Mental Health Commission
10.24.13 Minutes – 1st Draft

Agenda Item	Discussion	Action/ Follow-up
I. Call to Order/ Introductions	Chairperson Carole McKindley-Alvarez called the meeting to order at 4:30 p.m. <u>Commissioners Present:</u> Louis Buckingham, District III Evelyn Centeno, District V Jerome Crichton, District III Jack Feldman, District V Dave Kahler, District IV Carole McKindley-Alvarez, District I Teresa Pasquini, District I Lauren Rettagliata, District II Gina Swirsding, District I (arrived at 4:48) Sam Yoshioka, District IV <u>Commissioners Absent:</u> Peggy Kennedy, District II Colette O'Keeffe, District IV Supv. Karen Mitchoff, BOS Rep. <u>Non-Commissioners Present:</u> Kevin Burns, MHCC Laura Case, Officeof Supv. Mitchoff Andrea Clark, ANKA Marvin Edwards John Gragnani, Local 1, Mental Health Steven Grolnic-McClurg, MH Director Peggy Harris, Concerned Citizen Jessica Higgins, St. Mary's College Christine Johnson Shayne Kaleo, ANKA Radha Lampley, St. Mary's College Mariana Moore, Human Services Alliance Karen Shuler, MHC Executive Assistant Nina Smith, AOD Board Cynthia Staton Connie Steers, Consumer *Note: There were other attendees who did not sign in*	
II. Announcements	Carole made the following announcements: 1) Reminded Commissioners and all in attendance that proper decorum should be	

	used when conducting themselves in the meeting, and when Commissioners interact with each other, and staff. 2) The minutes are not verbatim. In an effort to ensure what it is you said is captured correctly, check the Minutes when you receive them and contact staff ahead of time so she can check the tape for accuracy. 3) A flyer was available for Project Hope -- a memorial every year for homeless people who have passed over the year. 4) Carole mentioned the need to use the Data Request Form to prevent multiple people from contacting the same person – a streamlined way to get information. Contact staff for a copy.	
III. Public Comment	1) John Gragnani spoke regarding a disturbing financial pattern. People in Homeless have been given pay raises and on call pay. He has been told raises occur when there is recruitment and retention issues, but there has been none. County doctors are being paid on call pay even when they aren't working on call. He asked the MHC to join them to review on call practices. 2) John Gragnani referenced Commissioners Buckingham's and Crichton's concerns regarding issues at psych emergency. He urged people to follow up with Health Care Partnership and visit PES. The Healthcare Partnership meets on C Street in Martinez. Teresa will send staff the address. 3) Cynthia Staton advocated for prevention and early intervention. [Comment attached.] 4) Kathy Myers says she is saddened because there is a lack of attendance and no continuity at MHCC. 5) Christy Johnson brought up some of the good things that have come out of MHCC – namely the SPIRIT program. Her problem was an employee issue. She followed policy and procedures and feels there's a need for more attention to the grievance procedure. Grievances need to be heard and not overlooked.	
IV. Commissioner	Lauren wanted to enter a picture of room at	

	Comments	Juvenile Hall that Chief Kader had posted to his website. We need to advocate for those who have no voice. [Comment attached.]	
V.	Approval of the Minutes from September 26, 2013	➢ Sam made a motion to approve the Minutes and Evelyn seconded. There was no discussion. Vote: The Minutes were approved as presented by a vote of 8-0-2. Lauren and Gina abstained	
VI.	Committee Reports	**A. Bylaws Task Force – Sam Yoshioka, Chair** Response to Commission request to review three Bylaws revision issues Sam gave a brief background of the Bylaws Revision Process, mentioning the three issues that were being addressed today. ➢ Jack made a motion, seconded by Evelyn to accept the revisions below as presented by the Bylaws Task Force. Discussion: Evelyn expressed appreciation to Peter for his input. She said the Task Force concentrated on streamlining the Bylaws so they only included responsibilities of Commissioners. **Green=Changes** **Red=Deletions** Black=No change 1) Article II, Section 2, pertaining to how the W&I Code responsibilities are listed. **MANDATED ROLES AND RESPONSIBILITIES** As specified in the Welfare and Institutions Code Section ~~**5600 and 5800**~~ **5604.2 (a) 1-8 (a), the local mental health board shall do all of the following:** **1) Review and evaluate the community's mental health needs, services, facilities, and special problems.** **2) Review any county agreements entered into pursuant to Section5650.** **3) Advise the governing body and the local mental health directors to any aspect of the local mental health program.**	

