MONTHLY MEETING MINUTES
MENTAL HEALTH COMMISSION (MHC)
January 4th, 2023 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. L. Griffin, Mental Health Commission (MHC Chair, called the meeting to order @ 4:34 pm Members Present: Chair, Cmsr. Laura Griffin, District V Vice-Chair, Cmsr. Douglas Dunn District III Cmsr. Gerthy Loveday Cohen, District III (left 6:00) Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Tavane Payne, District IV Cmsr. Pamela Perls, District II Cmsr. Barbara Serwin, District II Cmsr. Geri Stern, District I Cmsr. Rhiannon Shire, District II Cmsr. Gina Swirsding, District I Members Absent: Cmsr. Kerie Dietz-Roberts, District IV Presenters: Dr. Suzanne Tavano, Director of Behavioral Health Services Other Attendees: Amanda Allgood Colleen Awad (Supv Karen Mitchoff's ofc) Guita Bahramipour Angela Beck Jennifer Bruggeman Pete Caldwell Dr. Stephen Field Lucy Nelson Teresa Pasquini Patricia Perez Jennifer Quallick (Supv. Candace Andersen's ofc) Lauren Rettagliata	Meeting was held via Zoom platform
II. CHAIR COMMENTS/ANNOUNCEMENTS: i. Review of Meeting Protocol: ➢ No Interruptions ➢ Limit two (2) minutes ➢ Stay on topic ii. Brown Act Update (Rev 12/22); attached for reference, please review iii. Introduction of New Officers ➢ Chair, Cmsr. Laura Griffin, District V ➢ Vice-Chair, Cmsr. Douglas Dunn, District III iv. Storm warning: Protocol if meeting drops off due to loss of power	
III. PUBLIC COMMENT: None	

IV. COMMISSIONER COMMENTS • (Cmsr. Geri Stern) My neighbor had to call the sheriff because her husband (with Alzheimer's) was becoming agitated and threatening to run away. This happened in the evening a couple of weeks ago. The police came and during the course of the intervention, the police officer said to my neighbor "Do you have any medications to give your husband to calm him down?" She replied, "Yes, I think so" and gave him the medication and it did work. That was all great, but I was wondering if suggesting medication now part of the police intervention when mental health teams aren't available or called? I thought it was interesting they would make that determination. Anyone have any information on that? (RESPONSE: Cmsr. Leslie May) I was part of a team out here in Antioch and this is part of the training. The police will ask if this person has medication and have they taken it? If not, they want to confirm it is available and administered. Yes, it saves them from having to take individuals to the hospital when they just need the medication. They usually stay for 15-30 minutes while it starts to 'kick in' and calm the person. It is a normal response now. (Cmsr. Stern) Do you know when that protocol was instituted? (Cmsr. May) I believe, pulling these teams together and training, it is part of the training. It was decided while pulling all the training together for these teams. If a person hasn't taken their medication, has any type of mental health crisis and as long as they are not violent; it is preferred to go that route first before bringing them to the hospital. • (Cmsr. Gina Swirsding) As far back as I can recall (in 2006), they asked if I was taking my meds. Just to let you know, they do routinely ask that question. I was actually a bit offended by it because I was calling about a shooting in my area. It was just assumed I was mentally ill. I just wanted to give that feedback. • (Teresa Pasquini via chat) The last 20 years, this is a standard question.	
V. APPROVE December 7th, 2022 Meeting Minutes • December 7th, 2022 Minutes reviewed. Amendment to review comment by Cmsr. T. Payne *(UPDATE: EA/Chair/Vice Chair reviewed the meeting playback. It was determined no comment was mentioned regarding the phrasing mentioned by Cmsr. Payne. Minutes stand as approve and were finalized and posted per normal protocol)*. **Motion:** L. May moved to approve the minutes subject to review. Seconded by T. Payne (pending review) **Vote: 10-0-1** **Ayes:** L. Griffin (Chair), D. Dunn (Vice-Chair), G. Cohen, L. May, J. Metro, T. Payne, P. Perls, B. Serwin, R. Shires, G. Stern Abstain: G. Swirsding	**Agenda and minutes can be found:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. "Get to know your Commissioner" – Commissioner Kerie Dietz-Roberts	***Item tabled due to absence***
VII. DISCUSS Committee membership and attendance, Cmsr. Barbara Serwin	***Item tabled for February.***

