CONTRA COSTA
HEALTH SERVICES

1340 Arnold Drive, Suite 200
Martinez, California 94553
Ph (925) 957-5140
Fax (925) 957-5156

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION

Thursday • September 9, 2010 • 4:30-6:30 p.m.

John Muir Behavioral Health • Classroom A • 2730 Grant • Concord

********NEW LOCATION********

AGENDA

The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Executive Assistant at least 48 hrs. prior to the meeting at 925-957-5140.

Participants agree to follow the Mental Health Commission Meeting Decorum Policy.

Public Comment on items listed on the Agenda will be taken when the item is discussed. Times are approximate; items may be taken sooner than noted or out of the order listed.

1. 4:30 **CALL TO ORDER / INTRODUCTIONS**

2. 4:40 **PUBLIC COMMENT.**
The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.

3. 4:50 **ANNOUNCEMENTS**
A. Appointment of William Wong as District V At Large Member at the 9/14/10 BOS Meeting
B. Putnam Clubhouse – dinner fundraising event 10/4/10, 5:00 – 8:30 pm

4. 4:55 **CONSIDER APPROVAL OF MINUTES**
August 12, 2010 MHC Monthly Meeting

5. 5:00 **REPORT ON MHA DATA REQUEST FORM – Steve Hahn-Smith, Research and Evaluation Manager**

6. 5:15 **DIRECTOR'S REPORT – Donna Wigand, Mental Health Director**
A. Update on 20 Allen St. project Community Meeting on 20 Allen St. project
B. Budget update

7. 5:30 **MHC COMMITTEE / WORKGROUP REPORTS**

A. MHC Capital Facilities and Projects/IT Workgroup –Annis Pereyra
   i. Review the Workgroup's report
   ii. Consider recommendation.

B. Quality of Care Workgroup – Carole McKindley-Alvarez
   i. Review the Workgroup's report
   ii. Consider recommendation.

C. Diversity and Recruitment Workgroup – Peggy Kennedy
   i. Review the Workgroup's report
   ii. Consider recommendation.

8. 6:10 **MHSA UPDATE – Annis Pereyra and Teresa Pasquini**

A. CPAW – consider the 9/2/10 Monthly Meeting report and any Committee reports
   i. Consider recommendation.

9. 6:30 **REPORTS: ANCILLARY BOARDS/COMMISSIONS-**

None provided.

10. 6:30 **CHAIRPERSON'S COMMENTS – Peter Mantas**

A. November meeting date: Tues. 11/9 4:00 – 6:00 pm or Thurs. 11/11 4:30 – 6:30 pm
B. IOC meeting update and next step
C. Receive nominations for:
   i. Quality Improvement Committee
   ii. Healthcare Reform Committee

11. 6:40 **FUTURE AGENDA ITEMS**

Any Commissioner or member of the public may suggest items to be placed on future agendas.

A. Suggestions for October Agenda

B. List of Future Agenda Items:
   1 Rose King Presentation on MHSA
   2. Behavioral Court Presentation
   3. Case Study
   4. Presentation from The Clubhouse
   5. Creative ways of utilizing MHSA funds
   6. TAY and Adult's Workgroup
   7. Conservatorship Issue
   8. Presentation from Victor Montoya, Adult/Older Adult Program Chief
   9. Presentation from Crestwood Pleasant Hill
   10. Presentation on Healthcare Partnership and CCRMC Psych Leadership
   11. Presentation on non-traditional mental health services under the current PEI MHSA programs

C. List of Future Action Items:

1. Develop MHC Fact Book to be used in review meetings with appointing Supervisors
2. Review Meetings with appointing Supervisors

12. 6:40 **ADJOURN MEETING**

The next scheduled meeting will be Thursday, Oct. 14, 2010 from 4:30- 6:30 pm at the John Muir Behavioral Health Center, 2730 Grant Ave., Classroom A, Concord.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

Contra Costa County Mental Health Commission
Meeting Decorum

To participate in CC-MHC meetings, attendees agree to abide by the following rules:

- **A Commission meeting is a formal meeting.**
- **Upon arrival pick up a copy of the agenda and other materials provided at the door.**
- **Silence or mute the sound emitted from all electronic devices in their possession (including but not limited to cellular telephones, pagers, radios, personal data assistants, and hand-held or portable computers)**
- **Attendees recognize that the chair is in charge of the meeting, and will immediately abide by all calls for order.**

- **Attitude and behavior:**
  - **Attendees should treat each other with respect and be sensitive to the physical, informational, and social needs of others.**
  - **Demonstrate quiet and dignified behavior at all times.**
  - **Show respect for the speakers even if you disagree with them.**
  - **Devote full attention to the speaker. (No text messaging, sleeping, visiting with neighbors, etc. This is not a social activity with your friends.)**
  - **Avoid private conversations. They make it difficult for others to hear the proceedings.**
  - **There must be no outbursts. This includes commenting, whooping, shouting, booing, heckling, stomping feet or other inappropriate/suggestive gestures and/or disruptive behavior.**

- **During certain meetings the Chair may insist that attendees should wait until recognized by the chair before speaking and then address themselves to the chair (not to other speakers making previous comments), speaking only to the current issue.**
- **Commissioners should refrain from parliamentary maneuvering, political game playing, or attacking each other's motives.**

Putnam Clubhouse Invites You to Attend the Third Annual

AN AUTUMN EVENING IN THE GARDEN

Monday, October 4, 2010

5:00 pm - 8:30 pm

Centre Concord

5298 Clayton Rd, Concord

$50/person (of which $30 is tax-deductible)

Join us for an evening of
great food, friends, education, members stories, and prizes.

This year's keynote will be presented by Dr. Rachel Loewy, Assistant Professor of Psychiatry at UCSF. Dr. Loewy will tell us about new developments in preventing early psychosis and the promising outcomes from a recovery-based, early-intervention treatment program for young people and their families in San Francisco.

Our valuable raffle prizes are more exciting than ever this year-vacation homes, wine and winery tours, B&B's, gourmet restaurants, and more. We will also hold a live auction, which will include a beautiful quilt (handmade with love by Clubhouse members) and a luxury Cabo vacation package (condo for a week and two R/T airplane tickets). Raffle tickets can be purchased (booklets of five for $20) in person at the Clubhouse or at the event. You can view the raffle and auction guide now.

For more details about the event, download our complete description of the program, dinner menu, and presentation.

You can also download an order form for dinner tickets or call Tamara to reserve your seats at (925) 691-4276. Register soon so you won't miss out since space is limited.

We hope to see you on October 4th!

For more information about Putnam Clubhouse, visit www.putnamclubhouse.org

DONATE NOW!

DRAFT

Contra Costa Mental Health Commission
Monthly Meeting
Date 8/12/10
Minutes – Draft

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 4:30 pm by Chair Mantas. Introductions were made around the room.

Commissioners Present:
Peter Bagarozzo, District V
Evelyn Centeno, District II
Peggy Kennedy, District III
Dave Kahler, District IV
Peter Mantas, District III, Chair
Carole McKindley-Alvarez, District I
Colette O'Keeffe, MD, District IV
Floyd Overby, MD, District II
Teresa Pasquini, District I, Vice Chair
Annis Pereyra, District II
Sam Yoshioka, District IV

Commissioners Absent:
Supv. Gayle Uilkema, District II

Attendees:
Quentisha Davis
Rick Crispino, Bonita House
Tom Gilbert, Shelter, Inc.
Ralph Hoffmann
Mariana Moore, Human Services Alliance
Janet Marshall Wilson, MHCC
Connie Steers, MHCC
Willie Wong

Staff:
Donna Wigand, MHA
Sherry Bradley, MHA
David Cassell, MHA
Susan Medlin, MHA
Marsha McInnis, MHA
Jennifer Tuipulotu, MHA
Dorothy Sansoe, CAO
Nancy Schott, Staff to MHC

Chair Mantas welcomed everyone to the new location at John Muir Behavioral Health and introduced the 3 new Commissioners: Peter Bagarozzo, Evelyn Centeno -and Peggy Kennedy.

2. PUBLIC COMMENT

Janet Marshall Wilson: She handed out flyers for Spirit graduation 8/13 at Contra Costa College. Spirit Program graduates are consumers who have gone through intensive training to become mental health providers. Everyone is more than welcome to attend. She announced the County and City of Antioch sponsored Project Homeless Connect 6 to be held on 9/16 at the Contra Costa County Fairgrounds from 9:00 am – 3:00 pm. Project Homeless Connect connects people experiencing homelessness with food, medical and dental care, substance abuse programs, shelter and other services. The success of the day depends on volunteers; anyone interested can get more information at 925-313-6124.

Ralph Hoffman: He appreciated the selection of the new location. Attendees who take bus route #17 should leave at 6:25 pm. Judge Walker announced his decision regarding Proposition 8 and denied the stay. Same sex marriages can begin 8/18, subject to appeal.

3. ANNOUNCEMENTS

A. Commissioner Pasquini was notified by Gloria Hill that Steve Rothschild, a former Family Member Commissioner from Dist. III passed away. Services are tomorrow 8/13 at Oakmont Cemetery in Lafayette.

B. Update on new meeting location: Due to budget cuts, the Concord Police station is not staffed past 5:00 pm and the monthly meetings are not finished by that time so a new location was required. The Concord Police Station is available during the day for Workgroup meetings subject to availability. Any other locations of interest for consideration for monthly meetings, please notify Nancy Schott.

4. CONSIDER APPROVAL OF MINUTES

- **ACTION: Motion made to approve the July 8, 2010 Monthly Meeting minutes: (M-Pasquini/S-Overby/Passed, 7-0-0, Y- Kahler, Mantas, McKindley-Alvarez, Overby, Pasquini, Pereyra and Yoshioka/A- Bagarozzo, Centeno, Kennedy and O'Keeffe (not present at 7/8/10 meeting).**

5. REPORT ON POLICIES AND PROCEDURES SURROUNDING SENTINEL EVENTS - David Cassell, Quality Improvement Coordinator

(Sentinel Event Review Policy and PowerPoint slide handout follows minutes)

Commissioner O'Keefe asked if sentinel event reviews are processed for county facilities only or Contract agencies as well? David Cassell said most of the contract agencies have their own processes and he will address that later in the presentation.