	4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. **5) Submit an annual report to the governing body on the needs and performance of the county's mental health system. ** **6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.** **7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.** **8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to mental health board.** **(a) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and in the local community. And Section 5848 (b) and (c):** **(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and**	

	expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions. **(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.** 2) Article VII, Section 3B-Section 6B, pertaining to Committee membership numbers. **Membership** The membership of each standing committee shall include a minimum of **~~two (2) and a maximum of four (4) members~~ three (3) and a maximum of five (5) members** of the Commission 3) Article VII, Section 5B, pertaining to non-Commissioner membership on Task Forces. Membership **~~of Task Forces~~** The membership of each task force shall include a minimum of **~~two (2)~~ three (3)** members but no more than **~~four (4)~~ five (5)** members **~~of the Commission~~**, who shall serve on the task force as liaisons to the Commission. **~~Other members~~ Non-Commissioners may be appointed from the community when special expertise, advice or opinion is desired, at the**	Send proposed

	discretion of the Commission, but shall not exceed one half (1/2) of the membership of the Task Force. All members and attendees shall conform to the Mental Health Division client confidentiality statement. Vote: The motion to accept the Bylaws Revisions as presented passed unanimously 10-0. The proposed Bylaws will be forwarded to Mental Health Director Steven Grolnic-McClurg. **B. MHSA/Finance Committee – Teresa Pasquini, Chair** 1) The MHSA/Finance Committee recommends a motion to support MHSA Program Manager Warren Hayes moving forward to seek financial support to get a subject matter expert to assist in creating the methodology for Audit #2. Warren created a list of deliverables that included program fiscal compliance. ➢ Teresa made the above motion and Carole seconded it. Discussion: Gina asked about funds that go to state hospitals not being from MHSA – where does that money come from? Teresa suggested that a conversation about MHSA finances may be called for at the MHSA/Finance Committee meeting. Gina expressed concern about consumers. Carole suggested that it be addressed at the MHSA/Finance Committee but needs MHA staff support. Staff was asked to forward Gina's comment to the MHSA/F Chair. Lauren said the MHSA/F dovetails into Gina's question because it covers all "Finance" not just "MHSA" Teresa mentioned the audit is only MHSA. John: CPAW debated the Plan for several months. Then the MHC asked for an	Bylaws to Mental Health Director Steven Grolnic-McClurg with request that it he forward it to Dorothy Sansoe and County Counsel. Forward Gina's comment to MHSA/F.

	audit to be able to have trust and confidence in our system going forward. Sam asked for the status of the second audit and when will we hire an auditor? Teresa: That's what this motion is about. We liked what Warren presented, but it lacked details that an expert would be able to provide. We need clarity on where we've been and where we are so we can move forward. Steven: This has been a good demonstration of a great partnership, and he strongly supports the MHC in this. Vote: The motion was passed unanimously 10-0. 2) The MHSA/Finance Committee recommends a motion to request details of the current investigation of Mental Health Consumer Concerns, including asking if it includes a forensic audit. If not, why not; if yes, details. Have had ongoing discussion since April. The Committee feels the need to have more detailed information. ➢ Teresa made the above motion and Lauren seconded. Discussion: Sam asked the definition of forensic audit Lauren said one done by an auditing committee when it's thought something illegal has been done. It could determine if funds were used correctly, misused, or criminally misused. If it's determined there was misuse, the Board or individuals could be held criminally liable. The use of a forensic audit would clarify this. Jack: The Commission has not heard enough from the consumers who use the services there. He's heard from the MHCC Board the money was just used at the wrong time. Cynthia said she attended the MHSA/F Committee and she has mixed feelings because of the expense involved, but MHCC has not provided information. Where did the money she knew was there	