VIII. RECEIVE Presentation: "Survival: The Effect of the 2020 Pandemic on Youth and Adolescents, inclusive of Sexual Assault and Suicide"; Leslie May, LMFT, Commissioner, MHC The purpose of this presentation is to enlighten the Commission, the Board of Supervisors, and Behavioral Health Services of the need to address this epidemic in our county. I have been trying to bring this forward and address and bring this forward for the last year. To quote former Commissioner Teresa Pasquini, this is a "hair on fire" moment which needs to be addressed immediately. We don't have time to wait for the "correct political climate" to address this fatality laden epidemic. The time has come to set aside 'ego' and work directly with local law enforcement, the Federal Bureau of Investigation (FBI), and Homeland Security to address this runaway train and figure out how to stop it on the tracks! The opening slide contains photos that capture some of experiences and are representative of what those who have experienced this horrific crime feel as they navigate life after surviving. The descriptors of what these survivors go through during and after this type of assault. One client actually told me "I wish I could just disappear" Following is one example of the funding that the Contra Costa Human Trafficking Task Force has awarded in 2022 (*from: https://ovc.ojp.gov/) Awardee CONTRA COSTA, COUNTY OF Award # 15POVC-22-GK-03664-HT Areas Served: Contra Costa Congressional District 5 Status Open Funding First Awarded **2022** Total funding (to date) **$750,000** Original Solicitation OVC FY 2022 Enhanced Collaborative Model Task Force to Combat Human Trafficking **NOTE**: $750,000.00 a year is not nearly enough money to combat Human Trafficking! WASHINGTON (11/26/22) - Congressman Jim Costa (CA-16), who is the Chairman of the bipartisan Crime Survivors and Justice Caucus, voted to pass S. 4524 - Speak Out Act, a bipartisan, bicameral bill that would limit the use of non-disclosure agreements (NDAs) to silence survivors of sexual harassment or assault. This legislation now heads to President to sign into law. "Too often, non-disclosure agreements (NDAs) are used by perpetrators to silence and manipulate survivors of sexual assault in the workplace. We must reform this broken system that prevents survivors from speaking out!" said Costa. "We must hold perpetrators accountable." The Speak Out Act would bring justice for survivors of sexual assault and harassment by: • Prohibiting the use of pre-dispute NDAs between employers and current, former, and prospective employees, as well as independent contractors; • Prohibiting the use of pre-dispute NDAs between providers of goods and services and consumers, and; Invalidating existing pre-dispute NDAs in cases that have not yet been filed.	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

I could not access all crime stats for all cities in the county so I am presenting the crime rates in **Antioch** by year and sorted by type (rapes 2006-2019)
Read more: https://www.city-data.com/crime/crime-Antioch-California.html

Rapes per 100K:

- 35 (34.5) 2006
- 27 (26.5) 2007
- 29 (28.8) 2008
- 40 (39.5) 2009
- 32 (31.3) 2010
- 21 (20.3) 2011
- 29 (27.6) 2012
- 25 (23.5) 2013
- 54 (49.9) 2014
- 53 (47.9) 2015
- 55 (49.1) 2016
- 51 (45.4) 2017
- 56 (49.6) 2018
- 55 (48.8) 2019
- 2020-2022 not yet available (inaccessible)

A Second, Silent Pandemic: Sexual Violence during the time of COVID-19
From an article based on a study from that Howard University conducted *May 1st, 2020*

What happens when "safer-at-home" doesn't apply to everyone?

- NOTE: The term **sexual violence** refers to crimes like sexual assault, rape, and sexual abuse, which can be perpetrated by anyone. **Domestic violence** includes emotional, physical, and/or sexual harm by a current or former intimate partner. Research into the specific types of violence during and following emergencies is limited and often combines domestic and non-domestic sexual violence.
- For more than six weeks, the world has been consumed with talks of the global pandemic and subsequent lockdowns caused by COVID-19. As quarantine and stay-at-home efforts drag on, a second, silent pandemic persists. Evidence shows that **rates of sexual violence increase during states of emergency**, including natural disasters, active conflict, and health crises.

Populations at Increased Risk

- In March, minors made up half of the calls to the National Sexual Assault Hotline for the first time ever. "Unfortunately for many, and especially for children experiencing sexual abuse, 'stay at home' doesn't mean 'safe at home,'" said RAINN President Scott Berkowitz. Of minors who reported coronavirus-related concerns, 67% identified their perpetrator as a family member, and 79% said they were living with that perpetrator. This is unsurprising, as approximately 80% of sexual assaults are committed by someone known to the victim. Children living in foster care or with someone other than biological family may be particularly at risk.
- In addition to minors, individuals with physical disabilities, homeless residents, and those suffering from mental illness or substance misuse are particularly vulnerable to all types violence during emergencies.

- For more details on current guidelines, recommendations and resources for sexual violence victims in the United States, please visit RAINN.org. (**Rape, Abuse & Incest National Network**: **http://www.rainn.org/)**

Child Abuse: Contra Costa County District Attorney's Office

Child Abuse cases are prosecuted by the Sexual Assault Unit. The unit handles the felony prosecution of physical abuse and child endangerment by adult offenders against minor children. The unit also handles all felony physical abuse cases against minors.

Prosecution

- The prosecution of these cases begins after a police investigation is completed. The police agency then presents this unit with the results of that investigation in the form of police reports. At this time charging decisions are made.
- The unit is a vertical prosecution unit, which means one Deputy District Attorney is assigned to the case from the beginning to the end. This enables more effective prosecution as the prosecutor has an in-depth knowledge of the case. In addition, this allows for a better relationship between the victim and the prosecutor.

Confidentiality

- The unit makes every effort to respect confidentiality requests of victims, and to deal with these cases in as sensitive and respectful a manner as possible.