He reviewed the Quality Improvement structure; he is on the ad hoc Sentinel Event Review Subcommittee – the subcommittee is specifically called when a sentinel event occurs and requires review. Incidents are unexpected occurrences that may indicate the quality of care may not be what it should be. Sentinel Events are a subset of incidents. They are the most serious of the incidents. All incidents are reviewed, but Sentinel Events are reviewed in significantly more depth.

In a large and complex system such as Contra Costa's, there will be problems. Incidents should be reported to learn from poor outcomes and identify system improvements, to note things that could have been prevented or how to do things differently. There are different regulations that govern inpatient and outpatient reviews. In the outpatient system, the state requires a system for identifying possible incidents of poor care. These incidents would be included in the unusual occurrence category, but other incidents, such as a staff injury or vandalism, are also incidents, but not occurrences of poor care. Occurrences of poor care would be another subset of the broader category of unusual occurrence. The term "unusual occurrence" can be used interchangeably with "incident".

Quality of care issues can be an impression by a staff person not related to a specific incident such as

communication difficulties between two departments and therefore care isn't optimal. Sentinel events are the most serious types of incidents and the term is borrowed from inpatient hospitals/medical setting. The structure of an inpatient hospital review is more detailed than one for an outpatient review. For outpatient reviews, DMH has general language in the contract, but structural details are left up to the Mental Health Plan. Both inpatient and outpatient processes have protection for the process and the discussions held within the sentinel event review. In CCC the review happens within the QM and QI structure rather than going through County Counsel first. Quality Improvement (QI) is both an overall program as well as a concept and process for making sure that things that aren't ideal are addressed. Quality Management (QM) in our system is a committee which manages QI and related activities.

Items discussed in a peer review/quality improvement/sentinel event type of review are immune from discovery and cannot be subpoenaed. Hospitals must report to the state, but outpatient systems do not to avoid disclosure upstream outside the system. Protections are so people feel safe in reporting and the system can be improved.

Prior to the actual review, all available information is gathered, possibly from interviews, outside reports, incident reports, arrest reports, lab reports, etc. A timing balance is attempted between conducting reviews while memories are still fresh and obtaining all appropriate outside reports which can take months (ie. a Coroner's report). Appropriate participants in the review are determined including county staff with direct responsibility or clinical oversight for provision of care. During the review details are reviewed and issues raised then an action plan is created. After the review, different types of details are passed up through the QI/QM structures that stay within the structure, although aggregate information will be reported up the Committee stream. Issues and actions plans can be brought to QM for direction for potential system wide recommendations that QM delegates as appropriate.

Commissioner O'Keeffe asked for clarification of what aggregate data means. David Cassell said numbers and types of incidents without individual identifiers.

Commissioner McKindley-Alvarez asked if there was a specific time frame for an action plan to be developed. David Cassell said the investigation begins immediately, but an action plan is developed at the review; he attempts to conduct reviews within several months, but is dependent on information from outside sources (ie. autopsy report, physician reports, lab reports).

Commissioner Yoshioka asked if any hospital activity comes under MHA QI. David Cassell is part of the Mental Health Plan reviewing outpatient care and does not review hospital incidents. The mental health clinics are certified by the state Department of Mental Health (DMH); DMH delegates certification of contract clinics to Contra Costa Mental Health Division. Commissioner Yoshioka asked if the Assessment Recovery Center includes a CSU, who would license it. David Cassell thought it would be part Community Care Licensing and part DMH certified. He said it depends on if it is county owned and operated or contracted out.

Willie Wong asked who determines if a sentinel event has occurred. David Cassell said all incidents get reported and receive some level of review. A small subset of these incidents would be considered sentinel events, and be subject to sentinel event review. Unusual occurrences/incidents are categorized into different classes. Incidents in some classes may or may not necessarily be considered a sentinel

event. The determination of whether an incident should be considered a sentinel event is somewhat discretionary on a case by case basis, so it's not automatic because it belongs to a specific class of incident. He conducts a chart review, may consult a physician or other reports then determines if a sentinel event has occurred.

Commissioner McKindley Alvarez asked if there is a policy with criteria to determine if an incident is a sentinel event. David Cassell said if the incident occurs in a hospital setting there is established criteria, but the procedure for an outpatient incident is not as defined. He is a member of a statewide group of county QI Coordinators and there is commonality in their determination procedures. His determination can be based on years of experience or criteria that may not be written down and indicators of potential poor care. Commissioner McKindley-Alvarez noted aggregate data goes to QM Committee and asked if there a way to provide that information to MHC. David Cassell said generally it is kept within the QM structure and counties have some discretion in determining availability data, but that decision would need to come from someone other than him.

Commissioner O'Keeffe asked who makes decision to report. David Cassell said he tries to set up an environment to report everything and he will make a determination on what level of review is appropriate. There is a policy to report any unusual occurrence. It is difficult to police if people are actually reporting or not. If he hears of issues, he requests they be reported if only to begin the tracking process. Because Unusual Occurrence Reports are protected, they are not included in patient charts.

Commissioner Overby said hospitals have QI Committees that review surgical accidents complications and do their best to be objective.

Vice Chair Pasquini recalled the February 2009 event with attempted suicide of her son and also the suicide in October 2009 that was brought to the BOS. She looks at sentinel events differently now that she has participated in Kaizen events and recently sat in on the value stream mapping event for Safety Alert Detection/Quality Management Review at CCRMC. She understands staff need to be protected and the creation of a safe QI environment, but where is independent oversight reviewing the system? For her personal issue, she participated in the issue resolution process from the local level to state level, but didn't feel any satisfaction or relief when it was finished. How can the MHC do its job and participate in this process? David Cassell said those decisions are made at a level different from him. Chair Mantas said a very positive change is happening and Donna Wigand will have a Commissioner participating in the QI process. Beyond that, he would like to discuss how the MHC can obtain feedback on the review process when a sentinel event is presented to the Commission. The MHC should be aware of any follow up and corrective action taking place.

Vice Chair Pasquini asked if the inpatient review process has fewer protections than the outpatient process. David Cassell responded the inpatient protections are different in structure. Peer reviews and quality improvement dealing with sentinel events are all protected, no matter what the setting. Since her approval to sit on the CCRMC QM Review team was granted by County Counsel, she wondered why the same County Counsel wouldn't approve a Commissioner sitting in on the MHA QM Review team. Donna Wigand said different County Counsel representatives are assigned for MHA and CCRMC issues.

Commissioner Bagarozzo asked if Item 3E on the Sentinel Event Review Policy, "The reviewing

manager should assure that follow-up/future prevention has been addressed on the form", means the manager is requested, but not required to follow-up on reports. David Cassell said although the word "should" is used rather than "shall", managers are expected to follow-up. There is some degree of discretion on his part on the amount of follow-up he does with managers, but it is based on the seriousness of the incident. Some things that happen may not be significant by themselves, but if they happen over and over again, he will address the trend and there will be additional follow-up.

6. REPORT: MENTAL HEALTH DIRECTOR – Donna Wigand

A. A Community Meeting on the 20 Allen St. project will be held Tues. 8/31, Pleasant Hill Community Center, 5:00 – 7:00 pm. The CC Times picked up the press release and there is an article in today's paper. Although the ending time is stated as 7:00 pm, if required it can go past that time. The purpose is to give people a chance to comment on the 2 different program options on the table and discuss preferences and priorities. *(Newspaper article follows minutes)*

B. Federal Healthcare Reform update : The California Mental Health Directors Association (CMHDA) is becoming more active not only in the state Department of Mental Health (DMH), but the State Department of Health Care Services (DHCS). DHCS is doing most of the work with the Center for Medicaid Services (CMS), the entity that will shape national healthcare reform. DMH has been the intermediary between the County mental health organizations and DHCS, who have the contact with the Feds. CMHDA is now talking directly to DHCS and the federal Center for Medicaid Services (CMS)/Substance Abuse & Mental Health Services Administration. They feel California Behavioral Health (including Mental Health and Alcohol and Other Drugs) has been left out of the discussion. At the state level, California has a narrow definition of federal health care reform that includes only physical health. CMHDA determined federal legislation does include Behavioral Health and want to make sure they are included in the planning process. CMHDA is also very concerned Alcohol and Drug reform has not been included in healthcare discussions so far either at the state or federal level. In 38 out of 58 CA counties, Alcohol and Other Drugs and Mental Health are integrated (although not in CCC) into one Behavioral Health system. Alcohol and drug prevention/treatment availability is critical in order to manage and curtail overall health care costs. Prevention is the key to reducing acute care costs. She may be asking the MHC for advocacy assistance on this issue and feels having the MHC collaborate with the Alcohol and Other Drugs Advisory Board may be an idea worth considering.

The Federal Medical Assistance Percentage (FMAP) increase was extended on 8/11/10 by Congress. When Medi-Cal services are billed, the County contributes a portion through Realignment dollars provided by the state to draw down FMAP funding. FMAP used to be .50 for every dollar, but an increase was passed to assist states hit hard by economic conditions (such as California); it went to .62 for California, allowing the County to put up less Realignment funding and allowing Realignment dollars to provide more services. The increase revenue will be declining: 7/1/10 – 1/1/11 it will be approx .615, then it decreases again in March and June so there will be an overall reduction in funding for the fiscal year. For CCC the reduction is manageable and there should not be any reductions in the system of care. FMAP is due to sunset 7/1/11.

Commissioner McKindley-Alvarez asked if we are collaborating with other states on federal healthcare reform in addition to other counties. Donna Wigand said California belongs to the National Association of Behavioral Healthcare Directors and the group is very active in Washington D.C.

7. MHC COMMITTEE / WORKGROUP REPORTS

Chair Mantas indicated item 8A.i (consider recommendation on support for Knightsen Bonita House facility) should have been placed under item 7A (MHC Capital Facilities and Projects/IT Workgroup) and will be discussed now.

