Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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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.

QUALITY OF CARE Committee Meeting

April 20, 2017 ♦ 3:15 p.m.-5p.m. ♦ 1340 Arnold Drive, Room 112, Martinez

AGENDA

I. Call to order/Introductions

II. Public comments

III. Commissioner's comments

IV. Chair announcements

V. APPROVE minutes from March 16, 2017 meeting

VI. DISCUSS –Grievance advocacy for consumers- Bernadette Banks

VII. DISCUSS- Mission and goals for Children's, Transitional Age Youth and Young Adults- Jennifer Tuipulotu and Kathi McLaughlin

VIII. DISCUSS Behavioral Health Service's development of an action plan to support children and Transitional Age Youth (TAY) and young adults inpatient treatment facilities - Jennifer Tuipulotu and Kathi McLaughlin

IX. DISCUSS and CREATE action plan for 2017

X. Adjourn

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item may occur. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute time limit.
If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140

Mental Health Commission
Quality of Care Committee Minutes
March 16, 2017- First Draft

Agenda Item / Discussion	Action / Follow-up
I. Call to Order / Introductions The meeting was called to order by Committee Chair Barbara Serwin at 3:20 p.m. **Members Present**: Chair- Barbara Serwin, District II Connie Steers, District IV Gina Swirsding, District I **Members Absent**: None **Others Present**: Roberto Roman, Office for Consumer Empowerment, BHS Candace Collier, Office for Consumer Empowerment, BHS Duane Chapman, District I Lauren Rettagliata, District II Teresa Pasquini, Community/Family member Douglas Dunn, District III (arrived @4:06pm) Jill Ray, Supv. Andersen's office, District II Warren Hayes, Mental Health Program Chief (arrived @4:05pm) Adam Down, Behavioral Health Administration (left @4:30pm) Liza A. Molina-Huntley, Executive Assistant for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II. Public Comment • Gina- we had a Foster Care Youth Conference in Richmond and it went really well and Supervisor Candace Andersen was present, she was one of the speakers.	
III. Commissioner Comments None	
IV. Chair announcements/comments: • We are going to start with the Consumer Empowerment presenters and then we will continue with item VI- regarding the Methodology of the Children's Inpatient Facility Feasibility Analysis, with Warren Hayes.	
V. APPROVE Minutes from February 16, 2017 meeting • **Jill- I had a couple of changes, can we review those now? At the top of page 3- at the bullet point "noted by Jill, add and the BGO, Better Government Ordinance, that's what gives the 96 hours. Further down, in the same paragraph, starting with "Questions…remove and the Clerk of the Board."** • **MOTION VOTE: 3-0-0** • **Gina moved to motion and Barbara seconded the changes to be made to the minutes and approved to be finalized and posted on the website.** • **YAYS: 3 NAYS: 0 ABSTAIN: 0** **Present: Barbara, Connie, Gina** **Absent: none**	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**

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VI. DISCUSS, Behavioral Health Services Draft- Methodology of Children's Inpatient Facility Feasibility Analysis • **Warren-** Adam and Liza were kind enough to take an excerpt from a preliminary study, you have that with you. I will go through the report and give you the historical context of which this came to be and where we are at now and what is going on. Adam was part of the staff that created this- this started the summer of 2015. Up to that point there was a lot of advocacy for the chronic situation of kids who met certain criteria, needing to be sent outside the county because of the lack of bed space. It is a Medi-Cal cost and the advocacy came to the Behavioral Health Administrative offices and we agreed that it is important and the senior leadership took the problem over to the colleagues at the Finance department, stating that there is a real need that is well justified and also that we believe that financially it makes sense to have our own beds within the county. As you know, due to budgetary issues 4D was closed and only 4C exists now. We suggested to the Finance department to reopen 4D to create more beds for the kids and they requested that we do a feasibility study. The attachment provided is an excerpt regarding the costs. Matthew Luu (Deputy Director) asked a group of us to do this and asked if I would lead the group in putting the study together. We met several times to put information together that would tell us numerically if we should move forward. We do not have all the data, the Finance department does, but we do know that we contract out with 14 different facilities, we have a contract with each one of them and we have figures from the children's and the young adult system that showed how many folks are using the facilities and we also know that every child that was in PES for more than 23 hours could not be a MediCal reimbursable cost. Therefore, that is lost revenue, lost Federal Financial Participation (FFP). We tabulated what that cost is, based on the information on the number of kids that were in PES longer than 23 hours. There are two parts to the cost, one is the repurposing of the ward, which we are not sure how much it would cost but MHSA can pay via stakeholder process for a one time capital facility repurposing or construction. There are sufficient unspent funds, enough that we would not jeopardize future sustainability of existing commitments to programs. We did not budget that out, we just cited the funding source for that. As a program, we asked: "What would be the ongoing costs of the project?" We did two options: one is to provide the staffing foot print for a 10 bed facility and the other is for a 20 bed facility and what that would cost on an annual basis. We looked at the money that we are already spending, the monies that we are losing and the money that it would cost to staff the facility. There might be savings to the county to actually go this approach. What we did not know, if 4D was to be reopened, what are the operating costs that CCRMC would incur in support of this. That would take the Finance department and CCRMC's administration to figure that part out. The Finance department looked at what was actually spent on the contracts. We looked at an average cost per day, per bed, the average length of stay is 8.2 days, and the number of admissions is 392. The Finance department looked at past expenditures of what was actually spent. What was actually spent was significantly less, it was $2M +/- dollars, instead of $3.8 million. They did look at what it would cost CCRMC to support this, housekeeping, cafeteria, food, utilities and	• **Commissioners attend Children, Teen and Young Adult Committee meeting on April 13 from 11am to 1pm. Inform Liza/EA, to get on notification list for meeting. Meetings are held on the second Thursday of each month**