Human Trafficking Unit

- Human trafficking is a form of modern-day slavery. It consists of coercing and forcing vulnerable people into sex work or labor industries. Behind drug trafficking, it is the second most lucrative criminal enterprise. Traffickers will often prey upon transient or displaced people. Furthermore, victims do not have to be transported over state or national lines for human trafficking to occur. This makes human trafficking extremely hard to detect and prosecute as many people may not even be aware that they are being trafficked before it is too late.
    - In an effort to curb human trafficking, California has enacted Senate Bill 1193, mandating that certain businesses post notices in English and Spanish about human trafficking. In 2017, additional measures were passed, expanding the number and types of businesses required to post notices.
    - Sex Offenses | United States Sentencing Commission (ussc.gov)
    - Sentences: It pains me to share that sentencing of perpetrators is not usually what most people think. It is very seldom they are sentenced. I just had a case where an older man had been repeatedly committing this crime over and over to various family members for years. This is the highest case I ever had of a convictions. The Judge stated she wanted to give him 800 years because of his age, she gave him 300 and that was his sentence. That is the most I have ever heard. Unfortunately, most sexual predators ranges between 7 and 22 years on average. That is very disheartening and bills need to be pushed to allow for extended sentences. This is why I advocate and push to inform and educate everyone on this underacknowledged crime. People do not want to acknowledge this is happening in their community, much less their

own neighborhood. Everyone needs to know the signs and what to do, how to be aware and save a victim from trafficking.

California Megan's Law Website

Contra Costa County *per city listed with (# lost contact)

- County: Contra Costa Postable Offenders: 1128
- Antioch ZIP Code: 94509 Postable Offenders: 143 (31)
- City: Danville Postable Offenders: 8
- City: Concord Postable Offenders: 135 (28)
- City: Martinez Postable Offenders: 43 (6)
- City: Lafayette Postable Offenders: 6
- City: Oakley Postable Offenders: 46 (3)
- City: Brentwood Postable Offenders: 43 (5)
- City: Discovery Bay Postable Offenders: 10

Those lost contact individuals is unacceptable. Where are they? What are they doing? Recently I had to make a report because the father of a child was going to her school, picking her up and he is a registered sex offender. He can't do that. These are examples of how predators get around these rules.

CDC Report: Teen Suicide Attempts Surged During COVID Lockdown by Caroline Downey

The percentage of teenagers hospitalized for suspected suicide attempts surged during the COVID-19 lockdowns.

- A recently released CDC study showed that female adolescents ages 12 through 17 visited the emergency department (ED) for suicide attempts between February and March of 2021 at a nearly 51 percent higher rate compared to the same time frame in 2019 before the COVID-19 lockdowns and stay-at-home orders forced businesses and schools to close due to plummeting consumer demand and mandatory safety precaution.
- For a short period between March and April of 2020, ED visits for suspected suicide attempts among people ages 12 through 25 declined but then began to shoot up again during the summer of 2020. Between July and August, CDC researchers found that suspected suicide attempts rose over 26 percent among girls ages 12 through 17.
- While the increase in reported suicide attempts among girls did not directly correspond to more suicide deaths, the analysis states, "The findings from this study suggest more severe distress among young females than has been identified in previous reports during the pandemic, reinforcing the need for increased attention to, and prevention for, this population."
- According to the CDC, among the factors contributing to the alarming trend are COVID-mitigation measures that have proven to be socially isolating, including "physical distancing," "a lack of connectedness to schools, teachers, and peers," "barriers to mental health treatment," "increases in substance use," and "anxiety about family health and economic problems." The study noted that mental-health cases have spiked over the pandemic, suggesting they may be a function of children spending more time at home due to the lockdowns as well.

Suicide attempts surge in this California county (Evolve Treatment Centers)

- When the coronavirus pandemic hit, experts predicted it might significantly impact teen mental health. With no real school or

extracurricular activities, and limited opportunities for socializing or getting out of the house, professionals guessed that teens with mental health issues such as depression, anxiety, self-injurious behavior, and suicidal ideation might be more at risk than ever.

- We can now see firsthand exactly how COVID-19 has impacted the mental health of adolescents in one area of California.
- The trauma center at John Muir Medical Center in Walnut Creek saw an unprecedented number of suicide attempts and self-injurious behavior among young patients, ABC News reports.
- As Dr. Mike deBoisblanc, head of the trauma unit at John Muir, said in the report: "We've never seen numbers like this, in such a short period of time…we've seen a year's worth of suicide attempts in the last four weeks."
- A spokesman for the Walnut Creek hospital clarified the doctor's remarks. Typically, the hospital sees 20 to 25 suicide attempts a year and six deaths from suicide annually. So far, in 2020, there have been 21 suicide attempts and five deaths since January.
- According to the ABC report, doctors at Jon Muir have seen more deaths by suicide during this quarantine period than deaths from COVID-19.

Suicides in Contra Costa County

- Suicide is the third leading cause of death every year among Contra Costa County residents ages 15 – 34. In 2017, 107 residents died by suicide.
- Here are other statistics about self-injurious behavior and suicide in the county, according to Contra Costa Health Services:
- Between 2005–2007, 269 Contra Costa residents committed suicide
- On average, 90 Contra Costa residents commit suicide each year
- Males were more likely to commit suicide than females
- Teenagers and young adults ages 15–24 years are most likely to be hospitalized for self-inflicted injury (NSSI).
- Females are more likely to be hospitalized for self-injurious behavior than males
- Between 2005-2007, the highest number of suicides occurred among residents of Concord (35), Walnut Creek (30), Richmond (26) and Martinez (21).