A. MHC Capital Facilities and Projects/IT Workgroup –Annis Pereyra

i. At the 7/27/10 CPAW Cap Facilities and IT meeting, hard data reports were requested to be available before the Community Meeting (list of requested data reports on pg. 29 of the 8/12/10 MHC meeting packet). In order to substantiate comments made around at the CPAW Cap Facilities and IT meeting, the MHC Capital Facilities and Projects/IT Workgroup requested additional data reports from MHA listed on pg. 27 of the 8/12/10 MHC meeting packet.

Vice Chair Pasquini said MHA has rolled out a new Data Request Form discussed at the CPAW Data Committee meeting. She feels the MHC needs to rely more on data and less on anecdotal, emotional evidence. She asked if data requests need to be approved by the QI Committee as stated on the form? Donna Wigand said she did not believe so. David Cassell has already been approached to revise the policy.

The CPAW Housing Committee met. Although interviews have been conducted, clarifications on roles and responsibilities for the Housing Coordinator and Asst. Housing Coordinator have yet to be received from Vic Montoya. He will meet with CPAW Housing Committee next week to clarify and Commissioner Pereyra will report back to the MHC. The application from Bonita House for the Knightsen project was approved by the CCC Planning Commission in July and an appeal was filed soon after by neighbors. She requests the MHC write a letter advocating for the project to the BOS.

Rick Crispino, Exec. Director for Bonita House provided background information on the project. Bonita House has been in business for 40 years. They are located in Alameda County and primarily serve adults with co-occurring psychiatric and substance abuse disorders. They provide intensive residential treatment, transitional to permanent socialization programs, supported housing, homeless outreach, transitional programs, medication and outpatient services to approx. 850 people a year. A Beautiful Night (ABN) is a non-profit organization founded by CCC and Alameda county families with a dream to open a residential facility in a rural setting modeled after successful programs in other parts of the country. The group was successful in raising funds and purchasing a property in Knightsen (east CCC); ABN requested Bonita House take over the property/funds and carry on the vision. Bonita House applied in 8/08 to open the facility and are still working through the planning process. The project has been approved by the Planning Commission and the appeal to BOS by neighbors should be heard in October. The proposed project is a 10 bed adult residential facility for men and women overseen by Community Care Licensing and set up as a recovery focused program. Commissioner O'Keeffe asked if clients with Medi-cal insurance only would be accepted? Rick Crispino said yes. Donna Wigand asked Rick Crispino to let us know when the hearing is.

Marsha McInnis was involved in A Beautiful Night; she is concerned stigma has gotten -in the way of recovery. She feels caring for animals and growing things in a rural setting such as Knightsen, would be very beneficial to clients. Clients who would be placed there are not unstable or in crisis, but rather on a journey of wellness and recovery. She also requests the MHC support the project.

- **ACTION: Motion made to have the Chair write a letter from the MHC to BOS in support of the Bonita House Knightsen facility. (M-Pereyra/S-Kahler/Passed, 11-0-0, Bagarozzo, Centeno, Kahler, Kennedy, Mantas, McKindley-Alvarez, O'Keeffe, Overby, Pasquini, Pereyra and Yoshioka.**

Discussion:
Commissioner Pereyra suggested each the Commissioners their supervisors to advocate for the project.

Vice Chair Pasquini asked Commissioner Pereyra if she would like to add the visits to the supervisor's offices regarding the project to the motion. Commissioner Pereyra said since Commissioners are supposed to be visiting their supervisors offices anyway, it does not need to be included.

The Crestwood Pleasant Hill facility site visit originally scheduled for 8/24/10 10:00 am, will need to be rescheduled because the CPAW Capital Facilities and IT Committee meeting that she and Commissioner Pasquini is at the same time. The Crestwood director is on vacation for 2 weeks. The 2nd choice was 8/24/10 in the afternoon; 8/26 AM and 8/27 AM were third and fourth choices. She will let Nancy Schott know once a new date has been determined.

B. Quality of Care Workgroup – Carole McKindley-Alvarez

i. The Workgroup will be meeting 8/13. At the previous meeting, all the presentations to date were discussed and how to move forward with that data. A key area of proposed involvement is in the QI and QM components of MHA. Because Sam Yoshioka and Peggy Kennedy were not able to attend the meeting, discussions will continue at tomorrow's meeting.

C. Diversity and Recruitment Workgroup – Peggy Kennedy

i. Commissioner Kennedy was announced as the new Workgroup Chair. The Workgroup wasn't able to meet on 8/10 and they hope to meet 8/23 at 1:00 pm; staff to confirm location availability.

Commissioner O'Keeffe said she spoke with 2 consumers at Behavioral Health Court with experience in the forensic system who are interested in applying to the MHC. There is a third person as well.

Chair Mantas said when the Workgroup met on 7/23, not all members were present and although Peggy Kennedy was elected Chair, they agreed to elect a Vice Chair at next meeting. The Workgroup's focus is to reach out to the community and through education on the process, encourage participation in the MHC.

Commissioner Kennedy said the Commission is currently lacking in Consumer and Hispanic representatives.

Susan Medlin, Office of Consumer Empowerment works with consumers through the SPIRIT program and offered her assistance in recruiting consumers.

Chair Mantas said the Clubhouse has also offered to assist in recruitment efforts.

8. MHSA UPDATE – Annis Pereyra and Teresa Pasquini

A. CPAW – See Vice Chair Pasquini's Report on the monthly 8/5/10 meeting. *(Report follows minutes)* The 8/5/10 Monthly Meeting was 3 hours long as a test. Commissioner Kahler was also in attendance and suggested streamlining the meeting allowing better use of MHSA funds.

Donna Wigand said there will be a loss of $144 million in MHSA funds because revenue was less than anticipated. The shortfall will be divided between all the counties; CCC's share is a $2.5 million reduction; due to the prudent reserve, it will not have a negative programming impact.

Ralph Hoffmann requested Peter Mantas be chair of CPAW and reduce the use of facilitators.

9. REPORTS: ANCILLARY BOARDS/COMMISSIONS

None provided.

10. Consider approval of Candidates recommended by Executive Committee

A. William Wong, District V, At Large Member, through 6/30/11

- **ACTION: Motion made to recommend Dr. William Wong for District V At Large Member seat to Supervisor Glover (M-Kennedy/S-Bagarozzo/Passed, 11-0-0),**

Evelyn Centeno asked if the Executive Committee could tell the MHC about the candidate since he is not here. Commissioner Pereyra said the Executive Committee is allowed to ask only the questions on the interview sheets. Commissioners received copies of the applications and interview sheets. If there is a specific question though, feel free to ask.

Ralph Hoffman said statutorily the MHC is to be balanced by district and by Consumer/Member At Large/Family Members. He recommends continuing to recruit Consumers.

B. Lori Hefner, District IV – possible out of district placement for consumer seat.

Chair Mantas said the Executive Committee is recommending Lori Hefner for a possible out of district placement for a Consumer seat.

- **ACTION: Motion made to recommend Lori Hefner for an out of district Consumer seat to (M-Pasquini /S-Overby/Failed, 5-5-1)**

Chair Mantas asked Commissioner Pereyra why she wouldn't offer a second to the Motion when she recommended her at the Executive Committee. Commissioner Pereyra said after the meeting she had reservations about Lori Hefner being appointed to a Consumer seat rather than a Family Member or At Large Member seat. Commissioner Pereyra has herself struggled with whether or not she is better suited to a seat other than a Consumer seat though she feels she does bring the Consumer voice to the table.

Commissioner O'Keeffe said her activities are lacking in the consumer realm; no activity or training in consumer run groups as a consumer. She does provide financial overview services. Her application is oriented more toward staff than a consumer. Since there are other consumers in the pipeline, possibly we could postpone voting on her application.

Commissioner McKindley – Alvarez is concerned about an out of district placement. What are we doing to promote a consumer person from within West County? She would like to see a District 1 Consumer with experience within the system and specific to West County. West County has specific challenges that should be represented.

Commissioner Kennedy asked about the precedent for an out of district placement. Vice Chair Pasquini said the W&I code states if a Commission is out of balance, out of district placements can be considered. She said Brenda Crawford stated at the last IOC meeting there was concern and a possible investigation around the fact that the MHC was out of compliance for balance and diversity. Vice Chair Pasquini would prefer same district representatives, but there have been challenges with searching out consumers. The issue of "real" consumers is a delicate issue; there is not a definition in the W&I code for a consumer. She is concerned about applicants declaring as consumers and then the MHC declining to recommend them because they are not truly a "consumer" or there are other "better" consumers in the pipeline.

Commissioner Centeno said she can't support someone she hasn't seen or heard from and could we postpone the vote until Lori Hefner can attend the meeting. She would abstain.

Chair Mantas said the process is that the Executive Committee interviews the candidates then makes a recommendation to the full MHC. If a Commissioner has questions, he/she is free to contact the candidate to discuss prior to the meeting

.

Commissioner O'Keeffe said she has been recruiting for 3 weeks and found 3 possible applicants. She understands if an applicant declares he/she is a consumer, he/she is, but she would like applicants who have quality consumer experiences including consumer advocacy and participation in consumer run organizations.

Chair Mantas said if an applicant states he/she is a consumer, no additional clarification is required or allowed. Through the interview process, if there are multiple candidates, the qualities Commissioner O'Keeffe describes would be desirable. However, if there are not multiple applicants, the best decision must be made with the candidates on hand.

Vice Chair Pasquini said Lori Hefner recently joined CPAW; she is not sure if that is a problem. Chair Mantas said too many Commissioners on CPAW may result in consensus building and a Commissioner may have to resign. Currently there are 5 Commissioners on CPAW so there is no issue as quorum is 7. Dorothy Sansoe said Commissioners on CPAW should be careful of conversations with others outside the CPAW meetings to avoid the perception of serial meetings.

Vice Chair Pasquini asked if County Counsel has commented on this issue? Sherry Bradley said no.