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discovered that it is not feasible to reopen 4D, in terms of costs savings. The county would be at too much risk. We made the argument that all counties are experiencing the same issue and we are in competition with other counties for bed space. It is not cost feasible to create beds in our county and we still have a problem with lack of bed space. Our monthly Children, Teen and Young Adult Committee, that meets every month, is actively working on this issue. Children's Services is also interested in combining forces to continue to work on this issue; they meet the second Thursday of each month, in the large conference room upstairs. Their next meeting is Thursday, April 13, from 11am to 1pm. We invite the commission and members to come to the meetings to continue to work on this issue. Adam did pull out the essence of the numbers to be able to propose to Finance if they would consider this. • **Duane-** Is there a document that we were supposed to get to show what we were paying out and who we were paying it to? • **Warren-** Yes and the summary of that is in Table 1, of the handout, under "Inpatient Bed Costs". That was our estimate and then the Finance department compared it to what was actually being paid out and we were paying, we are paying $2 +/- dollars, approximately $1 million less than what we had estimated. • **Lauren-** You did the cost effectiveness study and the preliminary estimates and from what you calculated – operating 10 beds is less efficient but it saves the county more money. According to this, it states that the estimated costs savings for 10 beds, is $1.7 million and if it operates 20 beds the estimated costs savings to county is only $500,000. • **Warren-**Yes, it is less efficient, there is a pro and con to that. • **Barbara-** Well you have your fixed costs regardless of how many beds, so is that operational costs? • **Warren-** Yes, that's operational costs. • **Adam-** Here's where the details become important; it does not include any revenue derived from contracting with other counties to utilize any unused beds. We didn't know that we could fill those; it is possible that it would add more revenue but we cannot make that assumption in the analysis. • **Lauren-** In the analysis that you made, if you operated 10 beds, did you figure that they would be filled at 100%, 90%, what percentage did you use to calculate the cost effectiveness? Because when we did the Laura's Law analysis and Doug did most of the numbers, we knew that it wouldn't always be filled at a 100% because you always have people coming in and people coming out. You have to realize that if you operate a 10 bed facility, calculated at 80%, because you will have a loss time. I would have thought that you would have had a greater savings to the county if you operated the 20 beds but the analysis shows the opposite and I am curious to why? • **Doug-** Are you stating the notes below explain to why it is counter intuitive? • **Adam-** To me it does. • **Lauren-** If we look at the long arc of it, whether we operate 10 beds or 20, when we get the facility ready (it housed 23 adults at one time), the renovation would be a one-time cost. We can open the 10 and then move to 20 beds later one, if it proved that there is a need we can move to	

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more. • **Warren-** We can, but to Adam's point, we were showing that in a 365 day year, that we were utilizing 10 beds continuously; 20 beds we would have to rely upon outside revenue to fill the extra 10 beds and we did not include that in the analysis. • **Lauren-** So the extra possible revenue is not counted in the $547,000? The startup costs, whether you start with 10 or 20 are the same. We didn't factor in that we could receive other county contracts which would make the costs saving greater? • **Warren-** Correct. If they were filled, but we cannot make that assumption. • **Barbara-** Typically you do an analysis at zero, 5 people, 10 and you choose your center number, something to show some flexibility. Even if you said, 50% of the time so many of these beds will be filled, and enter those numbers and compare it back to the original numbers. • **Warren-** If you are thinking like the Finance department, they are looking at the proposed numbers that 10 beds will be full at all times, but what we know, but when the numbers are crunched at what was actually spent, paid out to the contracts beds, it was actually less than 10. In addition to that, we have an "X" amount of CCRMC's operating costs that need to support the project. • **Duane-** We have 10, for an operating level, right? • **Warren-** That's according to the number of days and the number of admissions to the 14 contracted individuals. I do not suspect that number has gone down, that is our level of need. • **Duane-** How many are in locked facilities outside of our county that we are responsible for? Do you have a total number, as of today? • **Warren-** The number of admissions is 392, so to your question Duane, we don't have an exact number because we are not sure if it is unduplicated; I would say that it is a close approximation. How many times does the same child go to a locked facility in the same year? • **Teresa-** All the time • **Gina-** Absolutely, especially during their teenage years • **Warren-** Ok, so then the number would be significantly less than 392 • **Lauren-** Basically my question is what we are talking about. I don't think we need to factor into this report further is the number of total days, it keeps increasing. Children are going more to PES and being held there and that is a red flag. That means we are not meeting the needs of our severely emotionally disturbed children. Obviously they are not getting the treatment they need, when they need it. They are getting some at PES and it's hard for doctors and social workers to keep on saying, this child needs to be sent out of county or out of state. Usually kids and families are patched together, the child is given less treatment than they deserve to have and it circles back into PES. And worse, some of these children do die. That's a factor that really needs to be considered in the overall analysis; are we serving the needs of the community? • **Teresa-** Obviously there is a great need, you cannot tell, from this number how many of these children require inpatient care. This number is not an indication of inpatient care need. It is an indication of some continuum but you don't need that level of care. A lot of the long term people are waiting for transitional beds, not necessarily acute beds and	