How Therapists/Clinicians Work With Clients

- Practicing from a trauma informed lens
- Building rapport with a traumatized client
- Sexual assault/abuse issues and blame, self-blame, family blame
- Human trafficking issues
- Strategies for ensuring clients don't terminate therapy prematurely
- How to dismantle rape culture-prevalent in families and generational
- Motivational interviewing
- Harm reduction
- Specific trauma interventions to regulate the nervous system
- How to provide psychoeducation to help clients understand trauma, including parents and caregivers
- How to work best with LGBTQ clients and sexual assault/abuse
- How to work best considering multiple diverse cultures around sexual assault/abuse

Emphasis on the need for healing before returning home:

- Imagine being sexually assaulted by a person, repeatedly, and maybe by the persons' friends.
- Imagine being sexually trafficked from the city you are from and transported to Nevada, Georgia, Florida, before you are rescued.
- Imagine you are a 14-year-old child and have endured these torturous conditions for days or even months before you are rescued.
- Imagine how you feel when law enforcement tell you they are making sure you get home to your family, who have been missing you.
- Imagine thinking about the sexual acts you have been forced to perform.

Land and Farm (https://www.landandfarm.com/): A cause close to my heart.

I have been working with Congressman Mark DeSaulnier and have met a few times online regarding helping this county in funding. This website (I am signed into for updates), my feelings is that when you have people that have been rescued from that life, including those not trafficked but sexual assault survivors and have been in the home with their perpetrator, there needs to be an outside step down facility such as Hope House, instead of just an examination and sending them home. They need a safe place to go to receive therapy, and have the opportunity to heal and recover before reintegrating into their previous life. Allow staff to work with their families and prepare them for reintegrating the family member back into their lives and how to help in the healing process.

Following example(s) on properties to obtain for a 'recovery house' rather than a clinical multi bed facility.

- California Land 6.7 Acres - Tehachapi, CA
  Cumberland Rd., Bear Valley Springs, CA | Kern County, CA
  $59,900
  6.7 acres
- Listing Status: Off Market
  Listing Type: Sale
  Property Type(s): Alternative Energy Residential Land Undeveloped Land
  Irrigated: No
  Residence: No
  Property ID: 30102302
  Property Description
  Owner will finance with a Down Payment of $2000 and a Monthly Payment of $680. No qualifying is necessary. Title is free and clear of liens or encumbrances. Access to this 6.70 acre Lot is guaranteed. Taxes are current. Stunning Views, Paved Road, Power, Water
  **Shovel ready project
- This is a source for the County to purchase land and renovate existing property on the land or build properties which serve as recovery ranches for sexual assault victims and suicide ideation victims.
- Children, adolescents, and youths carry shame when they are saved or rescued from situations which have severely affected their mental health well-being. We need to be "forward thinking" in recovery and provide an environment where they can heal, continue getting their education, have their physical and mental health needs addressed daily.
- A holistic, idyllic environment would provide the space they need for healing. Hiking, animal therapy, gardening, farming, and fishing is a possibility.
- This would address major depressive disorder, abuse, trauma, substance abuse, PTSD, and existential therapies.

Grants and Loans

- **https://www.usda.gov/topics/farming/grants-and-loans**
  The USDA provides loans which the county could qualify for
- **USA Grant Applications**
  Provides billions of dollars for organizations
- **Federal Grants to State and Local Governments | U.S. GAO**
  Provides grants to government for public services

Thank you for your attention to these important matters.

- Sexual abuse/assault/trafficking are NOT okay.
- We need to work toward strengthening laws which give the perpetrator more time for their crimes.
- We need to work toward making our children feel safe again.
- We need to work with families to help provide services for their children to feel safe walking to school, playing outside, shopping with their parents, and enjoying their childhood. There have been attempts of kidnapping with the parent present and this is not okay!

Questions and Comments

- (Cmsr. Swirsding) I really enjoyed this presentation. Thank you. We need to be better aware and I do believe that human trafficking is slavery as well. I was working for a long time (pre-pandemic) at our PAL (police activity league) and many of the kids invited by the police department were survivors of trafficking. The kids participating would leave with their abusers/traffickers. This is all over the place, in plain sight. The worst is in Nevada, taken or ran away from here and other places but end up in Nevada, especially. I am a survivor of sexual assault myself and I know there needs to be places where you can about it and get it out to heal. I have been to many different type of groups, received a lot of help but when you start to say it out loud, you aren't allowed as it triggers everyone. Once I was in a group with many others going through the same experience, we were able to speak about it. .
- (Cmsr. Payne) Commissioner May, excellent job! Your input is very valued and want you to know it is very much appreciated the hard work you do. I would like to add to the sentencing aspect of this presentation. I would just like to say that it is really sad being retired law enforcement, I actually had to process registrants of those with a court order to registered. You don't know what they actually did, only what they were convicted of and a lot of those folks were plea bargained down because the prosecutors want the convictions and the numbers. When you go on the search, and see what predators are in my area? It is misdemeanor (something), when they actually did something much more outrageous and/or heinous because they want the conviction. I would love to partner with you to do something about making sure those are not compromised any more just to ensure their record is wining all these convictions instead of trying to prosecute the win but what is actually deserved. I didn't know if everyone was clear on that. Through my experience in my position, I worked on the girls unit in Juvenile Hall and actually out on the street as a project to help women that are being (basically) 'pimped out' and this is what they have to do. I also worked in a home that actually housed those that were trafficked and assaulted
- (Cmsr. Cohen) I would also like to thank you for the presentation and information, Cmsr. May. I would like to help out as well. I was curious if, here in the county, is there a unit specifically for crimes against children