11. CHAIRPERSON'S COMMENTS – Peter Mantas

A. Consider length of meetings: He would like to propose going to a 2-1/2 hour meeting with a streamlined agenda (like today). It's challenging to get everything accomplished in 2 hours. Commissioner Kahler doesn't think the meetings should be longer and suggested the MHC can move a lot faster in meetings than we do now. Commissioner O'Keeffe is concerned if the meetings are scheduled to end at 7:00 pm, the meeting will end at 7:30 pm. Chair Mantas said if we keep the agenda

focused we should be able to end at 7:00 pm. He can keep meetings to 6:30 pm, but presentations and agenda items will have to be stopped precisely on time. He gave an example that David Cassell's presentation went over by 12 minutes; if he'd stopped it on time, all the questions wouldn't have been asked and answered. Commissioner McKindley-Alvarez is concerned about meetings longer than 2 hours. She proposed extending meetings on a quarterly basis; longer monthly meetings would be pushing it for attention span and the ability to get things accomplished. Commissioner Yoshioka recommended with 3 new members to keep to 2 hours for next meeting; let them attend a meeting and then possibly make a change. Chair Mantas agreed to keep meetings at 2 hours and liked Commissioner McKindley-Alvarez's suggestion of longer quarterly meetings.

B. Consider touring County operated programs: If more than 7 Commissioners are interested in attending, the tours must be publicly noticed. The tours will be scheduled based on Suzanne Tavano and Donna Wigand's availabilities. Donna Wigand said the Adult and Children's Program Chiefs and staff would also be involved. Sam suggested Commissioner interest may be based on location of the facility (east, west or central). Commissioner O'Keefe asked if a list of specific sites could be submitted. Donna Wigand said yes, both county run and contracted facilities are options. She asked if the MHC wanted to break up into groups based on interest. Commissioner McKindley-Alvarez suggested keeping the group size small since we are visiting sites that deliver care; it would also take care of the issues of noticing and members of the public attending. Chair Mantas stated the MHC has oversight county wide not only regionally; he would like to sites all over the county. Commissioner Centeno would like to see all the sites. Most Commissioners were interested in seeing facilities countywide rather than regionally. Donna Wigand said to accommodate the interest in seeing facilities in all parts of county, there will be a series of tours.

Chair Mantas reminded Commissioners to please have their photo taken for the MHC name badge before the tours. The name badges are to be used for official MHC business only.

C. Consider nominations for Healthcare Reform Workgroup and Quality Improvement

Chair Mantas said Donna Wigand has issued an invitation to the MHC to participate in the Quality Improvement (QI) Committee. Anyone wishing to nominate herself/himself or anyone else should do so at the September MHC meeting. For now, Commissioner McKindley-Alvarez will take on responsibility. If no one else is interested, the Chair will appoint her permanently, probably for a year term. If others are interested, the MHC will elect a primary and alternate MHC representative at the October meeting.

As Donna Wigand stated in her report, counties are beginning to address federal healthcare reform and she requested a MHC representative participate on the Committee. Vice Chair Pasquini will take lead unless there are other volunteers at the September MHC meeting. If no one else in interested, the Chair will appoint her permanently. If others are interested, the MHC will elect a primary and alternate MHC representative at the October meeting. Chair Mantas thanked Donna Wigand for the opportunity for MHC participation.

Donna Wigand said Marsha McInnis, the new Family Coordinator for East County, comes with experience as a former chair of the Alameda County MHB, Tri-Valley NAMI, has a loved one in the CCC mental health system, is a trained Family-to-Family teacher and has been on the board of Bonita House.

Public Comment:
Quentisha Davis requested the MHC place a discussion item on a future meeting agenda regarding consumer abuse in the workplace and employment sustainability which would allow people to come to the MHC, be heard and begin to work on solutions. She is an associate clinical social worker and has seen abuses within County mental health programs and services. She would like this issue to be public knowledge. Chair Mantas suggested she send Nancy Schott specifics on what she is interested in discussing.

12. **FUTURE AGENDA ITEMS**

Any Commissioner or member of the public may suggest items to be placed on future agendas.

A. Suggestions for September Agenda ***[CONSENT]***

1. Steve Hahn-Smith, Research and Evaluation Mgr. – Report on Data Request Form

B. List of Future Agenda Items:

1. Rose King Presentation on MHSA
2. Behavioral Court Presentation
3. Case Study
4. Presentation from The Clubhouse
5. Creative ways of utilizing MHSA funds
6. TAY and Adult's Workgroup
7. Conservatorship Issue
8. Presentation from Victor Montoya, Adult/Older Adult Program Chief
9. Presentation from Crestwood Pleasant Hill
10. Presentation on Healthcare Partnership and CCRMC Psych Leadership
11. Presentation on non-traditional mental health services under the current PEI MHSA programs

C. List of Future Action Items:

1. Develop MHC Fact Book to be used in review meetings with appointing Supervisors
2. Review Meetings with appointing Supervisors

13. **ADJOURN MEETING**

- **ACTION: Motion made to adjourn the meeting at 6:55 pm (M-McKindley-Alvarez/S- Pasquini/Passed, 11-0-0, unanimous)**

The next scheduled meeting will be Thursday, Sept. 9, 2010 from 4:30- 6:30 pm at the John Muir Behavioral Health Center, 2740 Grant Ave., Classroom A, Concord.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

Memo

To: The Contra Costa County Mental Health Commission

From: Donna Wigand, Contra Costa County Mental Health Director

Date: July 8, 2010

Re: Contra Costa County Mental Health Division Research and Evaluation *Data Request Form*

The Mental Health Division Research and Evaluation Unit currently receives data requests from outside agencies. An ***outside agency*** is any commission, committee, organization or individual requesting data related to Mental Health Services in Contra Costa County or general mental health data. The Research and Evaluation Unit is now requiring all data requests be made on the attached *Data Request Form*. Utilizing this form will:

- Ensure data requests are completed by the Research and Evaluation Unit as accurately and efficiently as possible
- Provide the outside agency with a liaison from the Research and Evaluation Unit who will work with the outside agency to complete the data request
- Aid the Mental Health Department to prioritize data requests

Data Request Forms are available at the Mental Health Administration office. Please email, call or mail the Research and Evaluation Unit to request a form (contact information listed below). The following is the procedure outside agencies will follow to submit their data requests:

1) The outside agency will complete and submit the *Data Request Form* (see attached) to the Quality Improvement Council:

Mental Health Administration
ATTN: Research and Evaluation Unit
1340 Arnold Dr
Suite 200
Martinez CA 94533
925-957-5150
Email: mhresearch@hsd.cccounty.us

2) The Quality Improvement Council will review all requests for data and/or reports. After review they will either approve or deny the request. They will then assign each approved request a priority rating and submit each to the Research and Evaluation Unit for completion. Please note: Any requests which violate the County's patient confidentiality policies and procedures will be automatically denied.

3) Outside agencies will be notified when the Quality Improvement Council approves or denies their request. If the Quality Improvement Council denies the request, the outside agency will be provided with a brief explanation of why the request was denied.

4) The Research and Evaluation staff member assigned to the request will contact the outside agency to clarify the request and establish a timeline for delivery of the final product.

5) The assigned Research and Evaluation staff will log the date s/he completes the request and will submit the completed request to the outside agency, in some cases after review by the Quality Improvement Council.

The Mental Health Division believes the use of the *Data Request Form* will allow the Research and Evaluation Unit to better respond to the data requests it receives from its constituents. Thank you in advance for your cooperation and understanding in utilizing this form.

Contra Costa Mental Health Division
Research and Evaluation
Data Request Form

Thank you for completing the Data Request Form. This form will help the Research and Evaluation team to address your request for research and data as efficiently and effectively as possible. Please respond to the questions below. Any missing information on this form may lead to a delay in your request. Submit your completed form to Mental Health Administration, ATTN: Research and Evaluation Unity, 1340 Arnold Dr, Suite 200, Martinez CA 94533. If you have any questions, please contact the Research and Evaluation Unit by email: mhresearch@hsd.ccounty.us or phone: 925-957-5150.

Date of Request: ____/____/_____

Contact Information

Name: _____

Affiliation (If any): _____

Phone Number: _____

Email Address: _____

Data Request Detail

1. Please provide a brief description of the data you are requesting:

2. Please provide the following details about the data you are requesting (i.e., age, gender identity, sexual orientation, race/ethnicity, language, region of county, population group, setting of care, timeframe of data):

3. How will this data be used? What is the purpose of obtaining this data? (for example: reports, speaking engagements)?

Turn Page Over

For Internal Use
Assigned Staff:
Date of Completion:

4. What format would you like the data to be presented in?
   a. Charts
   b. Tables
   c. Narrative
   d. Other: _____

5. By what date would you like your request complete? ____/____/_____

Disposition for Internal Use

Date Request Received by Quality Improvement Council (QIC): _____/_____/_____

Date Reviewed by QIC: _____/_____/_____ Request: □ Approved □ Denied

If denied, reason for denial:

QIC Authorization Signature_____ Date Authorized: ____/____/_____

Priority Level: □ High □ Medium □ Low □ Denied

Research and Evaluation Staff Assigned to Request:

Date Request Completed: _____/_____/_____

Notes:

For Internal Use
Assigned Staff:
Date of Completion:

Item 5

Mental Health Commission
Cap Facilities/IT/Housing Workgroup Committee
August 27, 2010

Meeting started at 3:00 PM
Annis talked about today's agenda in general until Teresa came. Evelyn volunteered to take notes. The group talked about structure and organization. Annis said she feels she is getting burned out and would like to be relieved from being the Chair. When Teresa came, we continued discussion on structure and organization. ***Annis resigned as Chair of our Workgroup and Teresa agreed to resume the Chairmanship until others are up to speed, unless someone else wanted to take over. Colette stated that she was not interested. Evelyn suggested Co-Chairs. The group discussed preferring having only one Chair. There was a vote and Teresa was selected as the Workgroup's Chair and Annis Pereyra was elected Vice Chair.*** Evelyn volunteered to be the workgroup Secretary. The workgroup unanimously agreed on the functional structure, as discussed.

The group moved to discuss agenda.