	go? [Comment attached.] Lauren said she is also very concerned about the consumers, and feels a forensic audit will protect the consumers and those at MHCC who have not been involved in any criminal activity. Sam said he wished we didn't use the word "forensic" – it's pre-judging. Just have an audit and then let the auditors decide if we need a forensic audit. Evelyn said forensic only means investigative work. Teresa: This committee received a lot of documents. The D.A. has become involved. She added she doesn't know what more a voluntary Commission can do and we are not being judgmental. We cannot verify rumors. This was a thoughtful motion that considered the reputations of innocent people at MHCC. She remains concerned about MHCC. Carole: In this motion, it is not directly requesting a forensic audit. It's asking the people who are doing the audit – did you do one, if so, what were the results. Vote: The motion passed by a vote of 9-0-1. Sam abstained. **C. Criminal Justice Committee – Evelyn Centeno, Chair** Committee Report. Julie Kelly will be attending the November meeting. They are requesting that she discuss the number of those listed as NGI (Not Guilty by Reason of Insanity); and how many in our jail are known to be mentally ill. At the October meeting, Erika Barrow spoke about the new West County multi-disciplinary Forensics Meeting. Jamie Miller from the Juvenile Justice Commission, reported that, Judge Haight gave JJC permission to investigate issues at Juvenile Hall. Also in October, Dr. Saldanha spoke about care in the PES. Hde will speak more about quality of care and lead into a discussion of	

		follow-up on 5150's. AB109 – Evelyn had no report as monies have been distributed. She will be attending the Citizens Advisory Board. Carole said someone at St. Mary's is doing a report on AB109. Steven spoke about money that had been awarded for an analysis of AB109. **D. Quality of Care Committee – Peggy Kennedy, Chair** Committee Report. Peggy, Colette and Lauren are eeting with Assembleywoman Joan Buchanan tomorrow about low cost dental programs. **E. Executive Committee – Carole McKindley-Alvarez, Chair** Did not meet.	
VII.	Accept Nominations for 2014 Chair, Vice Chair and Executive Committee Members	Nominations for 2014 officers and Executive Committee were opened. <u>Chair:</u> Evelyn nominated Jerome for Chair. He declined. Jack nominated Teresa for Chair. She declined. Louis nominated Lauren for Chair. She accepted the nomination. Lauren nominated Dave for Chair. He declined. Lauren nominated Colette. Colette was absent so unable to respond. <u>Vice Chair:</u> Jack nominated Sam for Vice Chair. He accepted the nomination. <u>Executive Committee</u> Evelyn nominated Jerome for membership. He accepted the nomination. Sam nominated Colette. Colette was absent so unable to respond. Evelyn nominated Louis. He accepted the nomination.	

		Nominations will also be received at the November meeting.	
VIII.	Discuss MHC position on implementation of Laura's Law (Assisted Outpatient Treatment)	Carole gave background of why this was on the agenda. The MHC has not solidified a position on this. AOT Workgroup is going to have 3 listening sessions, one of which will be hosted by the MHC. Carole suggested tagging it on to the November MHC meeting – 1 hr. for the regular monthly MHC meeting and 1-1/2 hours for the AOT Listening Session. Steven: We are looking at the issue of the needs for individuals who despite outreach will not participate in care and are at risk for being violent; we are looking for more opportunities for engaging people like this; how to better engage and support family members. Carole said she needs to know the MHC position because she needs to be able to speak to it at the meetings. Sam: 45 states have some type of Laura's Law or Kendal's Law. In working with his sister in Hawaii where there is AOT, he was able to plead in court for her to get medication treatment for her while she was in a hospital. When she was off her medication, she did not do well. On her medication she did well and within 2 months was out of the hospital and 14 years later she volunteers 4 days a week and maintains her medication regimen. We need an option for AOT. Lauren asked for the MHC to support the implementation of LL. It forms a treatment team. There's a commitment from the wellness team as well as from the individual. The individual can realize the seriousness of the treatment plan. It will reduce crime, homelessness. She asked that the MHC join her in asking that our county implement LL. ➢ Lauren made the motion and Teresa seconded it that the MHC take the position that CCC implement LL. Discussion: Teresa thanked Sam for sharing his sister's story. Her brother is also in the county system and she has also had to go	

	to court on his behalf. She supports the motion, but doesn't think we have the infrastructure, but we need to watch every dollar and create that system. She believes there must be treatment before tragedy. There are sometimes 900 5150's per month. 187 in WC jail are accused of murder or attempted murder. It's a systemic issue. There's accountability with LL. Her son went to Napa without a criminal history, and is now in the CJ system. Gina: We're passing a law that is not just covering those in the county system, but all that are mentally ill (including privately insured). You have to realize that those who are privately insured will not get the outpatient treatment that lower income people get. How will they get treatment? She has been forced to take medication against her will and it made her worse. That's why a lot of consumers refuse treatment. She feels going before a judge is not the way to do it. We're going backwards. There needs to be trust and then you'll cooperate. She feels it's a bunch of people who are for it and she feels alone now. You need to listen to the consumers. Louis: When you seek county services, you have to be too poor. If we had more facilities with in-house care to take care of our consumers, they would be stabilized. Evelyn: Supports the motion. LL will help the consumer fight to get stabilized. A lot of consumers need help from a wellness team. We need something that will take care of them the first time so there's no revolving door. LL will save money. Cynthia: Doesn't know why the MHC has to take a position and doesn't feel there's good consumer representation here on the Commission. She said she is pro-choice, and believes how people decide to live is their choice. We cannot force	

	people to take medications. You can educate them and encourage them but not force them. Georgette Howington: Her son has an illness but does not realize it. Off medications he is delusional and out of control. We have to deal with people on an individual basis. There are people who do need extreme measures. Steven: Clarification – LL does not allow for independent mandating of medication. Carole: As a Member-at-Large on the Commission, she appreciates hearing from people about their lived experiences, but where her concern comes in is we do not have the consumer voice adequately voiced here. It impacts people when some have more of a voice than others. Dave: LL simply doesn't have forced medication. If you had the room filled with consumers, they wish that mental illness would go away and it doesn't work that way. Vote: by a vote of 5-1-4, the vote for the Commission to take a position in favor of the County's implementation of Laura's Law did not pass. Ayes: Evelyn Lauren, Dave, Teresa, Louis Nay: Gina Abstain: Sam, Carole, Jerome, Jack, There is no clarity on the MHC's position. ➢ Carole made a motion and Sam seconded that the AOT host a listening session tagged on to the November 21st MHC meeting. The MHC monthly meeting would be 4:30-5:30, followed by the listening session 5:30-7:00. Discussion: Gina: Why? Only family members will show up. Teresa: Why is it called a Listening Session. Carole: It's us hosting it in a Public	

		Hearing setting. Steven: The AOT workgroup wants to have the opportunity to hear from the community so we have their information so we can pass on the comments we received. We're thinking about it being 15-20 minutes on issues and then receive comments. Gina: People who are severely mentally ill can barely get out of bed, let alone attend a meeting about LL. Teresa: The way it's set up, it doesn't sound like it'll be an educational outreach. There is no law enforcement on the workgroup. John: In CPAW he has been speaking about the need for new avenues to participate. Jerome: wondered if it's occurred that a one size fits all will not work. Vote: By a vote of 6-2-2, the motion for the Commission to host an AOT Listening Session did not pass.: Ayes: Evelyn, Sam, Carole, Louis, Jack, Gina Nays: Dave, Teresa Abstain: Jerome, Lauren	
IX.	Discuss Update on Mental Health Consumer Concerns and Make Recommendations Regarding Next Steps.	See Steven's report below.	
X.	Discuss the Possibility of Changing the date of the monthly Mental Health Commission meetings (as requested by Supv. Mitchoff).	Suggested dates (in order of preference): 1) 4th Wednesdays 2) 2nd or 3rd Mondays 3) 1st Monday 4) 1st Thursday 4th Wednesday is a conflict with AOD. Jerome: It's easier to move one than 10. 1st Thursday conflicts with CPAW MHC decided to remain meeting 4th Thursday	
XI.	Mental Health	Report from Steven Grolnic-McClurg	

