_c&feature=youtu.be

⁴¹ Contra Costa County Coroner's Office data 2011-2018. Information presented in Contra Costa County Suicide Data Deaths, Attempts, Ideation and Lifeline 2012 – 2018 Presentation.

According to the survey administered in schools to assess school climate and safety, student wellness, and youth resiliency within schools in Contra Costa County about 20% of students think about suicide and 30% express chronic depression⁴². In 2018, 81% of those that died by suicide had either a documented mental health challenge, a substance use disorder, or had been on a 5150 hold at some point in their lives. BHS continues to work with agencies to identify methods to support suicide prevention, awareness, and support for those affected by suicide, through programming and its Suicide Prevention Committee, which shares efforts with other groups invested in suicide prevention and awareness.

Figure 16: 2011 – 2016 County, State and National Suicide Death Rates per 100,000 Population Size

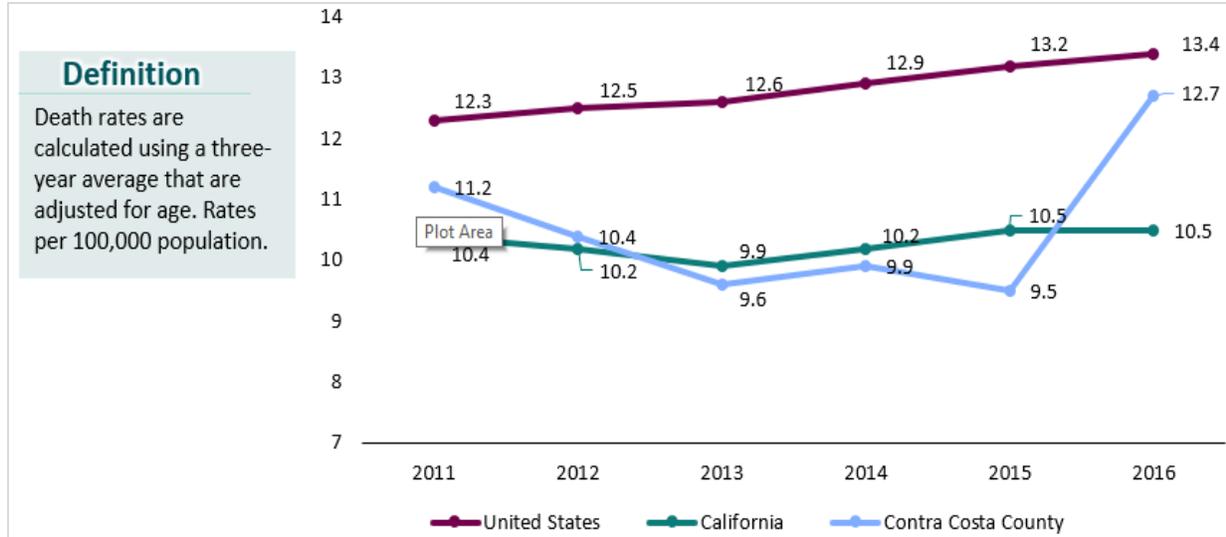
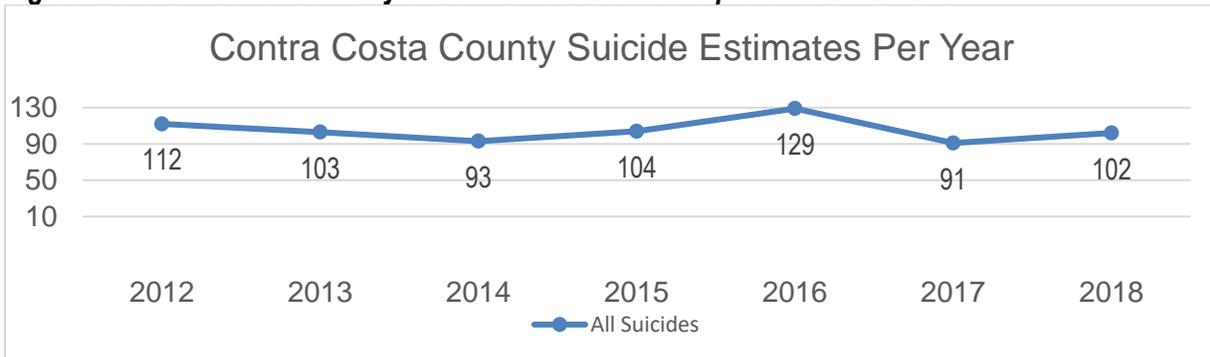