or internet crimes against children. In my prior district (in Albuquerque, NM) my female students were trafficked. The predators would tell them to take a picture or various acts and lure them to do things online and they would then send those pictures to other people and trick the girls stating they knew where they lived and threatened to go inside their homes to kill their families. I have experienced this in Brentwood with a student being trafficked. I agree with Cmsr. May when she spoke of consistency and people working with students (children) who are victims. They have to be there and there has to be a commitment. Another model they can use is attachment model to work with them. Lastly, for suicide, I learned in the training, working with my students that when a child tells you "I want to die." Many times they are actually saying "I really want to live, but don't know how" That is part of my job for 22years, finding the resources. I get very frustrated here in Freedom. When I moved here, I was moving to California and I thought I was going find all kinds of recourses for my students. No, sometimes when they need a therapist it is a six moth weight. We have a therapist (intern) at the school. Only one for 2500 kids.

- (Amanda Allgood) Hi everyone. I'm a little nervous. This is why I am in the Behavioral Health field. I was that girl. I was that groomed and preyed upon female as a teenager. I am going to share a bit of my story because it is a lot. I don't know if you all remember a man in (lost audio) As a 16 yo, I was groomed by my manager, he was 32 yo. He ended up to going on to have 94 identified victims of online human trafficking and is the father of my child. It is all perfectly okay to discuss. I am in this world to help and advocate and protect others. Talking and listening to you, Cmsr. May, I feel roles have aligned. I have fought through this, I am in recovery, I am clean, I have my own trauma and mental illness and have done all the work and learned everything I can in order to not let this happen again. I have a lot of ideas and have been talking to others and do not know how to get funding. I don't even have my degree yet but am just starting my journey in this world and know I can do a lot of good and make an impact due to my lived experience. I would love to work with you and share some ideas. I do believe we should have parent outreach because it does start online. There is in person, but online is a hundred times worse and just starting that conversation with parents, I counted 12 at Pleasant Hill Middle School and to be able to start that there would be a good start. There are many things I would like to see from my experience as a teenager and now as a parent, what I would like to see to support and educate parents and children.
- (Cmsr. May) You can get my contact information from Angela Beck – she is getting this to you. I want this commission to seriously put this on our retreat agenda this year. I want to work collectively, not ego driven, COLLECTIVELY with BHS to back them to obtain the funding and to tackle this taskforce. $750K is not enough just for treatment. The emergency at Contra Costa Regional Medical Center (CCRMC) for the site exam, then they are referred to our center in Martinez (my employer), the investigation, the medical (physical and mental health) treatment. The cost to bring this individual back and where they can function as a human being before the assault. I have the opportunity to meet Ms. Duggar that was captured in Antioch. She has written two books. I had an opportunity to meet her by to a private event. We just need to work together, as I stated last year, our numbers in this county are some of

the highest in the nation. We just had a teenage boy of 16 that thought he was sending pictures to another girl his age and it was and adult predator for another country that threaten to expose him and he took his own life. This was all on the internet. • (Cmsr. Griffin) This is a very emotional topic and something we really have to address. We are starting a K-12 committee but it is not quite where we were headed but perhaps we can coordinate something within that to bring awareness and advocacy to this. Thank you so much Amanda for sharing your story. It took a lot of courage and I appreciate it. People like you with lived experience can make such a difference to others affected. You know what it is like and don't give that up. We are here for you as a commission and invite you to come back and participate as much as you can. (Amanda Allgood) Thank you. I will be here every month then. • (Cmsr. Payne) Can we have a motion to add this to our agenda or a motion to create a subcommittee for this subject? Is that something we can do? (RESPONSE: Cmsr. Serwin) A motion can be made and voted on, I would just encourage the commission to consider practicalities fitting this in among other things. Is this moment the right time, is it six months when other projects are further along, or if it is now, to Cmsr. Griffin's point, how quickly can we pig-back on an existing effort. Logistical way of doing so that it is more than a statement of interest. • (Cmsr. Griffin) How about if we put this on the agenda for the February commission meeting? (Cmsr. Serwin) The Executive committee would be a good place to figure out the logistics. (Cmsr. Griffin) I will make it an agenda item for February. • (Cmsr. Perls) I was just going to say that I don't think you can act on anything that hasn't been previously announced on the agenda (RESPONSE: Cmsr. Griffin) Correct and that is why we will put it on the agenda. Also, I think it would be a great idea to invite someone from the Contra Costa Human Trafficking Coalition. We could contact them and have them as a speaker at the meeting, as well. We will discuss in the chair and executive committee meetings. Thank you everyone.	
IX. DISCUSS the response of the Behavioral Health Service (BHS) to the State Department of Health Care Services (DHCS) filing for the Federal Sec. 1115 California Behavioral Health Community-Based Continuum (CalBHC-BC) Medi-Cal Demonstration; Douglas Dunn, MHC Vice-Chair, and Dr. Suzanne Tavano, BHS (15 minutes) This particular issue is very time sensitive because public must be made back to the department of Health Care Services (DHCS) one week from this Friday (January 13th @ 5:00pm) so that is the urgency. This involves the IMD (Institute of Mental Diseases) 30-60 day waiver but it is actually a lot more (see Attachment C). Commissioner Dunn reviewed and summarized the attached documentation. There is a major letter by the Centers for Medicare and MediCAL Services (CMS) back in 2018 (11/13/2018). Finally, (I believe Care Court having a substantial part of it) the DHCS wants to further bill as a team of community-based care and ensure the care provided in intuitional settings is high quality and time-limited, especially for the needs of MediCAL beneficiaries with a serious mental illness (SMI) or children and adolescents living with serious emotional disturbances,	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