I. August 24 CPAW meeting.

a) Teresa distributed the draft minutes of CPAW 8/24 meeting that she and Annis attended. Peter asked for a brief history of 20 Allen. Teresa and Annis gave a short overview, covering the following, but not limited to CCRMC, Mobile Response Team, Crisis Residential Facility, and possibility of 20 Allen to be turned into a parking lot. Teresa also handed Peter B. the thick binder on 20 Allen project.
b) August 31 public meeting on 20 Allen project. The workgroup will be attending the meeting and scheduled to meet the next day, September 1 @ 2:30PM to formulate the workgroup's position for submission to MHC meeting as Action Items.

II. Site Visits.

a) Annis agreed to continue the workgroup's plan for site visits. She will re-schedule via Nancy. Workgroup also agree to use the same evaluation tool.
b) Colette's motion: Cap Facility W.G. to request copy of contract with Crestwood, 550 Patterson, and Angwin to be delivered ASAP (preferably before the Crestwood site visit) Second by Evelyn. Motion passed.
c) Teresa said Peter M emailed her the Marin County Mental Health Board site visit guideline. She brought copies and gave to Colette and Peter B. She will email me a copy of the guideline. Peter M provided the guideline copy for informational reading and consideration for our own procedures.

III. Updates on Housing.

a) Annis said we have the Benita House report. It will be in the MHC packet.
b) Annis reports on Housing Committee: There is a Family Steering Committee letter asking why service is inadequate. Housing is the greatest need in the county. Juggling housing needs to as many as 200 people on a daily basis. The Housing Committee is expanding the scope of the Housing Coordinator and they are in the process of interviewing to hire Housing Coordinator. Annis sent the

whole report from the meeting to Nancy, which will be included in the MHC packet.

IV. New Business:

a) Cap Facility/IT/Housing workgroup wants to have structure and elected the new officers: Chair -Teresa, Vice-Chair - Annis, Secretary – Evelyn.

b) Meetings. Length of meetings is not to exceed 1-1/2 hours. Regular meetings will be held every 4th Tuesday (after CPAW) of each month. Teresa asked members to check for conflict and advise her.

Adjourned at 4:50PM

Report on 20 Allen Community Meeting to MHC Capital Facilities Workgroup
Prepared by Commissioner Teresa Pasquini, Family Member, District 1

The 20 Allen Community Meeting held September 1, 2010 was a perfect blend of voices sharing lived experiences, pain, and hopes for an improved system of care. I attended the pre-event gathering at Round Table Pizza, hosted by Brenda Crawford, Executive Director of MHCC and coordinated by David Carrillo of MHA. It included consumers from West, East, and Central County and staff from Rubicon, MHCC, Crestwood Pleasant Hill, and the Clubhouse. I was grateful for the invitation and spoke to the group as a family member only and expressed my joy at their enthusiasm and desire to impact system change. I expressed disappointment that the consumers from Crestwood's, Our House, who are also Contra Costa County born and raised, were not extended the opportunity to share in the party or the experience of consumer, family, and provider unity that was the clear theme of the night. Until all consumers are provided the same opportunity for healing, recovery, and empowerment, in their own community, our job as advocates or commissioners will not be done.

The Community Meeting was very well attended and offered an environment for sharing stories of personal recovery, personal loss, and expressed preferences for ways to improve the system by expanding the continuum of care at 20 Allen. The options/choices were the following:

1. **An ARC** (Assessment Recovery Center) which would be open 16/24/7 and provide a place where all ages, children, youth, adults, and older adults could come voluntarily for medication support, therapeutic support, or a combination of peer and therapeutic support. A safe place to come in lieu of the Psychiatric Emergency at CCRMC.
2. **A CRF** (Crisis Residential Facility) that would be 16 beds and could be used as a transition from inpatient or an alternative to psychiatric emergency and inpatient.
3. **Other**-an open ended category that could include a combination of the two or any other ideas for Capital Facility funding uses.

The following themes/ideas were stated:

- Dual Diagnosis Treatment
- Alternatives to Hospitalization
- A safe place to heal, recover
- Discrete services for all ages, especially children and elderly
- Consumer and Family driven peer support combined with clinical services.
- An integrated continuum of care

Our Mental Health Director ended the meeting with a cry for advocacy and unity from all stakeholders to take our stories and ideas to the decision makers directly. I recommend that the Commission support the following recommendation from the Capital Facilities/It Workgroup:

> T***he Capital Facilities Workgroup supports the recommendation of the Mental Health Director to advocate, to Dr. William Walker, Pat Godley(CFO), and the Board of Supervisors for both proposed programs, the ARC and the CRF, to be built on 20 Allen with programming consistent with the above themes. That advocating will include the following: visits to BOS offices, letters, emails, and partnerships with consumer, family, and providers.. This recommendation is consistent with the Commission's previous recommendation at our April public hearing. It was also the clear consensus of the stakeholders who attended the forum.***

CONTRA COSTA TIMES
ContraCostaTimes.com

Public weighs in on new Contra Costa mental health facility

By Sandy Kleffman
Contra Costa Times

Posted: 09/01/2010 04:49:52 PM PDT

Updated: 09/02/2010 06:34:03 AM PDT

PLEASANT HILL -- The only consensus emerging from a packed community meeting this week to discuss what type of mental health facility should be built next to the Contra Costa County hospital in Martinez was that both options are vitally needed.

However, the county may have only enough money to fund one proposal, leaders have said.

Nearly 150 residents gathered Tuesday at the Pleasant Hill Community Center to help mental health officials decide which proposal to recommend. People spoke passionately in favor of each option:

- A 16-bed crisis residential unit where adults would stay voluntarily up to four weeks. Many would come to this highly supervised residence after leaving the psychiatric unit at Contra Costa Regional Medical Center. The goal would be to help the patients transition safely back to their homes.
- A 6,000-square-foot assessment and recovery center, open 8 a.m. to midnight, where people of all ages could get prescriptions refilled, talk to a counselor and receive other help. Local families have long complained that those who develop mental health issues have few options for early intervention beyond an office visit or hospitalization. The center would have separate areas for children and older or frail adults.The meeting was billed as the last chance for public comment before mental health director Donna Wigand recommends one option to county health leaders. The final decision rests with the board of supervisors. "We have been told that there is enough money to build one program," Wigand said at the beginning of the meeting.In a surprise move at the end, she urged the crowd to lobby her bosses and supervisors for both proposals, despite the county's tight finances."Politics trump finance," she said, urging people to "get political.""What I need for you to do is to make your voices heard and to say we cannot afford to choose, and we have to have both," Wigand said.For two years, county leaders have explored the best way to expand mental health services on a site that became available next to the hospital emergency room. The county health department bought the property at 20 Allen St. last year.Initially, mental health leaders planned a $25 million psychiatric pavilion that would have included a 16-bed locked facility, a 16-bed unlocked crisis residential unit and an around-the-clock urgent care center.But when the economy soured, Wigand said, she had to scale back this "Cadillac model" to something more affordable.Kenneth Melvin, a recovering addict, spoke in favor of the 16-bed crisis residential unit. The 53-year-old Richmond resident said he had been sober for nine years until his mother died, and he collapsed emotionally.He almost committed suicide and didn't know where to turn, Melvin said, adding that "I felt hopeless." A crisis residential unit would have been a big help, he said.After coping

Item 7A

Item

CONTRA COSTA TIMES
ContraCostaTimes.com

with the loss, Melvin said he has now been sober for two years."The little money that we do have -- let's spend it right," he said. "That 16-bed unit, we need that."Others urged support for the assessment and recovery center. Kathi McLaughlin, president of the Martinez Unified School District board and a candidate for the Martinez City Council, revealed that she tried to commit suicide several decades ago while living in Marin County, which like Contra Costa did not have an urgent care mental health facility. She could have turned to such a center for help before reaching a crisis stage, she said."It will serve all ages," McLaughlin added. "We do not have anything like this to serve our children."She said the county needs other options besides the hospital for treating children who are in crisis."It's just a terrible place to put a child," she said. "It's scary. It makes it worse, not better."Jon Rothstein also supported an assessment and recovery center, noting that his mother was billed $10,000 for his first inpatient hospital stay. "Outpatient services would be a great complement to what we have," he said.Others refused to choose between the two options, arguing that it may be more cost-effective to approve both programs because they can help people avoid crises that can lead to costlier levels of care."The cost of not doing the whole job is far more expensive," said Molly Hamaker, executive director of the Putnam Clubhouse in Concord.Wigand said she hopes to have a recommendation to the board of supervisors within a month or two.

Contact Sandy Kleffman at 925-943-8249.

Item 7A

My name is Teresa Pasquini. I have numerous affiliations including NAMI, the Vice Chair of the Mental Health Commission, the Contra Costa Mental Health Coalition, the Consolidated Planning and Advisory Workgroup, and the Healthcare Partnership of Contra Costa Regional Medical Center. Tonight I speak only as a lifetime Contra Costa resident and mother and sister to two seriously mentally ill clients who receive county services. I also speak as a committed advocate for the most vulnerable of our county.

I would like to urge the CCC Mental Health Administration to consider the recommendations outlined in a letter to the California Mental Health Director's Association dated June 9, 2010 which was signed by the Executive Directors of the following State Partners Forums: CASRA, California Family Resource Association, California Mental Health Planning Council, California Network of Mental Health Clients, NAMI California, Racial and Ethnic Mental Health Disparities Coalition, and the United Advocates for Children and Families. I will provide a copy of this letter to Sherry Bradley. It is regarding "Prioritizing Client and Family Driven Programs in Challenging Fiscal Times."

Their letter focuses on four strategies to support a client and family driven community mental health system. I would like to highlight one of those strategies which ~~are~~ 15 to increase implementation of crisis residential programs. The Partners Forum recommends using Capital Facilities funds, while leveraging CSS and Innovation funding to create crisis residential programs, using peer staff that would provide an alternative to expensive and often traumatic hospitalizations. They report that a facility of 15 beds or less is eligible for Medicaid reimbursement of $330/day which is less than a PHF at $585/day or an inpatient stay at $1,129/day.