Figure 17: Contra Costa County Suicide Death Estimates per Year 2012 - 2019



Through the CPPP, a Suicide Prevention Community Forum was held in 2019. Much of the input received from the community was the need for continued training, awareness, engagement and support for those affected by suicide. Specifically, many people requested training for addressing suicide, with a focus on education for families and children. There was also a voiced desire for services in multiple languages and more printed materials in other languages, as well as more crisis response support services; as well as further work to de-stigmatize mental health. It is recommended to support these efforts, as suicide is seeing an increase in the County.

⁴² California Department of Education California Health Kids Survey: <https://www.cde.ca.gov/ls/he/at/chks.asp>

Housing Affordability and Homelessness

As most other counties in the Bay Area, Contra Costa County also struggles with affordable housing and an increase in homelessness. Based on the 2018 Point in Time (PIT) Count conducted by the Health, Housing, and Homeless Services Division (H3) of Contra Costa County, homelessness has continued to increase in Contra Costa County⁴³. MHPA funds in Contra Costa County currently provide over \$7 million in housing support for individuals and families with a serious mental health illness⁴⁴. However, continued rise in housing affordability creates a challenge to identify and secure housing in general⁴⁵. BHS continues to explore methods to support further housing efforts, specifically for those experiencing mental health challenges specifically through No Place Like Home (NPLH) efforts as well as through the MHPA.

V. Findings

When appropriate, the findings outlined herein will also provide recommendations for further research and or case studies that may be needed to further address service needs. Citations from the 2016 Needs Assessments were used to identify data sources, when applicable.

Significant findings revealed through the 2019 Needs Assessment included the following:

- 1) There are significant identifiable gaps in service delivery when considering Asian/Pacific Islander, LatinX/ Hispanic and children ages 0-5 years which show to be underrepresented when considering penetration rates in comparison to other groups within Contra Costa County.
- 2) The ongoing need for housing support for those individuals and families affected by mental health continues to be the number one need.
- 3) Based on data analysis and stakeholder input, there is a need to strengthen services that can support children, youth and adults considered to need high acuity treatment, are in crisis, or have severe emotional disturbances or severe mental health challenges.
- 4) Further early intervention, suicide prevention, awareness, and training are needed throughout the County, with special consideration for youth and young adults.
- 5) As voiced in the 2016 Needs Assessment, the need for an electronic data management system which allow for systems evaluation and informative decision making and planning remains.
- 6) Workforce analysis and system delivery indicates the need to continue supporting a Loan Repayment Program to address the need for psychiatry time.
- 7) Workforce evaluation also indicated that there are minimal career progression opportunities for the classifications of peers and family partners.
- 8) Staffing for language capacity needs remains, continuing from the previous Needs Assessment, specifically for Spanish and Asian/Pacific Islander languages. Workforce staffing also shows that LatinX/ Hispanic and API groups are also under-represented in BHS staffing.

VI. Recommendations

BHS recognizes the importance of developing programs and services that are receptive to the clients/ peers/ consumers, families, and community as well as the development of a workforce that can support and respond to the needs of those served. Strengthening program development also involves collecting and analyzing data to better inform on planning practices. Input gathered through this data driven analysis complements the CPPP, where stakeholders which include clients/ consumers/ peers, families, service providers, the workforce and community in general provide input in various methods to prioritize needs.

⁴³ 2018 Contra Costa County 2018 Point in Time Count: <https://cchealth.org/h3/coc/pdf/PIT-report-2018.pdf>

⁴⁴ Contra Costa County Behavioral Health Mental Health Services Act Plan Update Fiscal Year 2019-2020: <https://cchealth.org/mentalhealth/mhsa/pdf/Plan-Update-FY-2019-2020.pdf>. Page 44

⁴⁵ Vital Signs Housing Affordability: <http://www.vitalsigns.mtc.ca.gov/housing-affordability>

The following recommendations are made as a result of both input gathered from the CPPP, as well as data analysis outlined in this report in response to the identified needs:

- 1) Strengthen outreach and engagement strategies for identified underserved populations identified as Asian/Pacific Islander, LatinX/ Hispanic, children ages 0-5 years across the county.
- 2) Continue to explore and strengthen methods on how to support all BHS clients/consumers/peers and their families in methods that support culturally responsive and humble practices and provide linguistic access to create more equitable outcomes.
- 3) Continue to strengthen integration efforts with Alcohol and Other Drug (AOD) Services to better serve clients/consumers/peers and families affected by mental health and substance use.
- 4) Provide outreach, education, and link treatment specifically for families with young children between the ages of 0-5 to promote and educate about early childhood mental health and intervene early so that children can have improved mental health outcomes and families can learn how to promote healthy mental health in early childhood.
- 5) As housing continues to be the top need throughout the State, it is essential to fund more Supportive Housing models designed to offer mental health support services for the most vulnerable populations affected by mental health challenges. Specifically, for youth with systems involvement, such as foster care, BHS is working to support the creation of a Short Term Residential Treatment Facility (STRTP) that can assist children with high need serious emotional disturbances, to be able to remain in Contra Costa County versus an out of county placement.
- 6) It is recommended BHS continue to apply for No Place Like Home (NPLH) funding to obtain more funding for permanent supportive housing, as well as continue to retain and recruit more augmented board and cares. Furthermore, BHS should continue its ongoing goal to repurpose the Oak Grove site through NPLH funds, as well as additional MHS County funds to house and provide on-site treatment for transition aged youth; as well as other populations that are affected by mental health.
- 7) It is recommended that continued support for flexible housing funds continue to provide flexibility in housing support for the various models of housing offered for those affected by mental health.
- 8) In efforts to address the need for high acuity treatment, further support for Assertive Community Treatment (ACT) to fidelity or Full Service Partnership (FSP) programs which are models that have shown to decrease visits to psychiatric emergency services (PES), hospitalization rates, and length of stay when hospitalized, as well as a decrease in Juvenile Assessment and Consultation Services (JACS) rates for juvenile population. Further work to identify law enforcement and judicial involvement data for adults is needed to gauge this outcome. Funding services for supportive housing and ACT to fidelity models, will also allow for movement of those individuals experiencing mental health challenges that are in locked facilities to have the opportunity to enter treatment as well as assisting with the decreasing PES visits for those individuals served. This effort also assists to address the associated high costs of those individuals which access PES, which allows funding to be utilized for programming.
- 9) Implement support for further suicide prevention efforts county wide to prevent, create awareness and support services and training in relation to suicide.
- 10) Continue to recruit and retain psychiatrists and psychiatric nurse practitioners through the Loan Repayment Program. Efforts made since the 2016 Needs Assessment have led to a decrease in the wait time to the average number of days to access services as well as retaining staff in hard to fill positions.
- 11) Improve capacity to strengthen a career progression for peer partners and family partners to be retained through the Loan Repayment Program to pursue higher education to obtain a behavioral health related degree and retain quality staff with lived experience. Create further Mental Health Specialist Positions within the County system to allow for those in peer and family partner

classifications to promote to a higher paid classification, and will permit for movement of others into peer and family partner roles; with consideration to hire individuals with other language capacities.

- 12) Further fund internship programs through partner CBOs with specific consideration for Spanish and Asian/Pacific Islander (to be further identified) language needs which enables further workforce development in efforts to support mental health for underserved communities.
- 13) It is also essential that BHS continue to increase the number of staff with other language capacities, specifically for Spanish and Asian/Pacific Islander languages as well as further recruiting individuals from these communities; as workforce staffing shows these groups are also under-represented. In general, BHS should continue to recruit staff that identify with the culture of those being served; not just considering ethnicity/race, but also considering age, lived mental health and systems involvement experience, sexual identity, gender and when possible individuals which come from the communities being served.
- 14) Lastly, it is recommended that BHS support an internal electronic data management system to better inform BHS and the community, as well as facilitate analysis, oversight, information gathering, and decision making as currently, there are many challenges in obtaining data, one being that information must be pieced together from various sources which often involves a lengthy and difficult process.

It is recommended that BHS take special consideration to the previous outlined recommendations and focus efforts and planning through its upcoming 2020-2023 MHSA Three Year Plan.