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that is another factor that you are not seeing in this report. It is an important factor for the committee to consider. • **Duane-** How do we see all these factors, I would like to see them on paper and for all of the factors to be included, all these numbers are off the top of our heads. • **Doug-** There are some factors that I want to bring up too. • **Adam-** No they're not, look at the paper, they are not off the top of our heads. You are right, the other details are not factored in but what we are trying to present to you is to start the conversation about this. • **Doug-** My own personal due diligence on this issue is that you have to look at children, ages 0-5, 5-12 and adolescents 12-17. Children's care, I got this information from the California Hospital Association which did a report that talks about the tremendous drop in beds, especially for children. The costs for care of children, zero to 12, particularly 5 to 12 years of age, versus the costs of adolescents 12-17 is higher. The nurse ratio is almost 1:1, case managers have to have a smaller case load, to handle children cases, than for adolescents. In my discussion with Vern Wallace, regarding adolescents, that is where the day to day goes up and down because when school is in session the rates go down and when school is out, the occupation rate is higher. Those are some factors to consider and I don't know if we are able to get to that level of details in a preliminary study. • **Adam-** That is why there is this giant disclaimer on top. This is really just a way to look at this and why I wanted to share it with you is to look at it and discuss and consider what can be done. • **Doug-** Personally, I want to advocate for this. You have to have as much precise breakdown as possible so you can advocate intelligently. For example, is the 10 beds assumed to be adolescents only? That's another question, what age groups are you proposing? Is it supposed to be a combination of age groups? With 20 beds you can do a break-down for 10 beds to be for ages 5 to 12 and the other 10 beds for adolescents. • **Warren-** It is a good question Doug. When we were assembling the team to create this initial analysis, we had a good representation of those who work with the Children's and Youth's systems. We did ask that question and again, this is just an initial report, it is meant to handle the age groups that we are dealing with and they are obviously aware of the previous 4D operations. The information that we obtained was from the experts from our children's system of care and they stated that this is the foot print that would enable us to handle the zero to 5, 5 to 12 and 12 to 17 age groups. • **Adam-** Regarding the staffing, that is actually based on and required by title IX • **Doug-** Can you answer if the 20 beds would include costs for both children and adolescents? Was the 10 bed just assuming adolescents, is it still a mix? • **Warren-** Again, this was a strategy to obtain from CCRMC, for their experts to calculate the costs and risk factors whether we have a 10 or 20 bed facility. If we obtained interest, then we would dive into a deeper analysis, we have not gotten to that level yet. • **Doug-** FYI, Santa Clara County had this discussion and their philosophy for a number of years was that they did not need psychiatric, inpatient, or	

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transitional beds, up to three or four years ago for children from zero to adolescents because it was sufficient. They did later realize that they do need additional capacity and they are now starting a joint venture with Kaiser and El Camino hospital but for only adolescents; again, because the cost of care for children zero to 12 is too high. The profit margin is greater with adolescents because the costs are low. • **Warren-** Santa Clara, almost exclusively, contracts out all of their bed needs. In Contra Costa we have a mix. • **Doug-** I do have one more question. Warren, it sounds like the financial risks to the hospital is substantially less with 10 beds, than with 20 beds, is that correct? We would need those numbers from CCRMC and from the Finance department. Like I said, I would like to advocate intelligently. • **Warren-** I would have to see the numbers that CCRMC came up with, before I answer that. • **Barbara-** That is the core issue, in terms of taking this further and truly collaborating on some level. • **Adam-** I believe you can come with a good set of questions from what is missing from this document. • **Lauren-** I think this is a wonderful first step. I understood that Santa Clara County was actually considering a children's psychiatric unit, in their county hospital. I will do some research and find out if they are and whatever other information I can get. I thought that San Mateo County was doing the outreach with El Camino Hospital too. I know I have seen some information but I will do some more research. • **Teresa-** I know Orange County opened a children's psyche ward. Just curious, how did the commission determine that there is a greater need in the county for children and adolescents, rather than adults? Was this all identified in the Needs Assessment? How do you know that children's beds are the highest need in the county? I am curious because 4D was an adult unit, at one time and it didn't close for budgetary reasons, it closed for regulatory reasons. We were told that there were going to be community services provided and that we were not going to need this level of care, all the numbers had indicated that we didn't require these beds. We disagreed then and continue to do that. In terms of children's versus adults. • **Barbara-** I can respond to that, as a committee we met with Vern to learn more about the work in his group and what their needs are. Vern was very clear about the need for beds for children and adolescents. This was a stated need. For me, it is a concern and a passion. The higher issuer, as it is with those at the State level, taking it up a level and making a comparative analysis of needs of adults versus children, I have not done that. I can only speak to the need that I have heard and believe that is there but I am not putting that in the context of other options of things that to move forward on. • **Warren-** That's an excellent question • **Teresa-** As a family member and a community member, knowing the expense of beds in State hospitals, not knowing how many people are in our jails, it's just a question that I'm raising, so individual's passions are really important but as a commission, I would hope that we would be looking objectively across the needs of what the community needs.	