Director's Report	**1) Mental Health Consumer Concerns** Behavioral Health Administration is attempting to ensure that essential services provided by MHCC can continue with the least possible disruption given the possibility of MHCC ceasing to provide services to the county after 12/31/13. MHCC has proposed a shutdown of services as of that date due to fiscal issues. The Request For Proposals (RFP) for the Wellness Centers currently run by MHCC is attached. We have identified a potential provider of required Patient's Rights activities as well, and have started conversations about moving this contract from MHCC to this vendor. Discussion: Steven: This is as far as we've gotten right now. Cynthia: [Comment attached.]. Teresa: Participated in the RFP conversation. Effort was there. Committee strongly urged there would be consideration for current staff. There are problems with the Patient's Rights people. Steven: There is no hidden agenda regarding who the vendors will be. **2) Assisted Outpatient Treatment** Behavioral Health presented the progress of the assisted outpatient treatment workgroup to the Board of Supervisors' Family and Human Services Committee on October 16th, 2013. The report is attached. This committee accepted the report and the recommendation included. I am requesting that the Mental Health Commission partner with us in conducting a listening session on the issue in the months of November and December. Our intention is to hold one public listening session in each region of the county (East, Central and West) and we are interested in how we can utilize already existing public meetings and groups to best accomplish this goal. We will also be posting information on the topic on our web page and asking for public comment beginning in November. Discussion	

	Gina asked for clarification regarding what family can and cannot be told. Steve: HIPPA laws prevent giving information without getting informed consent. **3) Access** An essential component of good mental health care is timely access to that care. Behavioral Health is engaged in a number of initiatives to improve access to that care for individuals who are currently not connected to care. These include: • Successful pilot of a program with Psychiatric Emergency Services (PES) and West County Adult Clinic. In this pilot, adults who are in this region and are being discharged from PES are referred to the adult clinic and, rather than being given a specific appointment for assessment, are given an open invitation to walk-in for care at any time. The referral is immediately faxed to the an intake clinician at the West County Adult Clinic, who tracks if this individual makes it into care and does outreach to encourage these individuals to come in for an assessment. The data for this pilot, which has been operating for several months, has shown an encouraging number of adults have entered care in this way, and less administrative burden on staff at both sites. It also lessons the burden on the ACCESS line, which previously received all such referrals and routed them to the adult clinic. We will be spreading this pilot throughout the adult system of care by January 1st, 2014. John: result from MHSA Plan. • Successful pilot of a program with the West County Health Center and the West County Adult Clinic. This pilot has allowed primary care providers within the health center to use Epic's inBasket communication portal to send referrals for speciality mental health care directly to the program manager at West County Adult Clinic. This saves time for	

		clinicians at both sites, and lessons the burden on the ACCESS line, where all referrals where previously sent. It also allows for a better feedback loop between primary care and mental health, so providers are clear what happened with referrals and there can be a developing understanding of the services available to those with serious mental health concerns. This pilot has also been a success, and we are working with IT to develop the infrastructure and workflows with EPIC to expand this to all adult clinics. • A Performance Improvement Project (PIP) at the ACCESS line. In response to concerns about the number of dropped calls (phone calls where the person hangs up before the call is answered) and wait time to get a phone call answered at peak usage times at the ACCESS line, a PIP has begun at the ACCESS line. Workflows are being mapped and data has been collected to accurately assess the issues and to develop possible interventions. While in process, this PIP is an important part of improving our access to care. • A system wide focus on reducing wait times for an initial encounter when someone is referred from the ACCESS line to one of the adult or children's clinics. Our goal is to have an initial appointment within one week for all referrals. Staff are looking at a variety of tactics to accomplish this and initial results are encouraging – current wait times in the children's clinics are within this time frame in all regions, and within this time frame in two out of the three adult clinics.	
XII.	MHSA Program Manager's Report	Address issue of MHSA monies being used for out-of-county placements. Warren did not attend as there were no new updates.	
XIII.	Commissioner Representative	Due to lack of time, there were no reports from Commissioner Representatives	

Reports.	1) Behavior Health Integration Steering Committee Report – Sam 2) Social Inclusion Committee – Carole 3) AOD Board – Sam 4) Homeless Board Meeting – Carole 5) Community Corrections Partnership (AB109) – Evelyn 6) Assisted Outpatient Treatment Workgroup (Laura's Law) – Carole 7) Primary Care Integration Committee – Colette	
XIV. Adjourn Meeting	The meeting was adjourned at 6:50 p.m.	

Respectfully submitted,
Karen Shuler, Executive Assistant
Contra Costa County Mental Health Commission

9.26.2013 Commissioner Comment Submitted by Lauren Rettagliata

As advocates for all youth who are being cared for by the Juvenile Justice System, I am asking you to contact the Contra Costa Supervisors and ask them to join us in advocating for an emphasis on rehabilitation for the youths who reside in the facilities operated under their authority.

The lawsuit by Public Counsel, Berkeley-based Disability Rights Advocates and a private law firm was filed on behalf of a teenage girl who is diagnosed with attention deficit disorder and bipolar disorder and two boys, who are listed as G.F., Q.G and W.B. The latter is a 17-year-old who, according to the lawsuit, began hearing voices after spending 90 days in an isolation cell. All three are in custody at the juvenile hall in Martinez.

The situation now stands that the County is unable to comment on the situation because of the law suit. Would not the funds that are now being spent to defend the suit be better used to remedy the dire situation that exists and a settlement be made that benefits the children?

I am asking you to contact both your County Supervisor to show your support for these young people and to insist that the juvenile facility meets its obligation of providing health, including behavior health care not just to the letter of the law but to the same standard that we would provide for our own children. We need to stand together as a voice for the voiceless children.

We simply should not tolerate the solitary confinement of children. The impact of this practice on youth under 18 is devastating – domestic and international experts assert that young people are unable to handle isolation and that the practice should be banned.

I ask you to call for the ban of isolation of youth as a punishment and limit isolation to circumstances in which juveniles pose an immediate and substantial risk of harm to others or the security of the facility (and only after all less-restrictive options have been exhausted); as soon as the safety risk was addressed, the youth would be released.

I ask that the county have youth in isolation evaluated "face to face " by a clinician within one hour of being isolated and every four hours after that. Youth who exhibit suicidal behavior, commit acts of self-harm, or show signs of serious mental illness would be moved to an offsite hospital or mental health hospital.

We simply should not tolerate the solitary confinement of kids. The impact of this practice on youth under 18 is devastating.

Please let others in your community know how their advocacy may help these very vulnerable children. Yes, they have done things that have placed them in detention, but we as a community have called for rehabilitation not punishment for our children.

MHC Meeting - Public Open Comment - C. STATON
October 2013

Because of Stigma and Discrimination, I have not openly shared my story or struggles with my own Mental Health. However, I have openly identified myself as both a family member and a peer. Because of this, I believe I can speak from personal experience.

Recently, someone dear to me, shared an analogy between the stages of mental illness and the stages of cancer. I cannot say that I place more importance on those at Stage 1 vs. Stage 4. Yes, those at Stage 4 are in crisis and require immediate care and attention. However, if we ignore those at Stage 1, they will ultimately end up in Stage 4, thus perpetuating the reactive level of care instead of the proactive. For this reason, I strongly advocate for prevention and early intervention.

[In jest, I think everyone can understand this need, for example going to the dentist for routine dental care to "hopefully" avoid a root canal.]

I believe this concept of prevention has been proven to work. Medical Plans such as KPorg are embracing it; companies are welcoming it by wellness offerings such as gyms, healthier food and support groups. The statistics have shown stress reduction, fewer illnesses and increased sense of *well-being*. Consequently more and more funds are being expended on prevention. Because it works, MHSA has addressed this need through funding of new resources for prevention and early intervention.

This county needs to step up and provide those funds for more services to aid those in the early stages of their illness to prevent a stage 4 crisis. As everyone knows, once you fall into crisis, it is very difficult to regain that which is lost.

MHC Meeting - Open Comment Agenda Item VI.B.2 - C. STATON
October 2013

I attended the Mental Health Commission Finance Committee Meeting this month. It was recommended that a Forensic Audit of MHCC be completed. I have mixed feelings because of the expense. However, MHCC has *not* provided public fiscal records of the alleged encumbered funds and how they have been expended to the degree that they are not able to repay Contra Costa County. At the time I left MHCC, 14 months ago, there was over $300,000 in a savings account and over $200,000 in the checking account. Positions have been vacant during this time resulting in excess funds. So where did the money go?

In addition Contra Costa County's Mental Health Department has *not* provided an explanation of how this could occur; nor am I aware of a proposed change in their process to prevent this from happening.

I would hope that a forensic audit would be revealing in all areas of contract mismanagement by the CBO, as well as the Contra Costa County Mental Health Department.

MHC Meeting - Open Comment Agenda Item XI.1 - C. STATON
October 2013

MH Director's Report – October 18th, 2013

MHCC

Behavioral Health Administration is attempting to ensure that essential services provided by MHCC can continue with the least possible disruption given the possibility of MHCC ceasing to provide services to the county after 12/31/13. MHCC has proposed a shutdown of services as of that date due to fiscal issues. The Request For Proposals (RFP) for the Wellness Centers currently run by MHCC is attached. We have identified a potential provider of required Patient's Rights activities as well, and have started conversations about moving this contract from MHCC to this vendor.

I am extremely disappointed by what has transpired since the last meeting, and I need answers. After six-plus months of allegations and investigation of MHCC, an RFP has been drafted by the County Mental Health Department regarding the management of what they are now terming "Recovery Centers".

This Mental Health Director's Report states the County has identified a potential provider of Patient's Rights Activities. Why is this contract not going through the RFP process? Who is this "potential provider" and what are their credentials and performance records?

And what about the other services provided by MHCC? The Service Provider [Individual Recovery Intensive] Training Program (SPIRIT)? WRAP Groups and Trainings? The Contra Costa Network of Mental Health Clients (CCNMHC), who supports advocacy and hosts the annual consumer holiday party and picnic? The QIC Program that performs mandated client surveys, and assists clients to attend conferences and trainings? The Tender Loving Care Project (TLC), which is part of the full-service partnership, as well as WRAP. What will happen to all of these programs and the funding that was being provided?

It is my understanding that the mental health director recently held a "private" meeting with approximately 15 people who were mental Health Consumers and OCE staff to determine what is needed at a "Recovery Center". Most of these consumers were from existing MHCC centers. This is definitely not a fair sampling of the county mental health clients.

The word Wellness was dropped from the previous title and the centers are now referred to as Recovery Centers; as a client I would not go to a recovery center to receive **prevention services**. Is this change to fulfill the need for assisted outpatient treatment options? If so, we need to look at other venues for wellness services.

Throughout the RFP, it is indicated that each client WILL have a WRAP plan. The RFP specifically asks how resources will be included and reinforced in each consumer's WRAP. As an advanced level WRAP trainer, I need to make it clear that WRAP is one of many **WELLNESS TOOLS**. As one of the Copeland Centers Ethics, having a personal WRAP is a *choice* and should NEVER be mandated!

SPECIFICALLY:

III (B).(e) Program Narrative

How appropriate health, mental health, co-occurring disorders, housing, social, educational and employment resources are engaged, included, and positively reinforced in each consumer's WRAP;

III (C).(2) Budget Justification

consumer reimbursements (if any) for activities that support independent living, social, education and employment activities in their individualized WRAP plan

The RFP submissions are to be reviewed and scored by a panel. Who is on this panel? What is their background, experience and vested interest in the outcome?

Of greatest concern is that the RFP applications are due November 12th and the Awardee Announcement is to take place TWO DAYS later on November 14th. How can a thorough review be conducted by this panel. Will they have an opportunity to visit the potential vendors' current operations? Will they have time to engage in a comprehensive discussion prior to making their decision?

It feels like the County Mental Health Department may have already decided on their vendor and is just going through the process.

I understand the need to stabilize the existing operations of MHCC. However, there must be some other alternatives, such as a short-term transition contract; as I believe that there must be an inclusive examination of what services these centers should provide, outcomes, and the best way to deliver these services. Otherwise we run the dangerous probability of repeating <u>all</u> mistakes.

I implore the commission to take action to suspend all movement on this RFP until a more thoughtful, substantiated and clear plan is in place to issue a contract for these services. Otherwise we will be" jumping from the frying pan into - - well, another frying pan". Please, let's not perpetuate our own ills within the current mental health system of care.

$1,312,500 / 18 mos. = $875,000 / 12 mos. ÷ 200 clients = $4,375 / client / yr.