Their recommendation supports the intent of the new Medi-Cal 1115 waiver which advocates for CRPs, transitional residential programs, including peer run residential programs. These residential programs meet the goals of the waiver by "...demonstrating improved outcomes, can slow the long-term expenditure growth rate, and emphasize coordinated care."

I believe that these crisis residential models combined with the new medical home model could bring us to a more integrated, seamless continuum of care in CCC. 20 Allen can be the model for integrating primary and mental health, using peer run services, which include both consumer and family supports and education. This model would follow the goal of MHSA and the new Healthcare Reform Act to end fragmented care that is provider based.

Historically healthcare has been a provider/medical driven industry that ignored behavioral and mental health needs and often the very patient seeking help. The MHSA changed that in California. While we are making daily strides to bring focus to the needs of the client and family, we are not there yet. The Capital Facilities/IT Stakeholder process in this county has been unprecedented in its scope. We have spent hours and hours in meetings. Much of the process has been adversarial, damaging and contrary to the intent of MHSA. Tonight I urge reconciliation and partnership going forward. I urge recommendations based on reliable data and financial information, not emotion or competition.

June 9, 2010

Members of the California Mental Health Directors Association
2125 19th Street, 2nd Floor
Sacramento, CA 95818

Re: Prioritizing Client- and Family-Driven Programs in Challenging Fiscal Times

Dear County Mental Health and Behavioral Health Directors,

On behalf of the undersigned organizations that participate in the Mental Health Services Act (MHSA) Partners Forum, we are writing to express our strong support for county mental health decision-makers to increase the allocation of MHSA resources to support and foster client and family driven programs and services during this fiscal crisis. We acknowledge the extreme challenges and competing priorities the County Mental Health Directors and local stakeholders are facing. While the fiscal crisis is taking a toll on the community mental health system, we believe that the use of client and family programming and alternative crisis services are cost-effective strategies that utilize the expertise of lived experience to effectively support recovery.

The organizations that participate in the MHSA Partners Forum represent a wide range of stakeholder constituencies, including client, family, and parent advocates, providers of mental health services and advocates for ethnic and cultural communities that have been unserved or underserved in the community mental health system. We are an informal group that comes together monthly to share information and discuss emerging policy issues related to the MHSA. Together, we all are concerned about how the reality of budget cuts at the local level could weaken the progress we have made through the MHSA to create a truly client and family driven service delivery system.

During a recent meeting, we discussed four strategies that can support achieving a client and family-driven community mental health system:

1) Increase consumer and family employment, including consumers and family members from underserved racial and ethnic communities, to capitalize on the value of lived experience in providing mental health services;
2) Expand client-run and self-help programs;
3) Emphasize community education and support through consumer and family organizations and community-based organizations specializing in serving multicultural communities; and
4) Increase implementation of crisis residential programs.

We would like to provide a very brief overview about these strategies and recommendations regarding why and how they can be supported with MHSA funds despite fiscal uncertainty. Instead of straining an overburdened system, the services outlined below are designed to save substantial amounts in service delivery costs while providing distinct benefits in terms of supporting clients' wellness/recovery. We appreciate this opportunity to share perspectives and welcome your feedback.

Consumer and Family Employment in the Mental Health System

The Working Well Together Collaborative (WWT) is a newly formed collaborative of four statewide client, family, parent/caregiver and mental health training and technical assistance organizations: California Network of Mental Health Clients, The National Alliance on Mental Illness - California, United Advocates for Children and Families, and the California Institute of Mental Health. Together, these organizations utilize their combined expertise, lived experience, grassroots networks, and mental health system connections to provide support to counties to identify strategies to hire and retain a successful consumer and family member workforce at every level of service delivery. The WWT Collaborative maintains an extensive knowledge base and provides supportive links to enable counties to effectively learn from each other. More information about this program, along with regional contact information, can be found at www.workingwelltogether.org.

Recommendation: County mental health departments are urged to take advantage of the training and technical assistance provided by the MHSA-funded WWT Collaborative. WWT continues to work with county partners to develop strategies to preserve and expand consumer and family member employment in the public mental health system during this fiscal crisis. County mental health departments should also emphasize recruiting and hiring consumers and family members from multicultural underserved communities.

Client-Run and Self-Help Programs

The California Network of Mental Health Clients (CNMHC) has set two policy priorities in this area: to promote peer support and self-advocacy programs and to promote the use of client-run crisis and outreach teams and crisis respite as alternatives to traditional clinical treatment. The MHSA has resulted in progress that counties and their partners are implementing new peer-run wellness centers and warm lines. Such services are designed to use the strength of peer support to create a welcoming environment for access to community services and supports for individuals who may not typically seek or be able to access services but have frequently been forced to use more costly psychiatric/medical emergency services or have experienced trauma in traditional clinical treatment settings. A growing body of research supports the efficacy and cost-effectiveness of peer support and peer-run crisis alternatives.[1][2] In addition, some counties will be using MHSA Innovations funds to establish peer-run crisis and respite and integrated service models, including several programs designed to serve unserved and underserved populations, and more research is proposed to measure the outcomes and costs of these new programs.

Recommendation: MHSA funds should continue to be used to promote and expand peer-run programs, in keeping with the MHSA statute and the DMH vision for the Act's implementation. Client- and family-run services can reach and engage hard-to-serve populations and save lives, while providing a cost-effective alternative to clinical models of service. These should include client and peer-run programs serving

[1] See, for example, Jean Campbell, Ed., "Emerging Evidence Base of Peer-Run Support Programs," National Empowerment Center, accessed online at http://www.power2u.org/emerging_research_base.html and National Empowerment Center, "Evidence for Peer-Run Crisis Alternatives," accessed online at http://www.power2u.org/evidence-for-peer-run-crisis.html

[2] See also Greenfield, et al. "A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis," *Am J Community Psychol* (2008) 42:135-144

multicultural communities that can provide services in languages other than English. Because client-run peer support programs have been historically underfunded, the concept of "practice-based evidence" is key in promoting them. People who receive services through peer-run programs and those who provide them can testify to the increased access to underserved groups, incredible healing power and tremendous cost savings peer programs deliver. While we recognize that reductions to the Medi-Cal Managed Care Program and reduced Realignment revenue has weakened counties' ability to provide their obligation to beneficiaries in the Medi-Cal program, there must be a will to reserve some MHSA flexible funding to support client and family-run programs. More work is also needed in collaboration with the State Department of Health Care Services to ensure that peer-run services can be readily reimbursed by Medi-Cal using the Rehab Option, reducing prohibitive paperwork through the adoption of a streamlined, simplified set of documentation and tracking requirements, and increasing funding flexibility for non-clinical peer-run programs by incorporating recovery principles into the state's standard for medical necessity.

Community Partnerships to Provide Client and Family Support and Education

Consumer and family member organizations and community-based organizations specializing in serving multicultural communities in counties throughout California are equipped to provide effective community support and education to clients and families in need. These consumer and family-member-provided services include long-term education programs for family members and consumers, support groups, and interactive anti-stigma presentations designed to benefit the entire community. Family-to-family education and support programs inform the involvement of family members in the recovery process, helping families to engage in supportive roles throughout. Family involvement, based on client choice, may significantly enhance an individual's wellness and recovery. Providing increased access to these recovery supportive programs will reduce dependence on public services for many individuals.

Recommendation: Encourage county mental health departments to contract with statewide and local community consumer and family member organizations including those that serve multicultural racial and ethnic communities to provide the supportive content they are already equipped to deliver. The dollars spent go directly to providing valuable training and stipends for volunteers. These are cost-effective programs that provide considerable savings in terms of prevention and early intervention and essential community supports for recovery.

Crisis Residential Programs

In March 2010, the California Mental Health Planning Council published an advocacy document to encourage local jurisdictions to establish crisis residential programs (CRPs) as a means to address shortages in acute inpatient beds and to provide a better quality of care for mental health consumers in crisis. CRPs vary, but they often rely on peer staff who are trained to draw on lived experience to help reduce the trauma of crisis and focus on healing. If a facility is 15 beds or less, it is eligible for Medicaid reimbursement at a rate of $330 per day. This is significantly less costly than a Psychiatric Health Facility (PHF) at $585 per day or an inpatient hospitalization at $1,129 per day. CRPs are operating in approximately 18 counties. The reason why more CRPs have not been established since the passage of the MHSA is unclear to advocates, who believe this model of service puts recovery into practice and supports a client-driven system. A copy of the California Mental Health Planning Council's report on CRPs is provided with this letter.

Recommendation: Support the use of MHSA funding, especially Capital Facilities funds, and blend it with CSS and/or Innovation funds, to create additional crisis residential programs, including peer-run crisis respite programs and crisis programs specializing in serving unserved and underserved racial, ethnic and cultural

populations. CRPs, along with transitional residential treatment programs, including peer-run residential programs, can be utilized to transform institutional dependency to community-based service capability. Also, community mental health systems should take the opportunity presented by the intent of the new Medi-Cal 1115 waiver to advocate for crisis residential programs, including peer-run crisis respite, and transitional residential programs, including peer-run residential programs, as the foundation of the new restructured system of care. They fully meet the goals of the new waiver in that they have demonstrated improved outcomes, can slow the long-term expenditure growth rate, and emphasize coordinated care. In the proposed new person-centered health care home, great care must be taken to protect peer-run services throughout the process of integrating health care systems. This is critical because although mental health client- and family-run programs and services have long been established as an essential part of the continuum of care in community mental health systems, the vital role of peer-run services has not yet been widely recognized in primary care systems.

Conclusion

The best run systems are those that view challenges as opportunities for change and improvement. The suggestions presented above are perfect examples of doing more with less and all are solutions that are well within our grasp. We hope that you will give them strong consideration in both your short term program planning and long range goals. We are confident that, if given a chance, these models will turn into the foundation of wellness and recovery-based services that make communities thrive.