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• **Duane-** So has an assessment been done? • **Warren-** so I can tell you that this particular need runs counter to the macro numbers. The macro numbers say that we spend more dollars on kids than we do on adults. The other thing is that in the MHSA Needs Assessment, comparatively we spend more on locked facilities than we do on community voluntary services. That has been a consistent finding. This is a unique need that is actually outside of, if you are trying to do a macro needs assessment with numbers, it doesn't fit there. Because it shows that we are already spending more on kids and locked facilities, and then the question would be asked - why do you want to spend more on this project? That is necessarily the best approach if you are trying to tell a number story. • **Duane-** So what is the best approach? • **Doug-** Another issue that has been brought to my attention, by other advocates of this subject, is law suit issues. Some children are held over 77 days in PES, what about civil rights issues, in terms of quality of care. I am just putting that out there. • **Gina-** I joined this commission because of kids. The needs that are out there and what I hear and see, I am involved in some community things with kids that have severe mental health issues and the issue that is occurring is that some of these kids are being hospitalized, through the county and being sent far away. Their families can't afford to visit them and when they come back and they have to reenter back in. It's trauma enough to be sent away and not seeing their parent, when your 10 years old and sent to St. Helena, the parents can't get out there due to transportation or their jobs, that is very traumatizing to the child and as a result, the kid comes back and has a break down and is hospitalized again due to the whole process and the fear of the experience. To me, what I see as far as the needs of the community, amongst the poor low income population, they cannot afford to be driving far away. In some ways, the whole idea of sending these kids, outside of Contra Costa County, is not right and that is why I joined the commission. • **Teresa-** I totally agree with you. I am not trying to compete about trauma and pain here; I was just throwing that out there as an objective. The commission is supposed to be objective but obviously we each bring our own personal passions, I brought my own personal passion etcetera. I am not disagreeing. I started my comment as I am not advocating for children to be sent away. My comment, in regards to Doug's comment regarding lawsuits, I would just again encourage facts to be gathered from actual providers of services at the hospital. I know Vic Montoya attends this meeting a lot, I would strongly encourage that you gather some facts about what has been done in terms of when the circumstances around some of the long term stays in Psych Emergency. What the circumstances were, what was done, what patient's rights, how were they involved and maybe gathering information instead of making assumptions in a committee about law suits and risks. • **Lauren-** I am going to reiterate that I think this is a really good first step. I think that Teresa has brought up some really good questions. One of the questions that I thought that maybe we could answer as a next step, this would take input from CCRMC: when we look at the number of children that stay over 23 hours, how many of these children require inpatient hospitalization? That number should be easily obtained from	

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CCRMC. Of those, the children that went to PES, how many require inpatient hospitalization. We have so many needs, as a Mental Health Commission of where we need to place our energy and our time and our advocacies. I think that question is the key. • **Gina-** Some kids are sent home because there's no place to go and some should be hospitalized. • **Lauren-** I think we need to ask, the cold hard facts of the medical discharge, how many require inpatient hospitalization? We don't have evil doctors at Psych Emergency saying that if this child really does need inpatient care, I think we can get a realistic number of how many do require the inpatient care. • **Barbara-** Would that actually be documented? If there is a system in place or not, that are not going to say. We did meet with Vern, early on, when we started getting interested in a children's inpatient treatment facility. There are legislation changes and that is part of the spark and his information is very compelling. • **EA-**Liza: Yes. Vern did inform, at the January meeting, that new legislation will take place this year and that children in long term care facilities will be limited to 90 days, I believe as of July starting this year. • **Duane-** Right now, how many children are sitting in Psych ER? Does anybody know? You see, that's what I am talking about. Can somebody tell me what happened last week? A year ago is over. What happened last week or today, that's what I would like to know. • **Adam-** You want to know how many people under 18 were in Psych emergency last week? I can get that answer for you. That's a workable question. • **Duane-** Something that we can have going forward. If we don't look at and analyze it then it's our loss. But we need you to provide the information. • **Adam-** But that's also the Behavioral Health department's loss because somebody has to make that happen every week. If we are presenting endless reports that people aren't looking at that is not really effective use of our time either. • **Duane-** First get the information to the board and we'll go from there. • **Gina-** Statistically, I was involved in the school system and helping kids and a lot of kids have problems after the Christmas break. It really increases because they are out of school, the reality of going back to school, so you will find the stats a lot higher during certain times of the year. • **Barbara-** I guess I also look at it from a philosophical standpoint - if children aren't treated, who are they going to become as adults? And that's a social cost that we cannot analyze and drop into our report. If you believe that, then it is a must do. • **Teresa-** Totally, which is what the whole philosophy around the MHSA was, which was to prevent, early intervene and prevent and maybe the Needs Assessment shows? How are the prevention dollars working? Why are we having numbers increasing? Why aren't we preventing children from having mental illness? A lot of those funds have to be targeted, 50% of those funds have to be targeted to children's services. So, are they effectively being used in a way that is actually preventing the harm you're speaking of? That is another system wide; Warren	