including children in state welfare programs across the state. Page 7 is where the federal demonstration opportunity for the IMD (and for CCC) it is primarily out of county Mental Health Rehabilitation Centers (MHRC) for adults 18 and above. Per person is a maximum of 60 days per year in an IMD and the if the length of stay exceeds the max, the federal financial participation (FFP), which is dollar for dollar payment and reimbursement coverage is excluded and they also have to meet statewide average length of stay of just 30-days. For children and adolescents, the key point is short-term residential therapeutic programs (STRTP) there will be an exemption for the 6 months length of stay requirement to allow a stay of up to two years is a person in an STRTP is in a facility that is also considered an IMD.

The purpose is to get all persons in IMD licensed STRTP out of the facilities within the two year period. Having seen the contracts that we have talked about at the MHC Finance committee, I don't think there are any STRTPs that are contracted with CCBHS that are also IMDs. I will communicate this further offline with Dr. Tavano and Gerold Loenicker, the children and adolescent program chief.

The DHCS proposes to allow opt in options. There is a push to make this not opted but statewide. Personally, I want to stress (even being a commissioner) speaking for myself, I think there should not be an opt in provision because this whole proposal, in my view, is built around Care Court and it cannot be successful statewide because it is a statewide, per county, program. It can't be successful statewide if counties can opt in out of the IMD 30 to 60 day waiver process.

Section 1115 demonstration application, California DHCS wants to seek the ability to maximize the dollar for dollar MediCAL match. That is with FFP truly means and this will help maximize the use of MHSA funds in the expand provision of services to seriously emotional disturbed adolescents and children and SMI adults throughout the state.

The DHCS proposes county opt in to receive FFP reimbursement for short term stays and there is more about this on page 25-27 of the 44 page document, but in order to opt in, the county has to cover the enhanced set of community-based services and must reinvest those funds that are FFP generated back into community-based care and there are robust accountability requirements that this document addresses. There is also the ability to cover peer services, including justice involved persons through the peer support specialist certification with the forensic justice involved area of specialization. Must demonstrate that MediCAL beneficiary will have sufficient access to specialty mental health benefits.

I know this is a lot of information in a six minute time period, please review.

Questions and Comments

- (Cmsr. May) I will go through this very thoroughly but something caught my eye on Pg 17, Activity stipends: I think this is great and what has been needed for children and youth in child welfare that don't have the access because that has been killing me this past year trying to find funding for some families where the kids need to be involved in things but they can't afford. I have been spending so much time in case management when I am a therapist, trying to find funding. This is really great and I will talk to you more once I really get a chance to go through this.
  (RESPONSE: Cmsr. Dunn) Again, if you want to comment, you must do so as a private person, not as a commissioner because the commission does

not have the authority as it is a state issue. We do not have the authority to take action on this issue. The link for that comment is in the summary that the DHCS sent out for the November 15th meeting and is Attachment C2. If you can't access, feel free to email me and I will get you the link if you are commenting. • (Teresa Pasquini) Thank you so much Cmsr. Dunn for raising this issue and all I wanted to add was that this waiver has been available since 2018 and many of us have been advocating and lobbying for the state to apply since 2018. We are grateful it is here, but we aren't thrilled with the option to opt in and think that just furthers the discrimination the IMD exclusion creates. I wanted to add that I did some advocating with the treatment advocacy center and some others. We have an action alert that I will share the link to that so that Angela can share to the commission for whoever wants it. It's 'fill in the blanks' if you are interested in supporting. It is a very easy to letter to sign on that. NOTE: This was sent on to the full commission and those in attendance of this meeting. Link: <https://www.treatmentadvocacycenter.org/fixing-the-system/take-action?vvsrc=%2fCampaigns%2f99495%2fRespond>	
X. DISCUSS BHS 2023-2024 Budget; Barbara Serwin, Commissioner (10 minutes) ➢ Strategy for BHS budget development factoring the knowns and unknowns of Behavioral Health Continuum Infrastructure Program (BHCIP) Funding; ➢ BHS budget priorities; ➢ MHC budget concerns and priorities; and, ➢ Next steps To move this conversation along regarding the BHS 2023-2024 Budget that we started last month. Today, I would like to ensure we have covered everything in terms of the MHC budget concerns and priorities first and then hear from Dr. Tavano the strategy for the BHS budget development, in particular with respect to the knowns and unknowns of the Behavioral Health Continuum Infrastructure Program (BHCIP), as we know is an opportunistic endeavor. Thirdly, to hear from Dr. Tavano about BHS budget priorities for the coming year and lastly next steps. MHC budget concerns and what we identified in our last meeting and see if we have anything to add. In no particular order of priority: 1) Housing & Care of the incompetent to stand trial (IST) population 2) Ongoing development and operations of the children's crisis stabilization unit (CCSU) to the extent that it needs additional funding. 3) Continued funding of Crisis Response system at an adequate level 4) Children's step down for those experiencing a mental health crisis, a place for them to go for healing if they are not ready to go home 5) Replacement for the Nevin / Niereka House 6) Focus on more housing, more housing, More Housing 7) Mental health treatment for sexually trafficked children (and adults) Do we have any additions or clarifications to make? **Questions and Comments** • (Cmsr. Swirsding) Regarding Human Trafficking, it really needs to be with the TAY (Transitional-Aged Youth) population, not just children.	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

- (Cmsr. Serwin) I will definitely be writing this up and providing it. If you have any additional ideas, I welcome and encourage you to do so by email and add them to the list.
- (Cmsr. Swirsding) We used to get a paper version of the whole budget, is it possible for us to get something like that? (RESPONSE: Cmsr. Serwin) it is currently in draft form and was hoping we could get a version while it is still in draft form, rather than when it is actually completed and we don't have any input. (Cmsr. Swirsding) Exactly, it was via electronic version in draft form.
- (Cmsr. Dunn) We hope to have Mr. Godley (the CFO) involved in the February commission meeting and that is one of the items I am following up on with Cmsr. Griffin.

XI. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano

I would again, like to make a very strong suggestion that this commission allows a presentation of CalAIM and payment reform. It is very difficult to talk about budget, budget projections and priorities without you all having some understanding because it is a monumental change in how BH is funded. I don't know that I have ever really had the opportunity to really explain it to you all so that you can understand the level of uncertainty right now. <int Cmsr. Serwin> That would be great. We do have (also) for the commission benefit the orientation module in which you spoke quite a bit about this and we can provide that as well as a presentation if that is something Cmsr. Griffin and Cmsr. Dunn would like to move forward on.

(Dr. Tavano) I don't feel like I have ever really explained it and (show of hands) do you all understand payment reform under CalAIM? I think we need to start there so there is a common shared understanding. The way we will be reimbursed is fundamentally different starting July 1st for many reasons and there are many moving parts to it. I would also say in all due respect to the DHCS and the very robust California Behavioral Health Community-based continuum demonstration document concept paper they put out, just to be very straight forward, we were supposed to receive (it's a very hard conversation to have without having explained it all to you and will try to do this in bits and pieces).

We don't know what our funding is going to become July 1st, 2023 and I can say all sorts of things but unless I am able to share the building blocks of this, it will be very hard to grasp it. I will take a few minutes to explain the building blocks (not all the other many parts of CalAIM). To date we are on a cost-based system and have been since the 1990's. Essentially, we set our own rates. As long as we have the local dollars to match the federal dollars, we have essentially been setting our own rates. Much of our delivery system has been cost-based. We have been able to cover our cost for doing business. July 1st, 2023 that all goes away. We will be paid on a fee per service methodology, and will not get paid for the cost of doing business or the cost of providing services. We will get paid for the actual services provided. That is a super fundamental difference for our entire delivery system, whether it is for specialty mental health services or a drug MediCal organized delivery system. Secondly, we not longer are establishing rates. The state tells each county what their rates are for each level of service and is entirely different than what it has ever been before. There is no money, no reimbursement beyond the rate the state sets. In combination with that,

currently, regardless of your professional classification, as long as you are working within your scope of practice, as service is billed as a service type. July 1st is it is the type of service provided in combination with the type of provider that is administering that service.

Example: In the past, an LMFT could do an individual therapy session. I licensed psychologist, a psychiatrist all can provide an individual therapy session. The reimbursement rate would be the same because it was the type of service and number of minutes. That goes away July 1st. It will be the combination of the provider type with the service type with all new codes for claiming those services. It has gotten incredibly more complicated simply because it is a huge shift. In a few years from now, it will feel like second nature but right now we are changing the business model based on payment and funding. We were supposed to get all our rates – and remember every county is getting different rates and no one can compare our rates are compared to Santa Clara's rates, San Francisco, San Diego, etc because every county privately through a very confidential portal was told what their county specific rates are. It is not going to be the same across the state, at all.

We were supposed to have received all the rates for all levels of care in September. However, it was just three weeks ago we received our outpatient rates and now we are in the process of going through these very complicated algorithms, looking at historical claims, not just what kinds, but the service types, the amount of time spent in those services and in addition who the provider was because that in combination with what the state tells us our rate is, that is how we will project finances for the division. It is really complicated and there are financial assumptions built into this and we are working very closely with CalMHSA (California Mental Health Services Authority) who is the intermediary with DHCS. That is just for outpatient rates and we still have not been given hospital rates, crisis residential rates, crisis stabilization rates, transitional residential rates, STRTP rates, or anything that is not a straight up outpatient service, we haven't been given our rates yet and we are doing fiscal projections based on outpatient rates only, going through the exercise I just described that is very complicated.

