

**PROGRAM DESCRIPTION**

**Greater New Beginnings**

1625 Filbert Street

Oakland, CA 94607

**Facility:**

Greater New Beginnings, Filbert House is a twelve (12) bed Short Term Residential Treatment Program providing specialty mental health services to clients located at 1625 Filbert Street, Oakland, CA 94607 in Alameda County.

**Hours of Operation:**

Greater New Beginnings, Filbert House provides services to clients 24 hours a day, 7 days a week. Normal administrative business hours are from 8:00 AM – 5:00 PM, Monday – Friday.

**Population:**

Designed to serve judicially-involved probation and foster youth, Greater New Beginnings, Filbert House serves males ages 12 to 18 (17 at intake) with co-occurring challenges, such as mental health diagnoses and behavioral and substance abuse challenges. GNB provides intensive residential care to stabilize high-risk behaviors and addresses therapeutic needs to young men of all races, ethnicities, sexual orientations, and gender identities, including transgender or nonbinary youth.

The target population served by GNB Filbert House are youth who have typically experienced multiple traumatic life experiences, including, but not limited to: attachment issues, behavioral challenges (such as aggression, property destruction, sexual acting out, gang affiliation, etc.), mental health challenges, mood disorders, substance abuse issues and educational challenges. As a result of some of this trauma, the youth may experience challenges with trusting others, including building healthy relationships, and difficulties with community living and conducting tasks of independent living.

**Services Provided:**

GNB’s services are rooted in safety, choice, trust, cultural humility and trauma-informed practice. Mental Health services include Individual, Family and Group Therapy, Individual and Group Rehabilitation, Medication Support/Monitoring, Collateral Services to significant support people, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Targeted Case Management, Assessment and Plan Development.

While the services are provided in a structured and therapeutic milieu, the treatment team is highly flexible and focused on each youth's individual needs, strengths, and capacities. The treatment approach to these youths utilizes principles and interventions from evidence-based practices as often as possible and works to ensure that all services are also culturally congruent to the needs of our clients.

The following minimum mental health treatment services will be available as medically necessary:

* **Assessment:** a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Includes but is not limited to one or more of the following: mental status determination; analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.
* **Plan Development:** a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.
* **Targeted Case Management/ Intensive Care Coordination:** Case Management/Brokerage is a service that assists a patient to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to: communication, coordination, linkage and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient’s progress; placement services; and plan development.
* **Individual, Family, or Group Therapy:** Mental Health Services are individual or group therapy and intervention services designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive.
* **Individual/ Group Rehabilitation/ Intensive Home-Based Services:** a service activity that supports the client’s individual treatment goals and addresses behaviors or emotions that arise. Interventions may include positive reinforcement, behavioral cueing, teaching and rehearsing skills, conflict resolution and individual counseling.
* **Collateral:** a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.
* **Crisis Intervention:** a service activity that supports clients in a mental health crisis requiring more intensive services to prevent the necessity of a higher level of care.
* **Medication Support Services:** those services that include the prescribing, distributing and monitoring of psychiatric medications or biologicals, which are necessary to alleviate the symptoms of mental illness.

The specialty mental health service (SMHS) activities provided through the Short-Term Residential Treatment Program as described above are documented in accordance with Medi-Cal and Alameda County’s policies and procedures and are listed in the client plan.

**Intake/Assessment Process:**

The process of screening and assessing potential clients for GNB Filbert House is designed to determine a person’s eligibility for services, GNB’s ability to provide those services and also to determine any potential conflict of interest. The screening and assessment are conducted to identify historical and current information of the potential client, as well as his/her individual strengths, needs and abilities. Assessment data is gathered through various means, including face-to-face contact, written material and from various individuals, including the potential client, his/her family; and external sources such as Probation Officers, Social Workers, and the CFT process. On the day of intake, the youth will be given a house tour and assigned to a specific counselor. This counselor will help the child settle into the home, unpack and meet the other youth in the facility. Individualized intake plans can be developed as needed to ensure a smooth transition for the youth.