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remembers that I use to beg for a value stream mapping. There has been various assorted attempts at that, I know, I have not personally seen one that I am satisfied with for our whole system to value stream map what we're doing and what our needs are. I think now more than ever, we need to do that with the changes going on in Washington D.C. and Sacramento. I applaud you and your morals and values are spot on. I use to argue back, you know it's children, children are the most vulnerable and I would have to push back and say really? I don't know? Have you been to Napa State hospital in a locked ward or a jail? That's why I caution about emotions versus facts. We had a level 14 home, the Chris Adams center that we lost at one time. Actually, this county fought to get reimbursed but I don't remember the terminology but again, there was a decision again to close that. What is the continuum of care? I am urging that there be more consideration of the overall continuum of care for all age groups and what the greatest needs are. • **Barbara-** I think the challenge there is how much data, this hard working team over here, Adam, Warren, etcetera, how hard it was to grab some information and it wasn't shown back in a transparent way by Finance. To develop the kind of analysis that you're talking about, that is a couple of people's theses. It's just so challenging. • **Teresa-** So have you invited Pat Godly to this meeting? Or have you invited Dr. Walker? • **Barbara-** You have to remember Teresa, we just started getting involved in this and we are doing our research now. When we learned of this report, we really wanted to hear what had gone into it. We don't have a plan yet, we are moving forward to put one together. • **Teresa-** I would like to know as a community member, I would speak to the board about this and look in terms of what are the needs – how many level 14 homes are we contracting with, how many kids are sitting here because I know that there were some that nobody would take too. That's another reason they sit there because nobody would take them and we don't have State hospital beds for children anymore. There are all sorts of system level issues that can't be necessarily fixed with an inpatient unit inside the county hospital. • **Duane-** We need to do to get a rundown of how John Doe A, who is a five year old, starts at the hospital and ends up until he's six. How can we find out what has happened to him through that time? • **Teresa-** You can ask the Children's Chief, or Children's services to extract a case study for you. That can value stream map and look at the system and see, they entered here, and then they went here, then sat here for this number of days, so you can take actual live examples. • **Gina-** In the county, when a kid goes into PES, they are assigned a social worker. Some of those kids are sent home and they are called to make sure that they're doing ok and not falling apart more. They work with the school system too, in helping them with those needs. • **Doug-** To redirect Duane's question Warren, in light of the counter intuitive nature of some of the numbers, what is the best way to advocate for this going forward? • **Warren-** Where I started, you join forces because the Children's Committee has been on this particular issue for a long time and know a lot more details. It's not CPAW, it is under the Children, Teen and	

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Young Adult Committee and it is supported, as far as staff, by Vern's Children's system of care. The meeting is up in the large conference room and it's full. You do have a lot of allies in that meeting, and you map out how you would like to go forth, that is my recommendation. It's a place to start. • **Duane-** What's the name of that meeting? • **Warren-** I'll say it again- it's the Children, Teen, and Young Adult Committee. If you would like to get on the notification list, just let Liza know. It's the second Thursday, of each month, from 11am to 1pm. The next meeting is on April 13 and Vern attends that meeting. This is something very near and dear to his passion as well and it's not something you have to be fighting on the second floor on, it's something that we have our lane, you folks have yours and the Children's committee has theirs. If you join forces, I think you will get some movement. • **Barbara-** Thank you for your advice Warren and thank you and Adam for the presentation. • **Adam-** One of the things about this is hoping that it can stir up a couple of questions on where you want to go with this, direct and help you ask the questions in a way that need to be answered and see what we are working with, see the data I can grab and help you to frame your questions or find the gaps. Then we can work with that, really this helps frame it for you. I want to encourage you to do that, lead you to the path, to gather more information that is needed.	
VII. DISCUSS overview of Behavioral Health Services Office of Consumer Empowerment- Candace Collier and Roberto Roman • **Roberto-** We are with the Office for Consumer Empowerment at Contra Costa Behavioral Health Services and we are grateful to be able to present a brief overview of our program. We prepared a handout. (Copies provided to everyone present). Candace and I will share about what we do at OCE and what it's about. It is a unit of Contra Costa Behavioral Health Services Administration. It encourages greater participation by consumers, in advocating, training and employment. We have moved our offices to 1330 Arnold Drive, in Martinez, and we are on the first floor. • **Candace-** The OCE staff is comprised of people with lived experience, meaning that they have had personal interaction with the Behavioral Health System of care**.** All of our staff has some sort of lived experience as consumers or with family members in the BHS of care. • **Roberto-** OCE was created in 1997, when then Mental health Director Donna Wigand hired Jay Mahler as the Coordinator. I was able to interview Jay Mahler a couple of years ago; this year is OCE's 20th anniversary. We recognize that we are part of something that has been around for a little while and grateful to be a part of it. We really believe in the work that we do. • **Candace-** OCE equips consumers and family members with peer and family provider skills through the Service Provider Individualized Recovery Intensive Training (SPIRIT). The SPIRIT program is one of the programs within our office. There are two instructors that teach the program and the program is held at Contra Costa College and it is a 9 unit college-credited course that is taught to family members, consumers	• **Gina would like the SPIRIT program to present at the Mental Health Commission meeting**