We are trying to make fiscal projections when we move from cost-based to fee per services for outpatient services. Are we going to come out behind, same or a little bit ahead. That is step one. That is just our outpatient rates and we are still finishing the fiscal projections to determine if that information would put us in the red, even or be ahead and we are not sure. We don't think we will be in the red and that is a relief but it has been taking a lot of work of a lot of staff.

We still need all these other service level rates and those will need to be set and we will have to go through all fiscal projections for each of those service types as well. Once we get the rates, we will do the fiscal projections and then it is in the entirety that we come out behind, the same or ahead. We can't tell you right now because we do not know. We don't have all the rates to make all those calculations.

The other big picture about payment reform the local dollars to match to the federal dollars. You cannot use federal dollars to match federal dollars. You can use state and local dollars. That means, the 1991 re-alignment, the 2011 re-alignment, and the Mental Health Services Act (MHSA). Those are our three pies to locally match. When we look at the MHSA, we are being very careful because we want to continue all our prevention/early intervention,

we want to move forward with innovation, we want to continue invest in work-force education and training. Under community services and supports, we want to ensure the majority of that funding is for direct MediCAL services because that would be the match to the federal funding. We have to be careful on how we use the MHSA funding. We want to stay with the required ratios for the different components within community services and supports, the emphasis will be using those funds to match the federal funds to keep the programs full. That is how the MHSA factors in as we are moving forward. As you all know we are deeply into that planning process.

The other big variables we have are an investment in IT because big parts of CalAIM have to do changing our EHR and building out inter-operability between our data system and other systems like CCHP, Anthem BlueCross, the NCPs that are our partners in delivering the overall benefit. So those are the pieces we don't have all the information we need in order to know exactly how our budget is going to be starting July 1, 2023.

Now understanding all that, we are starting training/education of the providers throughout the whole system. A couple weeks ago, we had an orientation session for all BHS county staff on what I just described because it changes for them. I think next week or so, we are meeting with the alliance executive staff to discuss a town hall that we will then be having at the end of January for all our contracted partners to share this information about the payment reform and how we are moving forward. These are orientation sessions and we will be building out a training curriculum for both county-operated and community partners. That is the big picture.

A couple months ago, the state passed new legislation, which made changes to the LPS act related to 5150s and I do want to mention this. It has not been an issue in our county but it has been in other counties. The main points that went into effect after January 1st is that when someone is placed on a 5150 hold, the starts the minute it is signed, not when they get to PES, not when they are hospitalized, it is out in the field when it is signed and that is the start of the 72 hour clock. If a person is on a 5150 in a facility that is not a designated intensive treatment center (John Muir Behavioral Health Pavilion or 4C/4D at CCRMC) they are not considered designated intensive treatment facilities so if a person arrives to one of those on a 5150, if they are till there at the 72nd hour, that facility needs to contact patient's rights and the county about it and then that person must have a probable cause hearing by the seventh day in order for them to be detained in whatever facility they might be in. It is incredibly different than what has happened before. It also puts us in an oversight responsibility of the emergency departments in all hospitals, not just CCRMC. I wanted to mention because it is a very important issue and it is already in effect.

Questions and Comments

- (Cmsr. Serwin) Given those projections, is there an assumed increase in the budget percentage wise? (RESPONSE: Dr. Tavano) If I can first finish.
- (Cmsr. Dunn) We will be following up with this with you Dr. Tavano for the February and March MHC meetings. We will try to get CalAIM on the agendas with sufficient time.
- (Cmsr. Swirsding) Here in CCC, I see a provider may charge $300 for my services but then I go to San Francisco and they may charge $400. Is this what you mean by each county having a different fee? Wouldn't this cause providers to end up moving to other counties to make more

money? We may lose providers. (RESPONSE: Dr. Tavano) We are experiencing this now, there is already price wars regarding what people get paid. That is a more complicated questions Cmsr. Swirsding and we can speak more to that at the next meeting. There are a couple other items I feel as a commission you should be aware of. What would you like Cmsr. Griffin? • (Cmsr. Serwin) Actually going back to the agenda, the last bullet point is BHS priorities in terms of the spending side and it would be great to hear that in the last couple minutes. (RESPONSE: Dr. Tavano) The priorities would be sustaining the delivery system we have and expanding upon it. Where you will see significant requests when the MHSA plan is put together, we will not necessarily know by that time which of our multiple BHCIP proposals might be funded by the state. We are hoping they all are, but If any of them are, we will have to put the local match under Capital facilities under the MHSA. That is certainly a priority. Also we will need to factor in, if we get all these buildings, the cost of the programs to go into the buildings and that would be a very significant part of the MHSA plan also. • (Guita Bahramipour) Is this true about AOD (Alcohol and other drugs) also? (RESPONSE: Dr. Tavano) Yes. We have the outpatient rates for specialty mental health and they are rolling it all out at once.	
XII. Adjourned at 6:33 pm	