Sincerely,

Betty Dahlquist, Executive Director, California Association of Social Rehabilitation Agencies
Leticia Alejandrez, Executive Director, California Family Resource Association
Ann Arneill-Py, Ph.D, Executive Officer, California Mental Health Planning Council
Sharon Kuehn, Executive Director, California Network of Mental Health Clients
Trula LaCalle, Ph.D, Executive Director, NAMI California
Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition
Oscar Wright, Chief Executive Officer, United Advocates for Children and Families

Enclosure

cc: Patricia Ryan, MPA, Executive Director, California Mental Health Directors Association
Stephanie Welch, MSW, Associate Director MHSA, California Mental Health Directors Association
Stephen Mayberg, Ph.D, Director, California Department of Mental Health
Sherri Gaugher, Executive Director, Mental Health Services Oversight and Accountability Commission
MSHA Partners Forum Distribution List

Quality of Care and Quality of Life Assurance Workgroup

August 27, 2010

Attendees: Carole McKindley-Alvarez, Chair
Peter Mantas, Vice Chair
Floyd Overby
Sam Yoshioka
Absent: Peggy Kennedy

This meeting was specifically designated to prepare a proposal for the Mental Health Commission (MHC) regarding the completion of the Mental Health Board and Commission Workbook which is a state outcome report.

The following is the proposal:

- The Quality of Care Workgroup would be responsible for completing the Mental Health Board and Commission Workbook and preparation of final report.
- Colette O'Keefe would be invited to join the workgroup to participate in this process. She would attend meetings in September and October.
- The Quality of Care Workgroup would use data from fiscal year July 1, 2009-June 30, 2010. Data from 2006-2009 will be used as a lens to understand current data and illustrate possible trends.
- The workbook only requires quantitative data. While answering each question the Quality of Care Workgroup will also indicate areas where qualitative data would create more meaningful findings.
- The deadline for completion of the workbook and submission of the final report is November 24, 2010 (4 months after the date of the training).
- The Quality of Care Workgroup would provide an update to the MHC during the October meeting.
- The Quality of Care Workgroup would submit a draft of the report to the Mental Health Commission during the November meeting for approval.
- The Quality of Care Workgroup would make any corrections suggested and approved by the MHC prior to final submission

Action item:
The Quality of Care Workgroup would like the MHC to approve this proposal.

Diversity & Recruitment Workgroup
August 23, 2010

Attendees: Peggy Kennedy, Chair
Dave Kahler
Evelyn Centeno
Peter Bagarozzo

Discussion: Workgroup mission statement and areas of interest including MHC recruitment, selection, orientation and retention (see below)
Current MHC breakdown in terms of ethnicity and state mandated mix of consumer, family and member-at-large representatives.

Identified underrepresented groups based upon said breakdown. (see breakdown below).
Note: Commissioner Kahler noted that he takes exception to any consideration of race in the process of recruiting commissioners and feels that doing so is racist.

The Workgroup decided to direct outreach efforts regarding the Mental Health Commission to underrepresented groups.

Next meeting: Monday, 9/13/10 at 1:00 pm

Mission Statement

The mission of the Diversity & Recruitment Workgroup is to advise, guide and support the Mental Health Commission and members of the Board of Supervisors in order to recruit, orient, educate and retain commissioners who collectively:

* have experience and knowledge of the Contra Costa County mental health system
* reflect the ethnic diversity of the client population of Contra Costa County
* represent the state mandated mixture of consumers, family members, and members-at-large from each of the county's five geographic districts

Areas of Interest

Recruitment
* Identify underrepresented groups
* Determine outreach opportunities to provide MHC information to those communities

Selection
* Clearly set forth expectations for candidates
* Review interview process to ensure that questions are relevant and presented in a professional manner
* Confirm that the MHC selection criteria is aligned with the Board of Supervisors' criteria

Orientation
* Timely and flexible commissioner training
* Provide user-friendly commissioner orientation binder
* Assign a mentor
* Create a standard list of commissioner resources including:
    + Key websites and sources of information
    + Key people and departments within the Contra Costa mental health community
    + A list of current MHC topics of interest

Retention
* Assist commissioners in overcoming personal obstacles such as transportation or disability issues
* Conduct exit interviews with departing commissioners

Diversity & Recruitment Workgroup
8/23/10
Current MHC Breakdown

12 current commissioners
8 white (67%)
3 Asian American (25%)
1 African American (8%)
0 Hispanic (0%)

Contra Costa County client population (2010)
18,351 clients

7,982 White (43.5%)
1,055 Asian (5.7%)
4,729 African American (25.7%)
3,504 Hispanic (19%)
1,016 Other/unknown (5.5%)

State mandated mix of consumer, family & member-at-large for 5 CC County districts:

3 open consumer representative spots for districts 1, 3 and 5

9/9/10 Mental Health Commission Action Item
Given the Diversity & Recruitment Workgroup mission statement and current makeup of the Mental Health Commission, the Workgroup would like authorization to outreach to groups underrepresented by the MHC through the following community organizations:
1. La Clinica de la Raza
2. NAMI Contra Costa
3. SPIRIT Consumer Empowerment Program
4. Contra Costa Community Colleges Disabled Student Services and Programs

Report of CPAW Cap Fac. Meeting 8-24-2010
Prepared by Commissioner Annis Pereyra

This committee met to collect input for the August 31st public meeting on the MHSA Capital funds 20 Allen Project. At the Mental Health Commission Cap Facility workgroup's request, there were new stakeholders included for this process. Todd Paler and Julie Kelley were present to represent CCRMC. One of the data reports I requested as a result of dialogue at the last month's committee meeting were presented to all by CCRMC staff without discussion, while the rest have not been received. Julie Kelley, CCRMC staff member, did mention that some of the requested data was not kept by CCRMC. For example, upon discharge from PES, the only information that is kept is admit to CSU or discharge. There is no outcome data, for example, to reflect if the visit was for meds only, and from a PES standpoint, those who receive services there just drop out of sight once they leave.

Todd and Julie discussed problems from the part of our MH system they represent. Both mentioned the profound difficulties they have with consumers who are in need of detox, and the comment was made that mental health issues underlying the drug and alcohol problems never get addressed or dealt with. Their suggestion was to also have AOD at the table as stakeholders. Their dialogue also indicated that being able to discharge detoxed patients to a CRF for continued assistance with drug and alcohol related problems would be a good addition to provided service.

Comments were made about different ways that services could be enhanced to increase service to the children's system without bearing the expense of a brand new building to accommodate them. I mentioned carving out additional $$$ from Community Services and Supports to allow for increased service by mobile crisis, which would add more support in the home environment. Todd agreed that since the majority of issues with children stemmed from behavioral issues, that could be an excellent way to approach increasing services.

Sherry Bradley reported that it has been 5 years since CSS was first rolled out and trimming some things that are not as effective as hoped to enhance other needs that would improve services was a good possibility. She did mention that some of the contracts the county

entered into were not rock solid and should have included a plan for deliverables that would state that CCC has the power of the $$ to say "if you are not delivering" the $$ goes away. She stated some contracts are already under revamp, and specifically mentioned that the contract for 550 Patterson should have been more stakeholder driven.

Dr. O'Keeffe revisited the idea of a Kaiser model of having a clinician at a call center to evaluate low-priority problems such as medication refills, which would decrease the need to visit CCRMC. In addition, more critical problems could be referred to local PD for 5150's and welfare checks. There might even be a link to transportation provided for consumers who need to come in for a visit. Problems with bus service to CCRMC were also revisited.

Susan Medlin mentioned having "recovery coaches" who could assist consumers after visits to CCRMC such as driving them to a follow-up appt., etc.

Brenda mentioned later that much of what CCC did with MHSA funds planning, (Cap specifically), was a learning process but one that had costs, and it is time to re-evaluate to find out where we went wrong. It is this Commissioner's opinion that the prior process was not data driven, nor did it focus on looking at the overall system to evaluate where the most critical needs were first, but instead relied on the opinions of interests that were most outspoken and well represented. It was not inclusive of all stakeholders in an early enough time frame for real participation from the beginning.

Annis Pereyra

8-26-2010

CPAW Housing Committee Report
Wednesday, August 18, 2010
Prepared by Commissioner Annis Pereyra

The CPAW Housing Committee met and Vic gave an update on the Phoenix Apartments on Clayton Rd, stating that HUD has extended their relationship with ANKA for an additional year. This should relieve the pressure of finding new housing for the residents on a temporary basis, but there may still be displacement at a later date.

The new Housing Coordinator position has not yet been filled, and the process has narrowed the field to 2 candidates. The committee reviewed expected roles of the position, and Vic stated that once this person is trained and ready to take over, he will step down from his position as a member of the team working on the 10 year Housing Plan so that he can focus on his primary job responsibilities.

I again asked about the data that I had previously requested which has not yet been received. Vic stated that some of the information is difficult to retrieve. In my request were the following:

- The total amount of MHSA Housing Money set aside for CCC?
- The total number of housing units secured to date, including:
  1) Name of each project, ie: Lillie Mae, Villa Vasconsuelos, Bissel Street cottages, and others, etc.?
  2) Location of each property?
  3) Number of bedrooms in each property?
  4) Cost of each project, including allocations set aside for long-term maintenance, etc.?
- What is the dollar amount remaining to be used for MHSA Housing?

In my position as the MHC representative for housing, I have heard comments about the expense for acquiring some of this housing when expressed in terms of cost per bedroom. I think that a simple explanation that this cost is not only for the purchase of the property but also for the long-term upkeep will help educate our concerned public. It is not a simple matter of buying housing at low cost in a distressed market, but the total cost over the expected 20-year use of this housing that escalates the dollar amount and causes confusion.

Annis Pereyra

The 9/2/10 CPAW Monthly Meeting Report is not included in the meeting packet, but will be distributed as a handout at the 9/9/10 MHC Meeting.

The following CPAW Innovation Committee Report will be referenced in the 9/2/10 CPAW Monthly Meeting Report.