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and providers of services. There is also an instructor of records. • **Adam-** So you do get college credits for that course? • **Candace-** Yes. • **Adam-** So what would a graduate from SPIRIT do? • **Candace-** I will use myself as an example, I went through the SPIRIT program and I applied through the application process. The program started in January; it's a college semester, until the end of May. At the of the SPIRIT program, there are three parts to it, so parts one and two, take place during the Spring semester and then the third part takes place during the summer portion of the college courses. During the third part of the SPIRIT program we are given an option to do an internship opportunity with the County agency or a community-based organization. In my case, I took the SPIRIT program and did an internship with the Office for Consumer Empowerment, during the summer, from June to the end of July and after there is a graduation ceremony in August for the class that has passing grades. That is used as a prerequisite to get a county position as a Community Support Worker, Peer Provider or as a Family Partner. I am a consumer and I actually graduated from the SPIRIT program in 2016 and was hired. • **Adam-** And then you're equipped to engage in part of the treatment team, that type of thing? How does that work? Does it depend on where you're at? • **Roberto-** If you're a Community Support Worker, based out of a clinic, you are more than likely part of a treatment team and work with the clinicians and Psychiatrist on staff. Our positions at the Office for Consumer Empowerment are unique because we are kind of in a centralized location and we do a set of work that is specific to what our office is charged with to do, administration and that is why we are considered a unit of the Behavioral Health Administration. • **Gina-** Connie and I graduated from the SPIRIT program. • **Duane-** How much are you and NAMI doing, are you overlapping? • **Roberto-** We collaborate with NAMI on certain projects. I was previously involved, with NAMI, as a facilitator of a Peer Support Group. That has been put on hold at this time because we did not have enough facilitators to rotate. We also collaborate with NAMI on the writer's group that takes place at the Rainbow Community Center, on the first Tuesday of the month. After this meeting, we are headed to the NAMI general meeting today because Candace has arranged for a REACH speaker's bureau presentation for tonight's NAMI general meeting. • **Duane-** Do you get out to East or West County, or how does someone contact you for help? • **Roberto-** Most of the activities that we are involved in at this point are based in Central County but sometimes we do outreach in East and West Counties. It depends on the particular occasion and the opportunity that might arise. We try to collaborate with as many people as possible. • **Lauren-** Someone asked about your connection with NAMI. Do you collaborate with them in Our Own Voice? I know you did for awhile. • **Roberto-** No. I, in my personal capacity, have been involved with Within Our Own Voice in previous years. After I obtained my permanent position at OCE a few years ago, it discontinued by virtue of	

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the act because I didn't have the time. The REACH speaker's bureau, which is the program that OCE is responsible for coordinating, is separate from Within Our Own Voice. It's not meant to replace or compete, it just simply a County operated program. • **Lauren-** Who now heads the Office of Consumer Empowerment? • **Roberto-** Susan Medlin announced her retirement last month and Jennifer Tuipulotu is our interim supervisor at this time. • **Teresa-** So there is a lot of overlap. It's well known that SPIRIT two years ago started including family members in their curriculum. • **Gina-** There is a Family Support Worker in East and West County and it's good that there is someone to help families with resources and get the help that they need in the county. Family members get stuck and don't know what to do. They work for Robert Thigpen. • **Connie** - Do you do any outreach to licensed board and care homes to the consumers that are there about their rights in residential facilities or possible program improvements? • **Roberto-** No, we haven't pursued anything like that recently. What I can say is that our role is not to be advocates on behalf of consumers but more to help and empower consumers to advocate for themselves. Where there is an opportunity for us to do that in that kind of a setting, I am sure we can look into that and try to pursue that further • **Barbara-** Adam, can you speak to this further? I was asking you about the lay of the land in general. • **Adam-** There are different things, this discussion started with OCE and why don't we let them finish with their presentation then I will address your questions. • **Roberto-** OCE collaborates with consumers, family members and providers around stigma and discrimination reduction at monthly Committee for Social Inclusion meetings. CSI is a Behavioral Health Services stakeholder committee that meets on a monthly basis, at 2425 Bisso in Concord. It consists of a combination of consumers, family members and providers. We meet every month to try to develop ways to overcome the mental health stigma and discrimination in the community. We meet on the second Thursday, of each month, from 1:30 to 3:30pm in the first floor conference room. I identify myself as lead support staff and we as a team are responsible for assisting that committee. The committee for Social Inclusion has two subcommittees: 1- Photo Voice Empowerment Project, features photography and narrative from persons living with mental illness. Highlighting how stigma affects their lives. It is a curriculum that was developed by Boston University Center for Psychiatric Rehabilitation and we use their model to facilitate Photo Voice classes in the community, at various venues, we have been doing this for several years, consumers are allowed to use photography and narrative and the opportunity to use those tools to express their own view point when it comes to stigma and discrimination and overcoming it. • **Lauren-** Does this overlap with Within Your Own Voice? Do they follow the same Boston University model? • **Roberto-** I believe not, because NAMI regards it as one of their programs. • **Barbara-** I have seen the photography from the welcome packet as an example of publishing their materials. Are there others? Are there more	