Within the first 5 days of placement, each youth will receive a comprehensive assessment that includes a thorough evaluation of their needs and establishment of medical necessity. The assessment will also include a statement from the youths clinician that the youth requires STRTP level of care. Based on this assessment, a needs and services plan will be completed in collaboration with the Child and Family Team.

**Referral/ Linkage:**

GNB staff will provide case management, brokerage and linkage services beginning at intake and throughout treatment as needs are identified that cannot be met by GNB staff directly. Youth will be assisted to access necessary public benefits, medical, educational, social, prevocational, vocational, rehabilitation, or other community services. GNB staff engage in communication with external providers, coordinate care, provide referrals, monitor services to ensure complete linkage and client access, monitor youths progress, assist in identifying placement services, and develop plans with external individuals to further the youths treatment plan. Additional case management services can be provided to assist the youth in obtaining permanency, including family finding, coordinating and scheduling visitation, and supervising visits as needed. This service will be provided internally without funding prior to receipt of the Alameda Medi-Cal contract and will be funded by the contract after its receipt. These services will be provided by qualified GNB staff, such as MHRS credentialed Residential Counselors, STRTP Clinicians, the Head of Service or Psychiatrists.

**Length of Services:**

GNB’s STRTP may be used as a short-term intervention when other supportive services such as individual and family therapy and behavioral interventions have not been enough. While each client’s enrollment at Greater New Beginnings is individualized to their unique needs, the average length of stay is 6 months. During the resident’s stay at GNB, they will find a family-centered approach using proven modalities promoting positive change in both the client and the family dynamic as a whole, paving the way for successful reunification with a strengthened and empowered family unit.

**Discharge:**

The overarching goal of GNB is for youth and non-minor dependents to successfully transition to a lower level of care in a home or independent living setting. As such, discharge planning begins at intake and is an ongoing collaborative process throughout the client’s treatment journey, which is reviewed every 90 days, at a minimum. This clinical review will substantiate the client’s status, progress in their treatment, and includes: justification for continued stay, intensity of services provided, client’s participation and a review of those goals and objectives, as well as any changes to interventions Updates to the client’s record of their progress with a review of objectives/goals and interventions will be conducted to determine transition to a lower level of care. If the impact of the services provided are not sufficient, or it is deemed

sooner that they do not meet the needs, then this should be addressed prior to the 90-day review by a licensed clinical staff.

By incorporating the youth, family, authorized representative, natural supports and other providers in focused discussions for the youth at monthly Child and Family Team (CFT) Meetings, the assigned STRTP Clinician can facilitate discussions related to permanency goals and discharge planning. This enables GNB and the CFT to monitor the youth’s progress and begin working on transition efforts from the very first day the client steps into the program. This collaborative and supportive transition effort is documented in progress notes and CFT Action Plans, which contains specific and well-defined goals and objectives for housing, education, well-being, continued mental health treatment and permanency. Additionally, the resident will have customized Needs and Services Treatment Plan, outlining their transition goals and objectives to meet their unique needs.

All youth enrolled in the program will have ongoing CFT meetings strategizing their transition to a lower level of care. Part of this ongoing transition planning process includes reviewing and updating their Needs and Services Plan every 30 days to ensure goals are being met and revisited, documenting changes to medications, or making changes to services, including therapeutic groups to address the client’s behaviors or symptoms. Transition specific CFT meetings will start at 90 days before the planned discharge, aiding in a smooth transfer of clinical services. This transition-specific CFT will discuss the youth-identified goals, their strengths and successes, specific needs during the transition to a less restrictive environment, any risks or potential barriers to meeting their goals, and discussion of roles and how each member of the Child and Family Team will support the youth toward meeting their goals. Continuity of care is of utmost importance to GNB. Accordingly, GNB’s role in the client’s services does not end on their discharge date from the program. The GNB STRTP Clinician offers aftercare services up to 90 days post-discharge, including monthly meetings with the youth. These monthly meetings with youth may also include an interdisciplinary team approach, as necessary, involving all parties including the client. Post-transition services that are available include: individual counseling, family counseling, case management support, and identification and linkage to community resources and referrals.