CONTRA COSTA HEALTH SERVICES

DATE OF REPORT: September 2, 2010

SUBJECT: Report to Consolidated Planning Advisory Workgroup

FROM: **Innovation Committee of CPAW**

Approved Charge of Committee *(Approved/Revised by CPAW - 5/21/09):*

1. Establish process for submission of ideas
   a) Come up with what to do
   b) Determine priorities
   c) Solicit (RFP/RFI) for projects
   d) Package and send to state as a proposed plan
2. Review materials
   a) Look at previously submitted ideas
   b) Attend community meeting
   c) Bring recommendations to CPAW
3. Review projects/outcomes
   a) Continue to monitor projects and outcomes

Reported from the **August 10, 2010** Meeting of the Innovation Committee:

Participants of Meeting: (list names/affiliation)

- CPAW Members: Brenda Crawford, Kathi McLaughlin, Ryan Nestman, Susan Medlin, Tony Sanders
- Staff: Sherry Bradley, Eileen Brooks, David Carrillo, Cindy Downing, Erin McCarty
- Facilitator: Judith Macbrine
- Absent: John Hollender, Anna Lubarov,
- Excused: Elvira Sarlis (staff)

RECOMMENDATIONS TO CPAW: (Indicate type: inform/approve/clarify/input needed)

- **RECOMMENDATION #1: Seeking Approval.**

The Committee recommends to CPAW the following that the Charge of the Innovation Committee be revised:

- **Establish a process for submission and review of innovation ideas**
  - **Attend Innovation Committee meetings.**
  - **Recommend Committee membership and identify Committee membership gaps.**
  - **Come up with a process for evaluating ideas (original and ongoing).**
  - **Review originally submitted and new ideas.**
  - **Recommend priorities (original and ongoing) to CPAW.**
  - **Suggest implementation process (e.g., RFP/RFI/staff run).**
  - **Recommend innovation ideas to CPAW for submission to the Mental Health Director.**

DATE OF REPORT: September 2, 2010

- Review proposed plans sent to the State for approval.

- **Review Projects and Outcomes**
  - Review project outcomes and learning goals on a quarterly and annual basis.
  - Liaison with the Data Committee.
  - Liaison with Innovation Project Managers.
  - Recommend to CPAW post-project actions and sustainability options.

➢ **RECOMMENDATION #2: Seeking Approval**

The Committee recommends the category of "Fast Track" ideas be established, with the criteria that ideas must be able to be quickly implemented once approved and project budget is $<250,000. The Committee recommends that Fast Track ideas originate from Staff or the public and that the Committee review one fast track idea per month.

➢ **RECOMMENDATION #3: Seeking Approval**

The Committee recommends to CPAW that the CalMEND Integration Process Project (FTINN-01) be approved for up to $250,000 and up to 24 months.

- The proposed project calls for:
  - Three Wellness Coaches.
  - 0.5 Community Support Worker for evaluation.
  - Recovery Innovation Training.
- The committee recommends a short-term continuation of the program to show its ability to be replicated.

➢ **RECOMMENDATION #4: Seeking Approval**

The Committee recommends to CPAW that INN-04, Trauma Services for sexually exploited female youth, be developed into a Draft Plan and RFI

- The proposed project would have two component parts:
  - Collect Data and Recommend Model. Contra Costa County data sources should be augmented with San Francisco and Alameda County data sources. A newly won federal grant in San Francisco and California Prevention Education Project (CalPEP) may offer additional data.
  - Implement New Model for Engaging Sexually Exploited Female Youth. Engaging this target population is the greatest challenge. A Harm Reduction Model is one possible approach.

Topics of Discussion

✓ Item #1: Get Alignment on What the Committee is supposed to deliver:

(See Recommendation #1)

DATE OF REPORT: September 2, 2010

- ✓ **Item #2: Align on Process of Delivery:** The Committee aligned on the process for moving Innovation Themes and projects forward. The Committee discussed process for accepting and review new ideas, including 'fast track' ideas; removing and changing ideas, while keeping in mind guiding principles of openness, transparency, and previously identified local stakeholder needs areas. The Committee also discussed the danger of Innovation moneys beginning to revert on 6/30/11. Assuming that it takes six months for State approval of Work Plans, projects need to be submitted by 12/31/10.
- ✓ **Item #3: Fast Track Ideas:**

(See Recommendation #2)

- ✓ **Item#3: Current Definition and Status Each of Current Ten Themes:** The Committee was not able to discuss the status of all 10 project themes, due to a lack of time.

  INN02-Mother's Custody was discusses, and barriers to the plan, as drafted were discussed. The Committee recommended that the current approach to INN-02: Addressing Child Custody Issues for Mothers Experiencing Episodes of Mental Illness be changed.

- ✓ **Item #4: CalMEND Integration Process Project**

(See Recommendation #3)

- ✓ **Item #5: INN-04 - Trauma Services for Sexually Exploited Female Youth**

(See Recommendation #4)

DATE OF NEXT MEETING: **September 14, 2010, 10 AM – Noon**

1340 Arnold Drive, Ste. 112 Martinez, Ca 94553

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
MENTAL HEALTH
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156
MHSA@hsd.cccounty.us

August 25, 2010

MEMO TO: Consolidated Planning Advisory Workgroup

FROM: Innovation Committee

SUBJECT: Draft Summary of Innovative Work Plan for INNFT01: Promoting Wellness, Recovery and Self-Management in an Integration Pilot Project

The following is recommended for development of Innovation Work Plan for Innovation Fast Track, as per the defined Fast Track Theme.

Background:

Contra Costa Mental Health proposes:

- Training Community Support Workers (CSW) in advanced peer support, including wellness, recovery and self-management coaching
- Using CSWs to link consumers using El Portal Mental Health Clinic who are participating in West County primary-mental health care integration pilot to locally available wellness resources
- Using CSWs to provide wellness, recovery and chronic disease self-management coaching to consumers in pilot

Work Plan:

The Work Plan is innovative because it:

- Is a substantial change of an existing mental health practice because it is integrating primary health care into mental health services in order to improve wellness and health outcomes
- Changes an existing approach to use peers (Community Support Workers) as Wellness Coaches to provide wellness activities and self-management skills as well as link mental health consumers to existing wellness resources in the community

Innovation Learning Goal:

The following is the main learning goal:

- To determine if adding peer Wellness Coaches to a primary health care-mental health care integration pilot project team: 1) increase the number of mental health consumers with wellness and/or recovery goals; 2) increase the number of consumers with self-management skills; 3) improves wellness and primary health outcomes for mental health consumers; and 4) increases

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
MENTAL HEALTH
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156
MHSA@hsd.cccounty.us

primary health providers knowledge about mental health consumer culture and mental health recovery.

Possible Indicators:

- Utilization of primary care and wellness services
- # wellness and recovery goals
- # self-management plans
- # recovery plans
- # primary care providers trained on mental health consumer culture and recovery
- # providers with knowledge of mental health consumer culture and recovery
- Consumers' wellness-related behaviors
- # consumer interactions with Wellness Coaches
- # and type of services provided by Wellness Coaches
- # linkages to community-based wellness services
- Consumer perceptions of stigma
- Overall health outcomes

Timeline:

- 24 months total
- 1st 12 months are done in conjunction with integration pilot
- 2nd 12 months will test the replicability of the adapted CSW model in other mental health and/or community settings

Budget:

- $250,000 over 24 months

Leveraging:

- Utilize Existing Primary and Mental Health Care Staffing
- Medi-Cal Billing
- Utilizing Existing Community-Based Wellness, Recovery and Self-Management Resources

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
MENTAL HEALTH
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156
MHSA@hsd.cccounty.us

August 25, 2010

TO: Consolidated Planning Advisory Committee

FROM: Innovation Staff Team (Sherry, Erin, Cindy)

SUBJECT: Draft Summary of Innovative Work Plan for INN04: Trauma Services for Sexually Exploited Female Youth

---

The Innovation Committee, at its meeting of August 10, 2010, is recommending to CPAW at the meeting of September 2, 2010, that it concur with, and approve, the following recommendation to the Mental Health Director:

Go forward with developing a Work Plan and an RFI for Innovation Theme #4, Trauma Services for Sexually Exploited Female Youth.

That would include the following:

- Send out Request for Expression of Interest (RFI) and if needed Request for Proposal (RFP)
- Goal of RFI/RFP: To contract with County Agencies/CBO (s) to
  1) collect data about the service needs of commercially sexually exploited children (CSECs);
  2) develop/adapt an out-patient, harm-reduction model to provide holistic trauma services to female CSECs and
  3) test the effectiveness of this model in engaging female CSECs youth in services as well as to determine if it should be expanded
- If service approach/model is effective, CCMH *may* use the data collected about CSEC population to expand use of service approach to all CSECs

The Work Plan is innovative because it:

- Is a substantial change of an existing mental health practice to collect data about CSECs and use it to inform service needs
- Is a new application to the mental health system of a promising community approach because it uses an out-patient, harm reduction model to provide trauma services to female CSECs

The following is the main learning goal:

- What strategies are effective in engaging female CSECs in mental health services? What trauma services are needed by female CSECs? Does the new service adapted/developed by the County and/or CBO chosen by the RFI/RFP increase the ability of female CSECs to access healthy choices and increase the number of female youth who recognize they can make choices about their risk behaviors?

WILLIAM B. WALKER, M.D.
Health Services Director
DONNA M. WIGAND, L.C.S.W.
Mental Health Director

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
MENTAL HEALTH
1340 Arnold Drive, Suite 200
Martinez, CA 94553-4639
Ph 925/957-5150
Fax 925/957-5156
MHSA@hsd.cccounty.us

Possible Indicators:

- Risk Behaviors
- Number of resources available
- Number of services/resources accessed
- Feelings of isolation and lack of support
- Enhanced coping skills
- Change in attitude about ability to make choices

Timeline:

- 18 Month Work Plan
- Months 1-6collect data about CSECS and design service approach
- Months 7-18 implement and evaluate approach

Budget:

- $300,000 over 18 months

Leveraging:

- Depending on RFI/RFP selected--potentially use existing County space, staffing, etc
- As part of the RFI/RFP process, the County or Contract Agency awarded the RFI/RFP will submit a recommendation for how to sustain effective program(s)/model(s) after the conclusion of the Innovation Work Plan