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photography and narratives available to the public? • **Roberto-** They are on display at various community-based organizations in the county and I can get you the specific locations, if you'd like? • **Barbara-** No that's ok, I just wanted to know in general. • **Adam-** There is some on display upstairs in our conference room, there are some in forensics. • **Candace-** There are some in East County Adult Mental Health, on Loveridge, in Pittsburg, there are some on display in the waiting room. • **Roberto-** We are working on a partnership with the public library system, its still in the works and we're hopeful. We try to expand the displays as much as possible. • **Candace-** OCE extends opportunities to consumers, family members and providers to share their experiences with the Behavioral Health System through its speaker's bureau: WREACH = Wellness and Recovery Education for Acceptance, Choice, and Hope. I am the coordinator of the WREACH speaker's bureau and what that consists of is family members, consumers and providers that have some lived experience, in the Behavioral Health System of Care, have an opportunity to share their experiences to empower their peers within the community. The objective is to help reduce stigma and discrimination in the community around mental health. We have a meeting that is held, every fourth Thursday of the month from 1pm to 2:30pm, at 2425 Bisso lane, in Concord. I conduct "Tell Your Story" workshops with the participants that are interested in the WREACH speaker's bureau, I help my peers and family members share their story in a structured format, with the public, without triggering language and learning how to share their story. • **Lauren-** How many people usually attend these meetings and who is usually in attendance at that meeting? • **Candace-** attendance varies, from 7 to 17 people and who has transportation to the meeting and it is open to the public. • **Lauren-** I am wondering if people from RI International, do people from Putnam Clubhouse, people from Crestwood, Pleasant Hill Manor- do they attend on a regular basis? Or do you draw from other sources within the community? • **Candace-** We do get folks from different programs that do come, I don't want to specifically identify who does comes to the meeting and which programs but we do get people from the programs you mentioned. I try to reach out to different age populations. In West County I have gone to Cali House, Bissell Cottages and others are in the works. I am planning to go to the Brookside Shelter. I am trying to reach out more to West and East County because I know that they are underserved communities. I am reaching out to the colleges as well and will be conducting a workshop at Diablo Valley College to encourage more mental health awareness. • **Roberto-** Another program that our office is engaged is in a new Mental Health Services Act Innovation Project called "Overcoming Transportation Barriers" which is dedicated to fostering transportation independence among our consumers. It is a five year MHSA Innovative project and the goals are to improve access to mental health services, system navigation, and independent living and self-management skills.	

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The target population is consumers of all ages and families served by County operated mental health clinics. The pilot will start in East County and will be facilitated by two to three commute Navigation Specialists, who have lived experience and have travelled using public transportation. An important aspect is to hire a bilingual peer, with lived experience, to reach out to the threshold language which is Spanish. OCE has hired two individuals for this project: One is a peer, CSW and one is a Family Partner. The Family Partner is bilingual in Spanish. The workgroup that is responsible for overseeing this project meets on a weekly basis; we are not part of this project, so I will not be able to elaborate with more details regarding this. • **Adam-** This is addressing a problem that has come up repeatedly in some of the analysis regarding a "no show" rate; it is particularly bad regarding Psychiatry appointments, in East County. Not only do we not have enough Psychiatrists, often times, the consumer does not end up seeing people when they're supposed to be seen. This project is a direct intervention to help solve the problem. Not only in East County, where the problem is more pronounced, but in other areas too. • **Gina-** East County is extremely difficult in getting around. • **Lauren-** You mentioned that you hired one peer and one Family Partner but who is the person in charge of this project? How many people are employed by OCE? • **Roberto-** That would be Jennifer Tuipulotu, as our interim supervisor. Lucy Espinoza Nelson is the bilingual Family Partner who is taking on the role at OCE and we recently hired Kristen Visbal. I believe we have a total of nine staff members. • **Duane-** So what does this do for the client? If I have a family member who has mental health issues andwho has problems getting to the clinic, do you help families to get the client to their appointment? • **Roberto-** The intention, from my understanding, again - we are not part of this project, it's not to give everyone rides to everyone that needs one because there's not enough resources to make that happen. The intent is to try to foster independence by working with consumers and family members around what transportation resources are available and direct them to the resources. Go over the bus schedules with a consumer, maybe even ride on the bus with a consumer to their appointment and go through the process to help that consumer feel more comfortable being able to use public transit on their own. This is just an example, I do not know for sure since I am not part of this project. • **Duane-** You have a person on general assistance, they do not get money for transportation, how is that person going to make their clinic appointments with no money for transportation? • **Roberto-** They should have access to a Regional Transit discount card that is available to disabled persons. • **Adam-** Then OCE would be able to help the client make the link to the resources. • **Duane-** What I'm looking for - do you provide money and/or assistance to people to get to and from their appointments? Yes or no. • **Roberto-** No. • **Gina-** I have a question with the same issue. I have helped many consumers through the process of getting assistance for transportation	

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and it's not an easy thing to do. Do you help consumers with the process? • **Roberto-** In terms of finding the resources, yes. • **Gina-** Another thing is some people get discriminated against, if you're mentally ill or have certain diagnosis; DMV can take your driver's license away. Do you help with that issue? This is through the ADA –the American Disability Act - they found that this is an ongoing problem. • **Roberto-** I am not aware of any specific assistance regarding that area, we could look into it. • **Duane-** (to Roberto) Read off the sheet and read to me what that says? • **Roberto-** "overcoming transportation barriers"… • **Duane-** I am missing something. I am seeing people having problems getting on the busses. One of the problems, for a lot of our people is money to ride the bus, even with a discount, therefore that is something you don't do? • **Roberto-** That's correct, we do not do that. • **Candace-** Let us restate that we are not part of that project and that is why we are reading off of a script, so if we are not able to answer all of your questions that doesn't mean that we do or don't provide those services or that we can't help consumers to get to the resources to those services. We do not specialize in this nor have we been a part the day-to-day of this project. We work in the office where we have colleagues that are working on this project. It's still in the works, it's still being developed. This is part of the Three Year Plan. • **Teresa-** So if this is part of the plan, because it was being discussed when I was part of the commission, it should be described in the plan. So this is part of what was discussed at CPAW. • **Duane-** I have asked for that to be in our Director's report, twice I have asked for it. • **Lauren-** Has it cleared the MHSOAC, did you go before them and get approved? I know that they wouldn't know but that's the question that we would need to know. • **Adam-** Candace and Roberto would not know that • **Gina-** I have seen this transportation project on the budget. • **Adam-** It is and we are hiring people for it. • **Teresa-** Then it's probably been approved then. • **Connie-** I'm wondering what would be the best ways to work with the Innovations Committee. If someone had a real program that they would like to help with and it would be voluntary and they have the resources, who would they contact? • **Adam-** I would probably start that conversation with Jennifer Tuipulotu or Warren; actually both. • **Candace-** Any further questions? We have to leave to our next meeting. • **Roberto-** The last point on our summary is: OCE remains focused on helping consumers use their voices on behalf of themselves and their peers. I was a client and able to move to a different place because people were willing to give me a chance and opportunity to go forward in a way that helped make my life different than it was before. A lot of things and people were instrumental to that and I have been working at OCE for more than six years and believe that the work that we do is important and makes a difference for the consumers in our system and I	

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am grateful that I have the opportunity to be engaged in this work and be able to help my peers. This is the kind of work that helped me when I needed the help and I try the best I can to be that kind of help to others and I hope that I am. I hope the work that we do continues and that we will continue to see benefits in the lives of the consumers in our community. • **Barbara-** Thank you so much, it's very encouraging. • **Duane-** Please tell your boss (to Roberto) to please get in touch with me. • **Lauren-** So it is an approved project for the fiscal year, 2017 to 2018 and the number to be served yearly is noted as 200 and the budget that has been approved by MHSA is $241,450. • **Gina-** For myself, going through the SPIRIT program, I learned a lot of things about myself and did get a lot of healing from it. I would like to, at some point, bring the benefits of the SPIRIT program to the full commission that we would have some kind of presentation. Because it is one way for a consumer to step in on helping with peer to peer counseling, this is very important. It helpful to those who help others. It's very encouraging and would like some sort of presentation about the SPIRIT program. • **Barbara-** Yes, I think that this is starting that process. • **Adam-** Along those lines, this conversation started about advocacy and patient rights and how that works. That's a component of it. These folks are further along than others, that would be a apart of the patients right program, or at least that's in my mind. I will try to work to get a presentation on how that works and what that entails for the next meeting. It's advocacy and at this point this is further along and this is teaching people how to advocate for themselves, including being part of the voice of the consumers in regards to policies and programs that we are doing in admin. Writing the "Welcome" packet, I write something and I realize I have blind spots in my language and the way I speak and they don't, they are much more in tune to things, it makes it more rich and appropriate and makes it better. It is a valuable resource in our system. • **Barbara-** One clarification, Adam- if you have some more time when Warren is finished with us, perhaps we can discuss a few things?	
VIII. DISCUSS 2017 Committee goals- incorporating consumer empowerment- • **Chair- Barbara- We will move this item to next month's meeting.**	***Agendize item for meeting on April 20, 2017**
IX. DISCUSS and create an action plan for 2017	• **CHAIR will email EA the goals for 2017**
X. Adjourned at 4:51pm	

Respectfully submitted,
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration