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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.

Executive Committee Meeting

Tuesday, April 25, 2017 ♦ 3:15pm to 5pm
1340 Arnold Drive, Martinez- 112 conference room, first floor.

AGENDA

I. Call to Order / Introductions

II. Public Comments

III. Commissioner Comments

IV. Chair comments

V. APPROVE minutes from March 21, 2017 meeting

VI. DISCUSS goals and protocol for residential and treatment facilities and potential for Mental Health Commissioner's participation- TBD

VII. DISCUSS, according to article IV, section 4, of the Bylaws of the Mental Health Commission regarding the recruitment of applicants

VIII. COMMITTEE DISCUSSION- regarding the Contra Costa County Data Notebook 2016 and consider next steps of action to be addressed

IX. DISCUSS the May 3- MHC hosting the MHSA public hearing draft agenda and May Mental Health Awareness month

X. DISCUSS proposal for renovations at 1420 Willow Pass- Adam Down, MPA

XI. DISCUSS and RECEIVE report regarding CALBHBC conference –Duane Chapman

XII. Adjourn

MENTAL HEALTH EXECUTIVE COMMITTEE
MONTHLY MEETING MINUTES
March 21, 2017 – First Draft

	Agenda Item / Discussion	Action / Follow-Up
I.	**Call to Order / Introductions** Commission Chair Duane Chapman called the meeting to order at 3:16pm. **Members Present:** Chair- Duane Chapman, District I Vice Chair- Barbara Serwin, District II (arrived @3:21pm) Diana MaKieve, District II Sam Yoshioka, District IV Gina Swirsding, District I **Commissioners Absent**: None **Other Attendees**: Jill Ray, Field Rep. District II Supv. Andersen's office Lauren Rettagliata, District II (arrived @3:25pm) Adam Down, Behavioral Health Administration (arrived @3:20pm) Liza A. Molina-Huntley, Executive Assistant for MHC	**Transfer recording to computer**
II.	**Public Comments:** • None	
III.	**Commissioners Comments:** • **Gina-** Would like a representative, from **SPIRIT**, (Service Provider Individualized Recovery Intensive Training), to present at the full commission meeting. Stated that she feels very strong about the benefits and helpfulness of the program and how it helps consumers become more independent heal and establishes confidence**.** The **SPIRIT** program assist others interested in mental illness wellness become certified Peer Counselors and obtain employment in helping others with similar issues. They also presented all the services, related to mental health, throughout the county. It's a really good program, peer on peer mentoring. • **Duane-** I suggest that you gather some material, from SPIRIT, for the Executive Committee to read and then we will take it from there. Get the information, give it to Liza, she'll send it to me and Barbara. Then we'll see when to have it presented at the full commission meeting. • **Diana-** Finds the minutes too detailed and feels that inserting the names of the speakers is unnecessary. Would prefer the minutes to only capture the essence of the meeting and conversation rather than the "he said/she said." • **Barbara-** Stated that the Executive Assistant creates the minutes, including the names of the speakers, as per her request.	Gina will gather information, from the SPIRIT program and forward it to Liza/EA
IV.	**Chair comments:** • **CHAIR**- Is out of town on April 4, 5 and 6 to the California Local Board Association for Mental Health. That board is going in a new direction; we	

	are going to start doing training around the state. We have come to the conclusion that everybody doesn't know everything, but we need to know most of the things. I sent each and every one of you the Facebook page and the website. That is something that we, as Commissioners, need to stay in tune with. • **Sam**- isn't that the same day of that the Mental Health Commission meets? • **Duane-** I might leave the Commission meeting early, or right after, I'll look into it. Let the record reflect that Barbara and Adam are present.	
V.	**Announcements:** • **Duane-** you all have received your Commissioner badges, with chocolates and a hand written note from the Executive Assistant, on behalf of the Behavioral Health Administration	
VI.	**MOTION: Approval of the February 21, 2017 minutes.** **Jill made the following corrections:** • **On page 2- should read as follows: "noted that just tracking actions is referred to as a "record of action"** • **On page 4- strike sentence: "Then if more details or additional…."** • **On page 5- change "supported to supportive…" and the change the word "bill to grant"** • **Diana-** I do have a comment, to me it's too detailed, about the minutes and I would love to see us pair it down to sort of just outcomes, rather than the "he said, she said." That's my personal opinion, it's too much. That is one of the reasons, because we have so much detail, we have to make sure it's correct because we are putting too much info**.** • **Barbara-** well I have asked Liza to actually put the names in. • **Diana-** I don't mind the names, I just don't think that we need the narrative of the entire discussion; we need more the lasting outcome of the discussion, to me, that is what I would prefer. • **Duane-** that means we need to stay focused and keep it simple and one conversation going, not all over the place, it would help us and the Executive Assistant. I agree it's too much to read. • **Barbara-** I love it! I want the details. **Gina moved to motion to accept the minutes, as amended, and seconded by Diana** **VOTE: 5-0-0** **AYES: Duane, Barbara, Diana, Sam and Gina; NAYS: none; ABSTAIN: none** **Absent: none**	Diane and Duane would prefer less details, Barbara likes the details. They will decide and inform the EA, regarding future minutes.
VII.	**DISCUSS fire incident, involving an elderly man, on February 28, in El Cerrito** • **Duane-** I did this because it happened at the Idaho Apartments, which in the past has served mental health clients. So my question is for staff, is there an incident report? • **Liza/EA-** no, the incident report has not been completed by the Fire Department, the fire is still under investigation. • **Adam-** the Behavioral Health Division would not necessarily get an incident report on that. • **Duane-** you do because it's part of the contract • **Gina-** yes, I think you do because I think it's part of the OSHA agreement, any resident of the state there has to be an incident report. • **Jill-** through the state, this is the county. So are you saying that the contract, with the provider, requires that they provide an incident report to the county? If it's a client of the county or at all?	**Jill- will inform Duane regarding information that is available to the public.** **Adam- will follow up with H3 regarding Fire Marshall report of fire on 2/28/16**

- **Duane-** it should be at all, they have Contra Costa County clients there.
- **Jill-** Are all, county clients, or the County places people there?
- **Duane-** the county places people there and I know that there are a lot of mental health clients living there
- **Liza/EA-** the provider's name is Life Long, for the Idaho Apartments.
- **Duane-** has anything come in from Life Long?
- **Liza/EA-** No, not that we know of.
- **Adam-** I am confused by this; I don't know what our relationship is with Life Long in this instance. There are people living there with mental illness, that's one thing, if we are working with these residents, that's another thing. I don't know that we would necessarily get an incident report on that? What I understand, that we are waiting on, is the Fire Marshall to finalize their report, stating the cause of the fire. The report will go to Lavonna, first, and we are keeping in touch with her.
- **Duane-** I will say it again and I have said the same in the past- it serves people with mental health, whether they are our county's or not, they are in one of our facilities that the county places people in or funds and no one has told me any different. It would be, if somebody would take the initiative to say, before I send an email out, blasting everybody- there is something going on here and we are going to look into it, it would be nice.
- **Jill-** I will find out, whether or not, it's a county client because that's the key. Whether or not it was a county, Behavioral Health, client.
- **Adam-** and if we did get an unusual incident notification regarding that person, you will not be able to see it, nor would be able to share it with the commission because it's a HIPPA violation.
- **Duane-** let's back up for a little, we can see it; you just have to remove the person's name.
- **Adam-** that's ridiculous, because there is totally identifying information.
- **Duane-** I will fight that! You remove the name.
- **Jill-** let's cross that bridge when we come to it; let me find out whether or not they are a Behavioral Health client to start with, because that could end the conversation.
- **Lauren-** I just wanted to ask a question about the apartment building because many people who are clients of the mental health clinics do live there, probably not being paid by county funds but they are using their own SSI or SSDI to live there or through section 8, we don't know- but, this apartment complex is known in the community as a haven for many people who are being seen at the San Pablo clinic. Where are these people now?
- **Duane-** they're still there, it was only one apartment.
- **Lauren-** good, so it didn't burn down the complex?
- **Duane-** no- thank…
- **Gina-** I do want to say, regarding incident reports; they use these reports for legal reasons too. That's why they cannot be released to the public. They can be utilized for a lawsuit; it is a legal issue too.
- **Duane-** my concern, and I will voice it again, it's just like the Riverhouse our people that our being placed there should and have a right to be safe. The county has an obligation; we have an obligation to advocate to the county to make sure that those people are treated and that they're safe! Is the program doing some in-service for the client? If you looked at the room, the man in the fire was a hoarder. They just give the man a key shut the door and that's it? There needs to be more done, than the people sitting in the office, not doing anything. Teach people how to live, show them how to

	live safely, make sure the fire alarms are working, this could have been a more serious situation, he could have lost his life, or others. I started this and sent out emails to everyone! • **Jill**- You did not include me on this. I know you're frustrated, you can reach out to me, and I will find the information that I can get and let you know as much as I can tell you. • **Gina**- Hoarding is common among consumers and I have tried to get people who are hoarders to get help, it's common. • **Sam**- I do agree with Duane, regardless whether the person is county sponsored or not, or receiving funding from the county, I think we do have an obligation to find the circumstances of what happened so that that doesn't get repeated again. • **Adam**- that information will come from the Fire Marshall, after they have finalized their report • **Liza/EA**- their report, is a public document • **Jill**- understand the jurisdictions here: you have a building in El Cerrito, so they are responsible for building inspections and code violations, that is not a County issue, unless they contract with the county to do those codes enforcement checks, that is not a county jurisdiction. The state has requirements, if this is a State licensed building, then they are responsible for some of it. Let's figure this out and sort it out. • **Adam**- I'm not clear on the Behavioral Health department's relationship or H3's relationship with Life Long? I know we have agreements with them but I'm not sure, there are a lot of pieces to this, and I don't think anyone is trying to say that it's not important or doesn't want to help. • **Duane**- I just want to make one thing really clear! This board is mandated, by law, to review and evaluate the community mental health needs, services, facilities and special problems; and that fits! I'm not arguing with you! • **Jill**- ok, let's do a deeper dive into it and I will find out what I can find out and we will go from there and determine who's responsibility it is to ensure that facility is safe. Ok? • **Gina**- I have done forgetful things too and we aren't sure what happened? • **Duane**- ok, thank you Jill for checking that out for us.	
VIII.	**DISCUSS the integration of Behavioral Health advisory boards = Mental Health Commission (MHC), Alcohol and Other Drugs (AOD), and Health, Housing, and Homeless Services (HHH) advisory boards- Sam Yoshioka** • **Sam-** we need to include and add the homeless advisory board as well • **Duane- (to EA-Liza)** make sure that it is documented to include HHH please. • **Sam- I** feel that we are not moving in the direction that Behavioral Health Services departments are moving, when we are still within the silo of mental health. The whole circumstance, condition, we are providing treatment services in an integrated form of mental health, alcohol and drugs, and homeless, it's right before us but somehow we are not in terms of our perspective as a an advisory board. We are a silo Mental Health advisory board and I believe that by the integration the perspectives of the alcohol and drug and homelessness, will be of great value, than what we are doing now. We will bring a perspective, a value in our recommendations and in the way we do things. I happen to be the liaison to the Alcohol and Other Drugs board and I really feel that that group seems to be a lot more active in the community and bringing about changes in the community that will help the recovery of the people with these	***Liza/EA- add HOMELESSNESS to the minutes regarding this discussion** ***Commissioners: Sam and Gina, will form an Ad Hoc committee whose sole purpose will be to write a report detailing the advantages and drawbacks of integrating the Boards of MHC/SUD/HOMELESS; stating the process of other counties that**

issues and problems. To me, we can learn a lot by having representation from that group and from the homeless group. The problems from homelessness keep on popping up here, in our advisory group. They know a lot more and can share a lot more that it would make our perspective a lot richer by going beyond the silo that we are currently. That's why I want to have a discussion about this with the Director of Behavioral Health and the Directors of the Alcohol and Other Drugs and of Health, Home and Homelessness and with the advisory boards, so we can have a sharing of a give and take and come up with perspectives that are a lot more valuable than just a mental health perspective, that's where I'm coming from.

- **Gina-** I agree with Sam, especially now, where a lot of people have a dual diagnosis and a lot of the problems with people who are consumers and also using it makes the situation and their problem worse when they have both of those issues. A lot of consumers use; it's a huge problem and a lot of them our homeless. A lot of the homeless are consumers too, they have mental health issues. It is an integrated issue.
- **Diana-** What would we do differently? I'm not quite sure what you are asking us to do?
- **Gina-** That's one thing I don't understand- somethings I don't agree with AOD, like the issues on Marijuana. People who are concerned about their health it is not good because it raises the serotonin in the brain and there's also drops and the suicide rate is very high, regarding consumers that use marijuana versus the ones that don't, especially with long use. I don't understand why the AOD was for passing that law.
- **Sam-** They were against it
- **Gina-** I thought they voted for it?
- **Lauren-** questions that I have on this are that the Mental Health advisory board or commission, the Supervisor's choose the word "commission" for us, our existence is founded within the welfare and institution codes and it is laid out specifically, who will be on this advisory board or commission. It delineates exactly who, that there will be a Supervisor representative a representative that have or have had a family member with mental illness, and a slot left over for members at large. I haven't read the exact law but it doesn't say, five will be this or five will be that. There is a percentage where people with lived experience have to have so much and it is written into the code, exactly what our duties are and we have them before us each time. Now to say that we don't have an understanding of alcohol and other drugs, many people do. At least, all the family members of all the people I have ever known and who have sat on the commission with me have experienced alcoholism and homelessness. I have known commissioners who have had a lived experience who have been homeless and other commissioners who have had experience of alcoholism, so I think that when you have a mental health advisory board or commission, you are by its very nature, going to have people on this commission, who have lived experience in the others. With our committees, now I've been a member of the mental health services finance committee for like 5 years now, and I was designated and have kept up that designation up, I am hoping to pass off the torch soon, my specialty is to always be alert and go to the Housing and Homelessness meetings. I go to two: the Homeless Committee, that has been formed off of CPAW, and I go, when there is not a conflict with the Coco on Homelessness.
- **Jill- the Council on Homelessness, the quarterly meeting or the monthly**

are comparable in size to CCC.

meeting?

- **Lauren-** sometimes I go to the quarterly meeting
- **Jill- it's the Coordinated Care**
- **Lauren-** My fear is, if we do this, we will dilute the work that we have to do for those who have a mental illness. We have to stay focused on that, with the understanding that someone with a mental illness, they will be experiences in these other areas. I think the way we have it set up now is Sam, going to Alcohol and Other Drugs meetings, Mike going to Homelessness, we have a representative many times from AOD that come to our meetings. I think that the board would get too large, too wildly and we would lose our focus.
- **Duane- I'm in agreement with Laura. I am sitting here looking at the W&I code, it's real clear. We can join forces by making sure that liaisons come and go. We send people their committee meetings and you report back to us and we need to make sure that they send somebody from their departments, to take part in our meetings and be able to report back, to what's going.**
- **Diana-** before we move off of this topic- there is no question that mental illness is not just in the justice department, jails, homelessness- I don't remember what the numbers are but, 30 to 40% of the homeless have a mental illness and they probably have an addiction issue that can be overlaid. Those are real true parts of mental illness. I don't know how many stories and articles I've read about the fact that our institutions are the homeless encampments and the jails. It is a major factor to the population that we are here to support and help. But, I'm not sure what we would need to do differently, because I don't know if I would want to combine drug and alcohol with the commission. I don't see what value or benefit we'd get. It clearly is part of the story.
- **Gina- I would say on the issues on services because I know with the youth, the TAY population, I think Thunder Road is the only one that's open for services and there's a very big need. A lot of our youth have mental illness, a lot of them are dual diagnosed, and there aren't enough services in the county, I actually think we lost some. The problem, I know there are a lot of services for adults but for the kids, no.**
- **Duane-** There's a pamphlet right on the table, with all the services in Western Contra Costa County that is the first place we need to start.
- **Jill- I think everyone around this table already knows this; the challenge to dual diagnosis facilities are traditionally MediCal wouldn't pay for both. Now, that's changing with the Drug MediCal Waiver. I think that moving forward that is being solved, at least in the short term, until we figure what is happening with the Affordable Care Act. I think that what you're discussing is past issues that are being addressed presently and into the future. If that's the reason you think combining the boards is a good idea, it's happening.**
- **Lauren-** I think a lot of times we perceive that Children's is being short changed, as far as receiving mental health dollars and services but remember the Assessment report that was done, it showed us that actually what we perceive is not true. As much money, if not more, is going towards children as is going towards the adult population, of those between 26 and 59 years old. In fact, in the assessment it actually showed that population, the adults 26 to 59, as far as services within our community, were receiving percentage wise, less of the money from MHSA.

I don't know about realignment funds. Our contract providers, show that more money is spent in children's than in adults. Everyone's heart strings go out to the children but we've got to look at the data and look follow the funding. We only have so much in the pot of money; we don't have parody in mental health and we are extremely short. I am hoping and working night and day so that, at least here in California, at the legislative level that we pass parody for specialty mental health. That will help us have a larger flow of money. If MediCal is block granted to the state and we have a law in place that says specialty mental health is on parody with physical illness, that will help our people who are experiencing mental illness to get better treatment.

- **Barbara-** I agree with Lauren there are differently first steps and the advisory boards and commission there's a limit in terms of what kind of work you can get done with a certain number of bodies. I don't feel like, putting them all together, as they are works. At the same time, I feel like each of these groups has some deep work to do and are overtaxing in and of each other. We need to do that work at that level and I'm looking at how the liaison option works, how well is it working, how can it work better or creating a inter advisory board committee, that comes together regularly to focus on the issues that overlap, can be another way to achieve the objectives that your identifying. I just wondering if there are different structural ways to accomplish the same.
- **Sam- I think there's a misconception going on here. There's already integrated Behavioral Health Boards in California and they didn't combine it. That misconception about combining doesn't fit the law. These boards existing now, in California, are basically under the mandate of the Mental Health Commission. OK? We are not talking about combining the two groups or three groups. We are still within the law that mandates the Mental Health Board, what they did was add to, which the law allows. We are not changing the proportions at all. We can add people from Alcohol and Other Drugs; we can add people from Health, Home and Homelessness and still maintain what is mandated in the law. We already have these boards in existence, we are not breaking any law, and we are within the law, but yet bringing the integration in the Mental Health Board Commission by changing it, by saying that we are now a Mental Health/Substance Abuse/Homelessness Advisory Board. There are different names on how to state it and there are several counties that already have made the change. The other thing that I want to emphasize is that I would never compare myself with some of the members on the AOD board or the HHH board, they have the commitment, dedication that I don't have. They are out in the community, trying to change and help people, which I don't do. I can't say that I will represent them, never.**
- **Duane-** Why don't we set up a committee, Sam and Gina, to see what the strength is in integrating and what the weaknesses are? I want a full report.
- **Barbara- Maybe looking at the experiences of the counties that have integrated, if it's working well for them, or not, how did they do it.**
- **Gina-** I wanted to say in the DSM 5, yes there is dual diagnosis, drug and alcohol, it's integrated in the system. With the kids there is a lack of helping people with issues, they have to wait until they're 18 for substance abuse.
- **Duane- Then all that information is what you need to put it in the report and give it to the committee, Executive Committee, and then maybe we can see that we need the law to be changed. Different boards that follow**

mental health the can take it to the State Legislator and say- the law needs to be changed.

- **Gina-** Does AOD take care of kids?
- **Attendees- yes, they do.**
- **Barbara- I just want to put out there and you may or may not want to consider this in your committee, these are just organizational structural approaches and there are many different ways in which we can achieve the objective of bringing all three groups perspectives together. There are many different ways to do it and you may want to take that into consideration.**
- **Duane-** I then ask the two of you (Sam/Gina) to put it all together for us, the size of Contra Costa, cause it may be easier for smaller counties to do it.
- **Lauren- Sam, it seems like you've done some research on this and I am not familiar with this and can you tell us where we would find information on what counties have already integrated?**
- **Adam**- quite a few, off the top of my head, I know that Sutter County has and a couple of others, I've done a little research on it too. Often times, what happens, speaking personally not for the department, I do think that there is some validity to efficiencies towards that, administratively. It is a lot of process and the Board of Supervisors will need to be involved and approving that sort of structural change. The departments will need to be on board, you will have to go as far as disband, by order, the current formation of those committees and reconstitute it by new appointments. It is a big bureaucratic lift, to do, but it's worth looking at. I think this idea of an ad-hoc committee to look at is a reasonable sound one.
- **Sam- I do have some information**
- **Diana-** What is the picture? The others go away and we become one large one? But you're saying that a representative from the AOD and HHH, that sits on our board?
- **Adam-** that's how some counties are doing it but it doesn't have to be, I suppose?
- **Jill- To give you a little back up, when you set up an advisory body, it's done through a "Board Order," it establishes it, it determines- we just did this with the Sustainability Commission, it's quite a process. You determine how many seats, who will sit on those seats, whether there district seats, specific named seats, then you go through- like the Mental Health Commission are all district seats, the Supervisor's all do their own. If it's named seats then that goes through either internal operations or Family and Human Services to do the recruitment, the interviews, and the appointments. You create the Board Order, determine what seats, fill the seats, determine what the terms are, what the mandate is, who they report to- so you do all of that. If you are talking about taking, for example, Mental Health Commission and AOD, and combining those boards, well you have two different Board Orders that establish them. You will need to go through a process to combine them and create one body, through board action. It's not impossible, by any means, like I said; we just created the Sustainability Commission. It doesn't happen often, we from time to time, sunset advisory bodies that are no longer serving a purpose for a variety of reasons. Sometimes we integrate what they do into another board or commission. It's a process and I think starting with a work group or task force, to research it and determine the best path to go forward is a place to start. My guess is that it would be easier to look**

at Mental Health Commission and what will now be called SUD (Substance Use Disorders). I think it will be too challenging to add Homelessness into it, quite frankly. They just redid the Council on Homelessness and it was really carefully planned out. Lavonna determined what seats would be best to really address that and it's different funding streams too. I think to do a deep dive first, then look at it, then you can propose it to the Board of Supervisors and if their interested they can take it up under Family and Human Services, or IOC, to determine whether or not that is in the best interests to the County?

- **Adam-** it's worth looking at, I do think its worth to study. If you guys want to do that, everyone's points are right on here.
- **Diana- if we didn't go forward, Lavonna came a couple of times to the commission and presented information on homeless and what was going on and what changes we expected to see, it was a really good overview. But, we don't have an active role now. It's more informational for us to fill in the picture and having that kind of a presentation from SUDS and have them come, annually, would be again the same thing, it would be more informational without really a role. If were to change it, were we had a more integrated role, then what would we as commissioners be doing differently? Is that what you're going to find out?**
- **Duane-** That's what they're going to find out and look at other counties like us. LA County has changed but it's a complete different one, they stand on their own. Do we need a
- **Jill- they have a lot of funding**
- **Lauren-** I was just wondering Adam, do you have to ask County Council or can you find out the one that I wanted to be assured of is that, whichever decision we make, that the mandated things that are set for the Welfare and Institutions Codes would not be lost if we disbanded and created another board? I don't know the answer to that.
- **Adam- that will all go through County Council for sure. The examples that I've looked at, and I am not the expert, but I have seen a couple of examples- the Welfare and Institution Codes was referenced as part it. That's the State mandate and the Board gives that authority out to you.**
- **Duane-** let me say this, Adam and Jill, you both seem very educated on this would you two assist Gina and Sam?
- **Gina- I would like to research more of this myself**
- **Adam-** you're welcome to bounce anything off of me, you're welcome to do so. Do you want to do an official motion to do the ad hoc committee?
- **Barbara- I have more comments, as far the research- you can look at what areas diverge. Because there's overlap and there's going to be things that are totally different, so how do you resources to cover these different things?**
- **Adam**- I think there's a ton of things to do with this, if this is something that we're interested in doing? The first step would just understand what's out there and we are on that path with doing some research**.**
- **Diana- and the drawbacks need to be included and part of the brigade.**
- **Duane-** So, do we have a motion to form this committee?
- **Jill- Is it a task force or work group? What does your official Bylaws say that you can create?**
- **Adam-** It's an Ad Hoc committee
- **Barbara- I MOVE THAT WE CREATE AN AD HOC COMMITTEE TO RESEARCH AND UNDERSTAND THE BENEFITS AND DRAWBACKS TO MERGE WITH THE**

	AOD/SUD AND/OR HOMELESS ADVISORY BOARDS. **Gina seconded the motion** **VOTE: 5-0-0** **YAYS: Duane, Barbara, Sam, Diana, Gina NAYS: none** **ABSTAIN: none ABSENT: none**	
IX.	**DISCUSS the scope and structure of the Commission's role in participating in on-site reviews of treatment and residential care facilities with Behavioral health Administrative staff** • **Lauren-** As far as MHSA, as far as those facilities that receive MHSA funds, we as a commission have been invited numerous times to go out to visit the different sites. I have had the opportunity to go to six different sites, only six, but there are more. There are residential sites and locked facilities that receive realignment funds one and two. I have not been to those sites. Duane and I went to the Brookside and Concord shelters to visit. I have gone on a number of occasions to the Don Brown's site, which is in Antioch. I have also been to other sites that many of our clients go to: the Bay Area Rescue Mission, the TLC homes, the By Brett homes, Diablo Valley Ranch and Riverhouse- I have done so as a concerned citizen. I've made four trips, with Bob Thigpen to Riverhouse. There are many times that Commissioners Connie Steers has been out many times to many of the facilities and Commissioner Tess Paioli. They have even gone in the middle of the night to help bring supplies and things needed to people at these facilities, especially at Riverhouse. It's very hard to bring a whole commission to visit a site. I don't think we're gonna get a true picture and we have to be vigilant and signing up for the MHSA program and fiscal reviews because you get a deep dive when you go to that. The committee that you work with will show you the contracts that are signed, the inner workings of the reports that have to be filed, monthly, you will receive a lot of information and go out on two occasions to see the site. Some of our sites there are very important and have two commissions go to the Crestwood in Pleasant Hill that has two programs going. Duane and I have been to Family Courtyard on several occasions. I have not gone to OUR HOUSE in Vallejo, although it's not in our county, it does have our residents, I haven't been to CRESTWOOD in Stockton or the one in Vallejo, these are more intense sites. If we wanted to do that type, I would think that type I would think that we would need to work closely with Joseph Ortega and Jan Cobaleda-Kegler that work with Adults and the bed committee. • **Duane- I thought we invited them to this meeting?** • **Adam**- I think we did too • **Liza/EA- Yes, they were invited, Joe was not able to come due to prior commitments to scheduled sites. He's out in the field doing reviews of sites. Jan had a schedule conflict with another meeting.** • **Lauren-** The other administrator who has deep responsibilities and is out dealing in the fields is Jane Yoo. I do believe that if there were specific sites that we wanted to look at, if we contacted Jane or Joseph, they both are very receptive. • **Duane- I agree that every commissioner should be doing a site visits, at least one or two and you should see where the county is placing people and what's out there. See what we are advocating for, see that people are being taken care the way they should be. I sent a copy of Napa's PROGRAM OBSERVATION REPORT, that they do, their commissioner's do. It's in the folder that the Liza/EA did for us; it's well done and good. It tells**	

you something different that the county reports are asking for. It fits the needs of what the Mental Health Commission do, so Liza, make a copy for everyone. We need to do this and we need to document that we're doing it. That's part of our mandates or jobs.

- **Gina-** You know how many places that I've been, a lot, all over the county, even in East County, Central County to different facilities. What are you asking, are you asking us to do the review? I do not understand, so please tell me.
- **Barbara- It came from me, to get it on to the agenda that I have heard that people have said- there are all these homes out there and we're advocating to your point; do we know what we are advocating for? Is it our responsibility to be out to the sites?**
- **Gina-** most of the times that I've gone, it's because I've gone with a consumer. I've been to Putnam house, Hope House, AOT, to the Native American Center, to Cali House, Crestwood- it's usually because I'm invited by a consumer or just happens to be a circumstance. I don't understand what you want?
- **Duane- let me tell you what we want: we need to develop a form, for Commissioners to take with them and when they're at a facility, like whether you went to visit a facility for one reason or another, there's some questions on here that you can ask, as a Commissioner, or should be asking.**
- **Gina-** How do you do that when- I am more a participant**.**
- **Duane- If you're going as a Commissioner, you are obligated to report back observations of what you see. If you go as a private or public citizen, it doesn't matter. If they are inviting you as a Commissioner, then you do need to report, you need to follow the Bylaws.**
- **Gina-** I've been doing this since I've been on the Commission and there is a need or stuff comes up.
- **Barbara- to me, we have the list of the facilities and I feel as a group we should be tracking and become familiar with them.**
  And, we need to follow up and divide the list among the Commissioners to be responsible.
- **Gina-** driving is an issue for you and I need to know where I'm going and where it is.
- **Barbara- so you would sign up for a place that's close to where you live**
- **Jill-** I think you have to be careful and I think that's what the Bylaws cover. If your there as an invited guest with somebody, then you're not wearing your Commissioner hat, otherwise it winds up like an "I gotcha" if you see something
- **Gina- I am not into "I gotcha" I don't want to do that.**
- **Jill-** Right? So that's what I'm saying. Versus, if you go as part of a review of residential care facilities with Behavioral Health, then you're in that role of observing and documenting what you see.
- **Lauren- There is one group of housing that was funded by MHSA that has no one going to see. It's permanent housing, it was built with Capital Facilities money and there are a number of apartments/homes that were built. It was like $8 million dollars that were put into these facilities and I don't think that we, as a Commission, have never been out formally to see the units, to be assured that these units are still being used for what they were bought and purchased with MHSA funds and were to remain as housing for the mentally ill. That's something that we need to check with**

Jane Yoo and Joseph Ortega. How are we being assured that these residents are being kept and set aside for those with a serious mental illness?

- **Liza/EA-** Can you please state the name of the facility or facilities?
- **Lauren- Villa Vasquenselas is in Walnut Creek = has three units, Virginia Avenue in Richmond = has two and Garden Park in Concord = one unit, Lilly Mae Jones in Richmond = has seven units, ANKA ONE in Antioch has four units, ANKA TWO in Pittsburg has four units, ROBIN LANE in Concord = has five units, ALONE GARDENS in El Cerrito = has five units and THIRD AVENUE in Walnut Creek = has five units. I think this is something that the Commission should make sure that is happening because some of these sites reside in very coveted areas.**
- **Adam-** Housing and facilities is a huge topic and I am trying to get into a manageable chunk to do something with here
- **Jill- that concern seems to fall outside the scope of item VIII.**
- **Adam-** what do you guys want to do? I want to make it happen for you but I am trying to get clear on where to go with it first?
- **Barbara- That's why we are here discussing this now**
- **Gina-** This is what I'm thinking about, me going by myself to a place, I don't feel comfortable
- **Duane- housing visits are made- yes or no?**
- **Jill-** As worded in item VIII-" …onsite reviews of treatment and residential care facilities with Behavioral Health Administrative staff" is that what you're talking about?
- **Barbara- I put together the language for this and I wasn't paying that much attention to it, to me it was any or all or a sub-section of it. That's why I threw the cast or the net.**
- **Adam-** I'm wondering, even taking a step back, residential care facilities and treatment, which is a big enough job. Where do you want to start with that? What committee is this coming out of? What meeting do you want to go first? Do you want to arrange something with Crestwood? Does it want to happen by itself? Does it need to be with a staff member?
- **Barbara- I think that's what we're starting with, it's to get this conversation going. What the objectives would be? How we would do it? What are our options for conducting the work?**
- **Duane-** This is something that we are mandated to do! And we are trying to figure out: how we're going to do it, what do we need? We need help in doing this. The help we need is for the people that are going to do a site visit. If staff know that they are going to do visits, they have a schedule, why not share that schedule with us so the commission can choose who wants to go to what?
- **Gina- Are we going alone? Or are we going with someone? Oh, ok**
- **Jill-** Here's where the confusion is happening. I know you just used Riverhouse as an example, we are not responsible for inspecting Riverhouse, so we don't do that, so that's the challenge. So that's where we're having a hard time with this. Let me back up one step further, you're doing the visits with the MHSA funded programs, right?
- **Diana- right**
- **Jill-** don't go beyond that, help me here, so you do the visits with the MHSA programs, you've done that?
- **Diana- We've had the opportunity, I have not done one and we haven't really talked about it in for almost two years**

- **Jill-** So that's happening or happened?
- **Duane- it's happened one time, twice. Last time we went with the mental health staff was to Family Courtyard, or did we go on our own?**
- **Lauren-** we went with mental health staff, because they had never been there before
- **Jill- Explain to me the next layer that's missing. Not using Riverhouse because we don't inspect Riverhouse.**
- **Lauren-** ok so we have a number of facilities that we have not stepped foot in that are paid for through realignment one and realignment two. These are the locked facilities**.**
- **Adam- so they're MHRC's**
- **Lauren-** Yes, they are locked facilities and there are unlocked facilities such as, Our House, that we have contracts with and we don't really even have that mapped out. So I would think that one of the first things that we need to do is to have a discussion with Jane Yoo and Joseph Ortega, as to where they go. What they visit, how they visit them? I'm sure that they are visiting them on a regular basis and filling out reports. We don't see that. If they aren't visiting them on a regular basis, then maybe that is something that we as a commission would want to suggest happen. Maybe there are times that we would like to see, since we're spending as a county, I don't know what the number is, let's say $1.7 million dollars are being spent on youth homes and nobody is visiting these sites, how do we know what is happening? Let's go see what is happening with that money. We have a number of people that are in locked facilities at Crestwood Stockton, do we consider that facilities, as Contra Costa residents feel that they are adequately providing for the needs of our people?
- **Adam-ok, so there's so much there and that's a full program job to do that.**
- **Barbara**- I think, just back up here- this is a discussion and we are tossing out what we know and what questions we have. Just to talk about those ideas doesn't mean that it all needs to taken in A or B, that anything we do, I can see the implementation being staged and there's only so much we can do as a commission. The commission, we need to decide what our particular goals are and the highest priorities of types of facilities we need to focus on**.**
- **Adam- It sounds like you're interested in seeing the Crestwood facilities**
- **Lauren/Duane-** we've seen Crestwood
- **Adam- so which ones are you interested in- Crestwood Vallejo, you've been out to those ones?**
- **Lauren-** no, we've been to Crestwood Pleasant Hill
- **Jill- So I guess the first question is: What is the Behavioral Health visitation schedule for these types of facilities? That would be the first question, right? And then, from there, once you've gathered that information you all determine what parts of it you want to implement in what stages, right?**
- **Duane/Diana-** right
- **Barbara- I think the first phase is figuring out what our objective is**
- **Jill-** I thought I heard that, it was just to be familiar with what we're providing out there in the community, I know I heard somebody say that.
- **Adam- What I would suggest, as far as the Crestwood go- without talking about the broader issue which needs a lot of work, to massage out, I would like to try to arrange some sort of meeting with Joe and Jan to see**

how that might look? That might be the easiest first start. It doesn't have to be a full commission meeting; it can be just a chat to see what that is like? I don't know, maybe a smaller group of the commission, another ad hoc to discuss it. I think that's a good place to start. That specific one because that is a big one. As far as an ongoing thing, there's some structural things Barbara, like your saying, where we going to do this, what are we trying to get out of it, how do we want to do this, on an ongoing basis or what committee is looking at it, what's expected of the staff, how to arrange the calendar, all that stuff, can be discussed down the road. As far as the Crestwood one, I don't know what the rules are and I don't know how comfortable the providers are or our staff schedules or how all that works. Not that you can't go see them, I just don't know these things, so I think that's where we start that conversation with Jan and Joe.

- **Barbara-** regardless if, it's an organized thing or not, we have a right to go visit these sites and a responsibility to do so.
- **Jill- sometimes- if it's a locked facility, you need permission to gain access**
- **Barbara-** I'm saying within reason.
- **Diana-** I have a couple of thoughts- with the MHSA, physical reviews, we have a process in place where we can in fact, open participation to the broader commission, and we could. Right now it's been a focus of the Finance committee because that's where the funding is. That has a process that we could easily play into with a model. That is one thing that we can acknowledge that we want to expand that role. Like I mentioned before, when I first started on the committee we had a lot of discussion and opportunity to join Warren and his team to do that. I haven't heard it come up that we have been invited for a long time to participate.
- **Lauren-** About six months ago, the list went around again
- **Diana- Maybe I missed that meeting. But I think that that is one place that we have. And that gives us a model on what you're looking at and how you might go about it. If we have the conversation that we talking about with Jan and Joe, to sort of see what the options are and tag along on a visit might be interesting to see what we learn.**
- **Barbara-** Right, I think we should be piggy backing the whole way.
- **Adam- the stuff on the MHSA side is a tighter ship. Joe is out at these facilities every day; he's there all the time. Warren administers that program and that might end up being a discussion. That is easier to integrate and that is the lion share of the adult, you get most of the board and cares in that. What you don't see is the MHRC's and those other ones and that part, is again, operated out of the Adult Program Chief, it's a little bit different.**
- **Gina-** I have a question, I know that the State comes in and makes visits at the facilities; don't they come into the locked facilities too? Just talking about this, my anxiety level is like at a ten! I don't want to go to a locked facility. I think from the consumer side, if you're coming over to do a visit, if it was me, I would feel like your invading my space. I have to understand what the reason is to tell these people.
- **Adam- I would imagine that the state does a lot of certification. You guys do have a role to see them and visit them and I'm ok with that, it's just how we make it happen. Regarding item IX, let's get Joe and Jan to talk about this at the full commission meeting to talk about this.**
- **Barbara-** you wouldn't sign up for that then Gina- you don't have to go to a

locked facility, you pick the ones you want to go. Well, they were supposed to be here and I am sorry everyone that their not.

- **Adam- just so everyone knows, we are in the middle of our triannual audit right now. We are all wildly preparing documents and its six inch binder's worth of stuff that is going to get reviewed right now, everyone is putting this together, and staff is a little bit scarce and slammed. I just wanted to let everyone know, if we've feeling a little bit distant at the moment that goes to the Behavioral Health side.**
- **Duane-** I walked in one day, unannounced, ok to the Brookside shelter, and when I got in there I noticed that there were more fly's than clients. The flies were everywhere and when I saw the flies on the food, I had enough. I reported what I saw and of course there were excuses made but it got straightened out. That's what I'm saying, I don't care what we do, and our clients have a right to be treated with dignity and respect. That means that they shouldn't have flies flying all over their food. Maybe we don't have what we need to have but what we've got we need to make sure that it's being taken care of properly.
- **Diana- I think that takes a certain amount of comfort level to go unannounced into a facility. I probably wouldn't do it. I would want to go holding somebody's hand, at least the first few times and have a fairly good checklist of things that I would look at or do or respond. And who knows what that's going to look at because I can't build it. So, Gina, your concern, put it away because I right there with you.**
- **Gina-** I think I would be fine if I was with someone like Warren, I'd feel more comfortable because you're going with someone who is a staff person and that for me is very important. I don't want to go by myself, that's all I know. I have gone to facilities, but to go as a commissioner and come back with a report, that's a whole other issue. But I do think that it's important, I agree, we do need to see what's going on.
- **Duane- I would never ask any of you to go by yourself. Some of us have more experience doing this and are ok going by ourselves. Let's look at the observation report from Napa, look at the information that they gather. We need to see what information we need. Because right now, we have none! I hate it when someone says to me- well somebody says- no, no, no…if somebody said something, have them write it, I want it in writing. That is more powerful than – somebody said. Then we as a commission can look at it and close the gaps and it tells the people that we are really looking at what they're doing.**
- **Lauren-** I wanted to thank Adam, the information that he did. Because we do get scattered information all the time. This report he did is clear and delineates what is what. The fact that we have this Napa observation example helps, having this discussion helped to put a lot of things in a workable framework that we can move forward on.
- **Barbara- we started this in the Quality of Care Committee because we were looking at it from that perspective but we then realized it's a full commission effort that needs to be made.**
- **Liza/EA-** That's why I gave you all the copies of the Napa example so you collectively, as a group, can decide what you would like me to fine tune. Then, I can create the Contra Costa Mental Health Commission observation report.
- **Lauren- we did have one, I don't know if it got lost, once when the computer got fried, it was a few years ago.**

	• **Liza/EA-** Your right, there was an old one but I do think that this form is better • **Lauren- I think your right, it's much better**. • **Duane-** I love this Mental Health Board Task List- where did this come from? This is beautiful. • **Barbara- I suspect, I know who that was** • **Duane-** I looked at this and I wanted copies for Barbara and I and I want copies for everybody. It's clear, it tells us what to do, what we're responsible for and I know we haven't done any patients' rights advocacy updates. • **Liza/EA- I did, I provided a copy for everyone** • **Barbara-** we just started that conversation in the Quality of Care committee, with the different groups that are active, like OCE (Office of Consumer Empowerment). • **Gina-** there is a problem with people under conservatorship and I don't think OCE deals with those issues.	
X.	**CONSIDER forwarding, to a future Commission meeting, an agenda item to receive and report on housing and residential placement including topics requested to be addressed** • **Barbara- Can we move on to item ten and come back to this? I thought that there was one that there is so much going on and that you would like to see a report. What kind of report would you like to see?** • **Sam- Any of these concerns have resolution? Or do we just pass on to the next?** • **Barbara- I don't know, I am not certain to what it is that you would like to be presented at the commission** • **Sam- I can email them to you** • **Barbara- that would be great** • **Diana- what about the homeless count? Lavonna's information and update last year was really good, maybe we can do that again, I would like that to be an annual update.** • **Jill- the homeless count is not in yet.**	**Sam- email Barbara a list of items to present to the commission** **Barbara- Invite Lavonna to do another update regarding the homeless**
XI.	**DISCUSS outreach and communication Commission goals for 2017 responsibilities for visiting facilities in 2017** • **Duane- the one thing I would like to see as quickly as possible the mailing list for the Mental Health Commission.** • **Jill- Are you asking for that email list offline or to be presented at the next meeting?** • **Duane**- just for me, I just want to see what are we lacking and who are we missing? One of the providers said that they are not getting any information about our meetings. I want to see what's going on. • **Liza- Since I did get the website changed, with my contact information, I have been getting calls and emails for request to get added to the list. At least two to four a week that I'm adding to the list.** • **Duane-** We need to have our information on the web page updated. • We need to take a picture, the next time we have everybody together, with our badges. • Has anybody thought about us doing a newsletter? • **Liza/EA- or a brochure? I was given a sample, this week by Adam, and I will get started on it so it's ready for Mental Health Awareness month in**	**Liza/EA- will forward the email list for MHC to the Chair the following week and will have the web page updated and create a brochure for the Mental Health Commission** **Lauren/Barbara- call NAMI (Dave) to request a column in monthly newsletter and write an article for Mental Health Awareness Month** **Duane- call Chair of**

May. • **Jill-** that would be great to present the new brochure at the next EC's agenda in April and everyone can make changes, edits and then roll out in May. • **Lauren- you're talking about a newsletter, I was wondering, I know that they will give you a column if you asked, but NAMI puts out an excellent newsletter each month that zeros in on very specific topics. This month, Jan Cobaleda-Kegler, is the person in administration that they're interviewing. Dave Kegler is the editor and puts out a beautiful newsletter each month.** • **Jill-** is the Mental Health Commission monthly meeting posted in there? • **Lauren- yes and we can ask for a column, he would love it** • **Liza/EA-** who would be in charge of writing the column from the commission? • **Duane- I think it would be a beautiful thing for Barbara and Lauren to do it together** • **Lauren**- no, I am not writing any articles for NAMI, sorry • **Barbara- Liza, you're a good writer** • **Liza/EA-** it should come from an advocate's point of view, don't you think? • **Lauren- we could rotate it amongst the committee's we could do that** • **Gina-** we can give an update about our committee's and write a little article about the meeting • **Lauren- we talking about 300 words but 300 words of editorial quality, monthly, it would take some time** • **Barbara-** it can be quarterly? • **Duane- ok, so Barbara and I will work on that** • **Liza/EA-** how about having an article posted for May, for Mental Health Awareness Month? • **Jill- that would be a great kick off for that** • **Duane- we need to make a presentation to the Board** • **Lauren**- we did one year do a beautiful presentation where Roberto Roman did a singing number, the year before • **Jill- somebody needs to contact either Supervisor's Glover's office or the Clerk of the Board and get it on the agenda, for a presentation. Cause they only allow three presentations a meeting.** • **Duane-** Jill, can you help us with that? I won't do the presentation. Somebody from the commission needs to ask Supervisor Glover • **Jill- you contact Supervisor Glover and let him know you want a presentation done for Mental Health Awareness Month, they do the resolution and the put the place holder in. He's the Chair of the Board this year, so that's how you do it, so he would be the one doing the resolution.** • **Duane**- ok, I'll do that, I'll contact him**.** • **Jill- I have one other suggestion when it comes to presentations. Since we already have an outline for the resolution, you can provide it to the cities that anybody is willing to go to get on their agendas. Some of the cities will put it as a presentation others will just do consent and sent you a resolution afterwards. But anybody can go to the meeting and submit a speaker card and it's pulled off of consent and you can talk about it at public comment. If you want to get awareness out there and stigma reduced, that's the way you do it. Prescription drugs does it, all these**	**the Board of Supervisor's Glover for Resolution for Mental Health Awareness Month to add to agendize the presentation- ASAP**

different organizations do it and go to all the different cities. • **Liza/EA-** Even if you just do your own city, where you reside. • **Duane- that's a good idea** • **Lauren-** you would have to do it this week to get on the different venues of the different cities • **Gina- there must be someone who does outreach to the mental health community, who is that person and how can we be a part of something like that or do something like that? Outreach events, we can't we do something and invite the community?** • **Lauren-** NAMI rotates their community outreach events because you have to sign up, depending on availability, primarily in Concord. Not West County or East County to bring the consumers in and contact all the facilities and make sure that the people have rides to get there. NAMI has a lot of community fund raisers. • **Jill- there is no funding for PR anywhere within the County. The Information Officer interacts with the media, in charge of the website and to keep it current**	
XII. Adjourn Meeting at 5:13pm	

Respectfully submitted,
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
March 31, 2017

on June 30 in the appropriate year. The Supervisor appointed to the Commission serves until replaced by the County Board of Supervisors.

SECTION 4. VACANCIES AND RECRUITMENT

4.1 Role of the Commission

At the discretion of and to the extent requested by the Board, the Commission shall be involved in the recruitment and screening of applicants.

When an application is received, the Commission will appoint an Ad Hoc Applicant Interview Committee, pursuant to Article VIII, Section 5.1. Following an interview by the Ad Hoc Applicant Interview Committee, it will forward its recommendation to the Commission. After Commission vote and approval, the recommendation for nomination of the applicant shall be forwarded to the appropriate member of the Board of Supervisors for that Supervisor's consideration.

4.2 Applications

The Commission shall receive applications on an ongoing basis.

4.3 Commission Recommendation

a) Pursuant to Article IV, section 1.2, the Commission shall, to the extent possible, recommend for appointment those persons who will assist the County in complying with the ethnic and demographic mandates in the Welfare & Institutions Code.

b) To the extent possible, the Commission shall recommend for appointment applicants who have experience and knowledge of the mental health system, preferably in the County.

ARTICLE V
MEETINGS

SECTION 1. REGULAR MEETINGS

1.1 Regular Meetings

Meetings of the Mental Health Commission shall be held monthly.

1.2 Schedule of Meetings

The meeting schedule for the following year shall be set in the month of December. If no meeting will be convened during the month of December, the meeting schedule shall be set at the last regular meeting of the calendar year. Meeting schedules shall be available online.

1.3 Minimum Number

A minimum of eleven (11) meetings shall be held per year.

1.4 Holidays

If the regular meeting date falls on a holiday, a new meeting date shall be selected.

SECTION 2. ORDER OF BUSINESS

2.1 Agendas

Agendas shall be prepared for regular Commission and Executive Committee meetings at the direction of the Commission Chairperson. When feasible, agendas shall be e-mailed and mailed seven (7) days prior to the meeting, but at a minimum 96 hours prior to the meeting. Agendas shall be posted, e-mailed and mailed and made available to the public in accordance with the Brown Act and the County's Better Government Ordinance. 5

SECTION 3. QUORUM

A quorum is one person more than one-half of the appointed members. The Commission must have a quorum present in order to hold a meeting.

County, the Board may substitute representatives of the public interest in mental health who are not employees of County Mental Health, Department of Health Care Services or on staff or a paid member of a governing body of a mental health contract agency.

c) On this Mental Health Commission, membership shall consist of:
   1) One (1) member of the Board of Supervisors
   2) Five (5) members shall be Consumer Representatives - individuals who are receiving or have received mental health services, preferably in Contra Costa County.
   3) Five (5) members shall be Family Members - parents, spouses, registered domestic partners, siblings or adult children of consumers who are receiving or have received mental health services, preferably in Contra Costa County.
   4) Five (5) members shall be Members-at-Large - individuals who have experience and knowledge of the mental health system, preferably in Contra Costa County.

1.2 Demographic and Ethnic Representation
   a) The Commission membership should reflect the ethnic diversity of the client population in the County.
   b) The composition of the Commission shall represent the demographics of the County as a whole, to the extent feasible.

1.3 Membership Restrictions
   a) No member of the Commission or his or her spouse shall be:
      1) A full-time or part-time employee of any Contra Costa County department that is directly involved in the provision of mental health services; or
      2) An employee of the State Department of Health Care Services; or
      3) An employee of, or a paid member of, the governing body of a mental health contract agency.
   b) Commission members must be eighteen (18) years of age or older and, except as otherwise provided in these Bylaws, must reside in Contra Costa County.
   c) Members of the Commission shall abstain from discussing or voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

SECTION 2. ATTENDANCE

2.1 Attendance requirements
   a) Regular attendance at Commission meetings is mandatory for all Commission members.
      1) A member who is absent from four (4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission. In such event the former Commission member's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission's minutes. The Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member's resignation and request the appointment of a replacement.
      2) Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the Commission.

SECTION 3. TERMS

3.1 Duration

The term of each member of the Commission shall be three (3) years in duration. Terms shall be staggered so that approximately one-third (1/3) of the appointments end each year. All terms end

3) The Chairperson shall provide monthly reports to the sponsoring standing committee or the Commission.

4.6 Removal

The Chairperson of the task force may request of the Chair of the Commission replacement of a member who fails to regularly attend the task force meetings.

SECTION 5. AD HOC COMMITTEES

5.1 Purpose

Ad Hoc Committees shall be established by the Commission as needed to address issues within the normal course of Commission responsibilities, including but not limited to applicant interviews and officer nominations. They shall be required to report back to the Commission.

5.2 Composition

An ad hoc committee shall consist of a minimum of three (3) and a maximum of five (5) members of the Commission.

5.3 Appointment

The Commission shall appoint Commission members to an ad hoc committee.

5.4 Meetings/Actions

All matters coming before an ad hoc committee shall be determined by a majority of the members of the ad hoc committee.

5.5 Chairpersons

a) Selection

Each ad hoc committee shall have a Chairperson, and may have a Vice Chairperson, selected by a majority of the members of the ad hoc committee. In the event of a vacancy in the position of Chairperson of an ad hoc committee, the Commission Chairperson may serve as temporary Chairperson of the ad hoc committee for up to sixty (60) days while the ad hoc committee selects a new Chairperson.

b) Duties

1) The Chairperson shall preside at all meetings of the ad hoc committee and perform his or her duties consistent with the procedures outlined herein. The Chairperson shall be in consultation with the Commission Chairperson.
2) The Chairperson shall direct the preparation and distribution of agendas for the ad hoc committee in the manner required by the Brown Act and the County's Better Government Ordinance.
3) The Chairperson shall provide monthly reports to the Commission.

5.6 Removal

The Chairperson of the ad hoc committee may request of the Chair of the Commission replacement of a member who fails to regularly attend the ad hoc committee meetings. 10

SECTION 6. COMMISSION REPRESENTATIVE

The Commission shall appoint an officer or other member of the Commission as the Commission Representative to the California Association of Local Mental Health Boards/Commissions. The Commission Representative shall represent the Mental Health Commission at statewide meetings and to report back to the Commission.

ARTICLE IX
COMMISSION/MENTAL HEALTH DIVISION RELATIONSHIP

SECTION 1. STAFF SUPPORT
The County's Mental Health Division provides clerical support services to assist the Commission in the management of its operations and activities. The Executive Assistant shall maintain all necessary records. The budget of the Mental Health Division shall fund the position of the Executive Assistant to the Mental Health Commission.

SECTION 2. STAFF ATTENDANCE AT MEETINGS
The Mental Health Division staff provides information to the Commission and its committees regarding agenda items and attends meetings on a regular basis.

SECTION 3. ACTIONS
The Commission by its Chairperson shall regularly inform the Mental Health Director of Commission actions.

ARTICLE X
BYLAW AMENDMENTS

SECTION 1. AMENDMENTS
These Bylaws may be amended by a majority vote of the Commission in a regularly scheduled meeting as defined at Article V, Section 1. Before the Commission may consider or vote on Bylaw amendments, proposed amendments shall be submitted in writing to Commission members at least thirty (30) days prior to the meeting date at which they are to be considered.

California Mental Health Planning Council

DATA NOTEBOOK 2016 FOR CALIFORNIA BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Susan Morris Wilson, Chair
Linda Dickerson, Ph.D.

California Mental Health Planning Council

Data Notebook 2016

This is a CA Mental Health Planning Council (CMHPC) project as we want information from the local Behavioral Health Boards/ Commissions in order to meet our mandates to report to the state legislature.

California Mental Health Planning Council

Data Notebook 2016

History of the Data Notebook:

- Previous *Workbook* was developed in the 2000s, but only 17 counties completed it in 2010.
- Past: Focused solely on penetration rates and retention rates as measures of access to mental health services.
- Action: we undertook a major re-thinking of this project and released the first *Data Notebook* in 2014.
- New: Emphasized integrative approaches to “Care for the Whole Person” in reviewing MH services.
- Last year in 2015, we received 50 Data Notebooks!

California Mental Health Planning Council

Data Notebook 2016

- Developed with the assistance of many different people and organizations, including the CA Association of Local Behavioral Health Boards and Commissions (CALMHB/C)
- Identified sources of county-level data with public availability
- Identified sources of data that are timely
- Simplified the document
- Set the stage for reporting locally on issues of importance by providing a template for a report

California Mental Health Planning Council

WIC 5604.2

WIC 5604.2: What are the Reporting Roles of Mental Health Boards & Commissions?

- Review and evaluate community mental health needs, services, facilities, special problems;
- Advise governing body and the local Mental Health Director on any aspect of local mental health program;
- Submit an annual report to governing body on needs and performance of the local county mental health system;
- Review and comment on local county mental health performance outcome data, AND communicate findings to the CA Mental Health Planning Council

California Mental Health Planning Council

Data Notebook 2016

- The structured format and questions will assist local Mental Health Boards to review data and report on local county mental health programs:
  - ✓ Fulfill state requirements
  - ✓ Accountability of programs for quality improvement
  - ✓ Reduce health disparities by examining programs for equity and fairness
  - ✓ Report successes and share innovative programs
  - ✓ Explore topics of local importance including the challenges and needs of special populations
  - ✓ Discover gaps and unmet needs to assist in the community planning process

County Behavioral Health Directors Association:

- In an August 25, 2015 letter, the CBHDA endorsed the expectation that:

  "the process of gathering this data should be collaborative between the Advisory Boards and the Mental Health Plans (MHPs)."

  They also stated that "then the process would be more natural to the actual dynamic that exists in the counties."

- The CMHPC fully supports these statements and finds them consistent with the spirit and intent of the statutes

California Mental Health Planning Council

What do we want to know?

- What programs need improvement?
- How do we improve quality & services?
- What helps people get better?
- What measures of quality should we use?
- National measures of quality in health care programs, applied to Behavioral Health
- Integrative view of MH: Treating whole person
- CMHPC Performance Indicators: which to ask, based on data available?
- What sources of data actually available?

California Mental Health Planning Council

Development & Selection of Questions for Data Notebook

- Long process: review of existing literature and recent program evaluation reports
- Identifying sources of recent/current data
- Participation in other evaluation efforts
- Workgroup, stakeholder input (MHB/C)
- “Plan, Do, Study, Act” cycle in monthly meetings to review and revise documents
- Presentations to inform CSI group, CMHPC and others, get input on the selected questions

California Mental Health Planning Council

Mental Health Data Resources

Human Resources:

- Input from local advisory boards and stakeholders with “lived experience”
- Quality Improvement Coordinators
- Behavioral/ Mental Health Directors
- County Mental Health Services Act (MHSA) Coordinators and data from programs
- Directors of Alcohol & Drug Programs
- County Departments of Juvenile Probation

California Mental Health Planning Council

Sources of Data and Reports

- DHCS: Child/Youth Mental Health Performance Outcomes System (New):
  - excellent graphs and tables
  - Short-Doyle specialty MH, funded by Medi-Cal
- DHCS: Office of Applied Research and Analysis
  - Substance Use Disorders Treatment Services and Outcomes
- KidsData.org: gather and analyze data from CA departments of justice, public health, education, health surveys
- CBHDA: eBHR Reporting System for "MOQA":
  - MHSA-funded programs: Full Service Partnership report data

California Mental Health Planning Council

More Sources of Data Reports

- EQRO (External Quality Review Organization:
  - most current data and public availability
  - county-level & statewide reports,
  - excellent graphs and tables
  - Short-Doyle specialty MH, funded by Medi-Cal
- MHSOAC:
  - MHSA-funded programs: fact sheets and full reports
  - Prevention and Early Intervention programs
  - CSS: County Services & Supports (FSP programs)
- County CSI & DCR data sets:
  - usable summaries now available in many counties

California Mental Health Planning Council

Why does it take so long to get data for any fiscal year?

- Data derived from Medi-Cal claims involve many delays
- County must submit the claim to DHCS
- DHCS verifies the client is/was on Medi-Cal at the time that Specialty Mental Health Services occurred
- Information sent to payment section and to the group that collects and analyzes Mental Health data
- Data are accumulated over a year, but there is “claims lag.” Many claims are submitted months later.
- The data are checked in order to fix errors.
- The reporting group analyzes data and prepares reports.
- The reports undergo a lengthy and complex internal review process for compliance with HIPAA, etc.

California Mental Health Planning Council

Any Questions ?

California Mental Health Planning Council

Plan for Discussion:

- What are the different parts of the Data Notebook?
- Review Theme and Questions in the Data Notebook
- Show examples of Data we provided to local boards in the Data Notebook for their review
- Discuss: how to answer the Questions?
  - **Examples of answers received** (Statewide Overview Report)
- Sources of Data & Info available, includes:
  - Lived experience & opinions of board members *(That's you!)*
  - County MH leadership: QI Coordinator, MH Director, others

Letter of Instructions for Board Chairpersons and BH Directors– *will be attached separately to email.*

California Mental Health Planning Council

Date: April 20, 2014

To: Chairpersons and/or Directors

Local Mental Health Boards and Commissions

From: California Mental Health Planning Council

Subject: **Instructions for Data Notebook 2014**

We ask that this report be prepared by the MH Board or Commission members. You are the most important resources for identifying program strengths and needs in your community.

On the first page, please fill in the requested information for your county websites:

- Department of Behavioral Health/ Mental Health
- Public reports about your county's MH services.

Please send a copy of the filled-in first page to the Planning Council along with your final report which contains your answers to the questions in the Data Notebook. Please submit your report within 60 days by email to: DataNotebook@cmhpc.ca.gov.

California Mental Health Planning Council

Please locate <u>your</u> county Data Notebook report in your folder.

California Mental Health Planning Council

Please update information for your county "Information Page:"

Monterey County: Data Notebook 2014

for California

Mental Health Boards and Commissions

County Name: **Monterey** Population (2013): 424,713

Website for County Department of Mental Health (MH) or Behavioral Health:

_____

Website for Local County MH Data and Reports:

_____

Website for local MH Board/Commission Meeting Announcements and Reports:

_____

Specialty MH Data from review Year 2013-2014: http://caeqro.com/webx/.ee85675

California Mental Health Planning Council

County "Information Page:" what else is there and why?

Numbers must have context: Population (2013): 424,713

Total number of persons receiving Medi-Cal in your county (2012): 127,254

Average number Medi-Cal eligible persons per month: 101,847

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 50.7 %

Adults, ages 18-59: 39.8 %

Adults, Ages 60 and Over: 9.5 %

Total persons with SMI[1] or SED[2] who received Specialty MH services (2012): 4,556

Percent of Specialty MH service recipients who were:

Children 0-17: 42.8 %

Adults 18-59: 50.3 %

Adults 60 and Over: 6.9 %

California Mental Health Planning Council

2016 Topic Focus: Children & Youth

Major Data Sources to be used this year:

- Mental Health Performance Outcomes System (DHCS)
- KidsData.Org: Multiple Subject Areas
- Full Service Partnership Program: Client Outcomes Data

California Mental Health Planning Council

Table of Contents: Overview

- We've discussed this Introductory material earlier

Table of Contents

California Mental Health Planning Council

Table of Contents: Overview

- Background and information for Questions #1 - #2:

California Mental Health Planning Council

Table of Contents: Overview

- Next, information for Questions #3 - #6

California Mental Health Planning Council

Table of Contents: Overview

- Information for Questions #7 - #9

California Mental Health Planning Council

Potential Disparities in Access to Services by Race/Ethnicity

- Overview of pie chart data: local data by ages or race/ethnicity; those eligible vs. those served.
- Service penetration rates for those who received at least one mental health service during a fiscal year. Also look at trends over time.
- "Retention Rate:" a different type of penetration rate, percentages for those who received five or more services during year; measures continued engagement in mental health services.

Access: Outreach and Engagement with Services

QUESTION 1A:

Do you think the county is doing an effective job providing access and engagement for children and youth in all of your communities?

Yes ___ No____. If yes, what strategies seem to work well?

QUESTION 1B:

What strategies are directed specifically towards outreach and engagement of transition-aged youth in your county? Please list or describe briefly.

QUESTION 1C:

Do you have any recommendations to improve outreach or services to specific ethnic or cultural groups of adolescents or transition-aged youth?

Yes ___ No____. If yes, please list briefly.

QUESTION 1D:

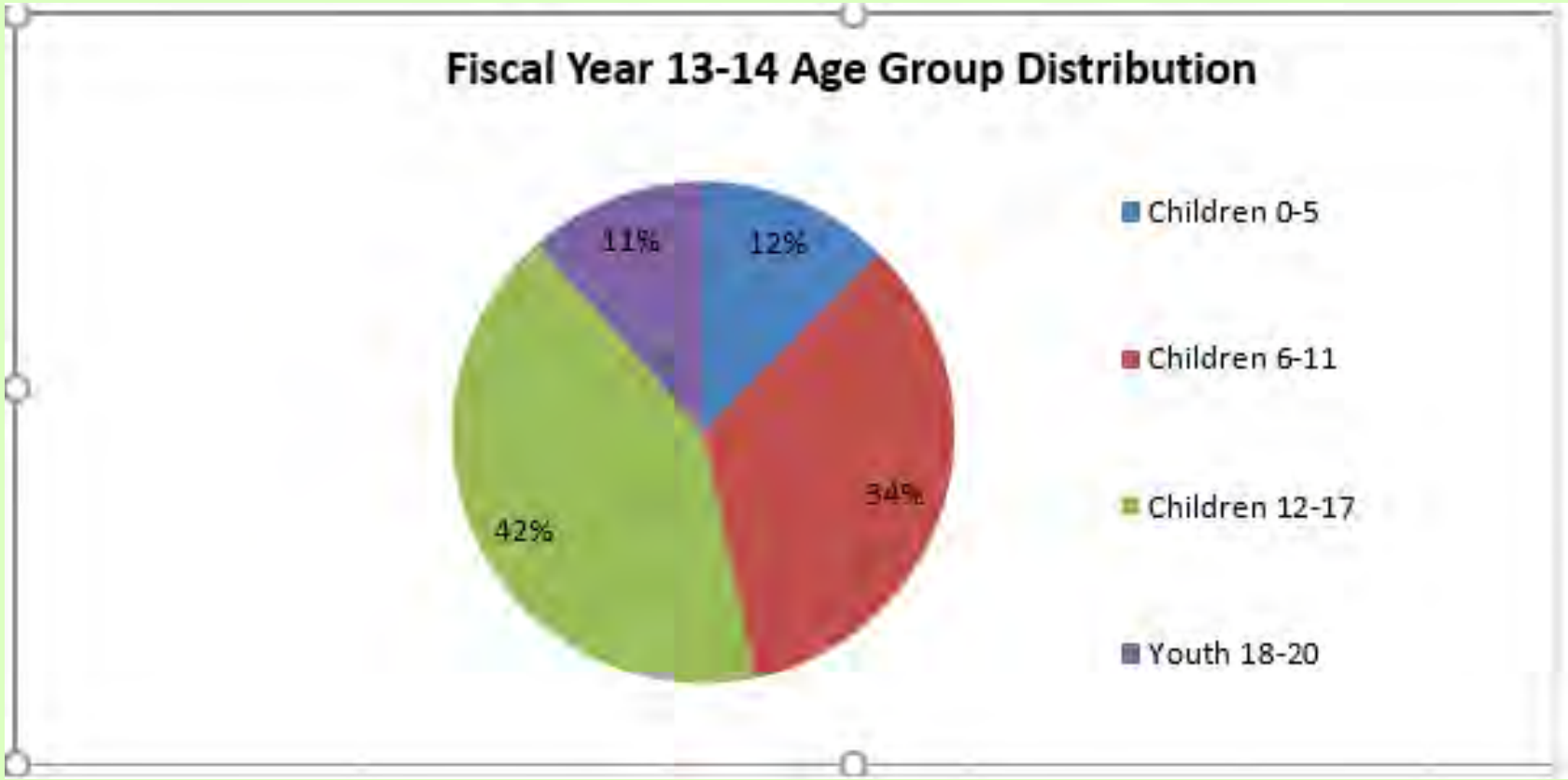
What are your main strategies for assisting parents/caregivers of children with mental health needs? Please list or describe briefly.

California Mental Health Planning Council

Data: Age Distributions of Medi-Cal 'Eligible' Children/Youth receiving Specialty Mental Health Services in CA

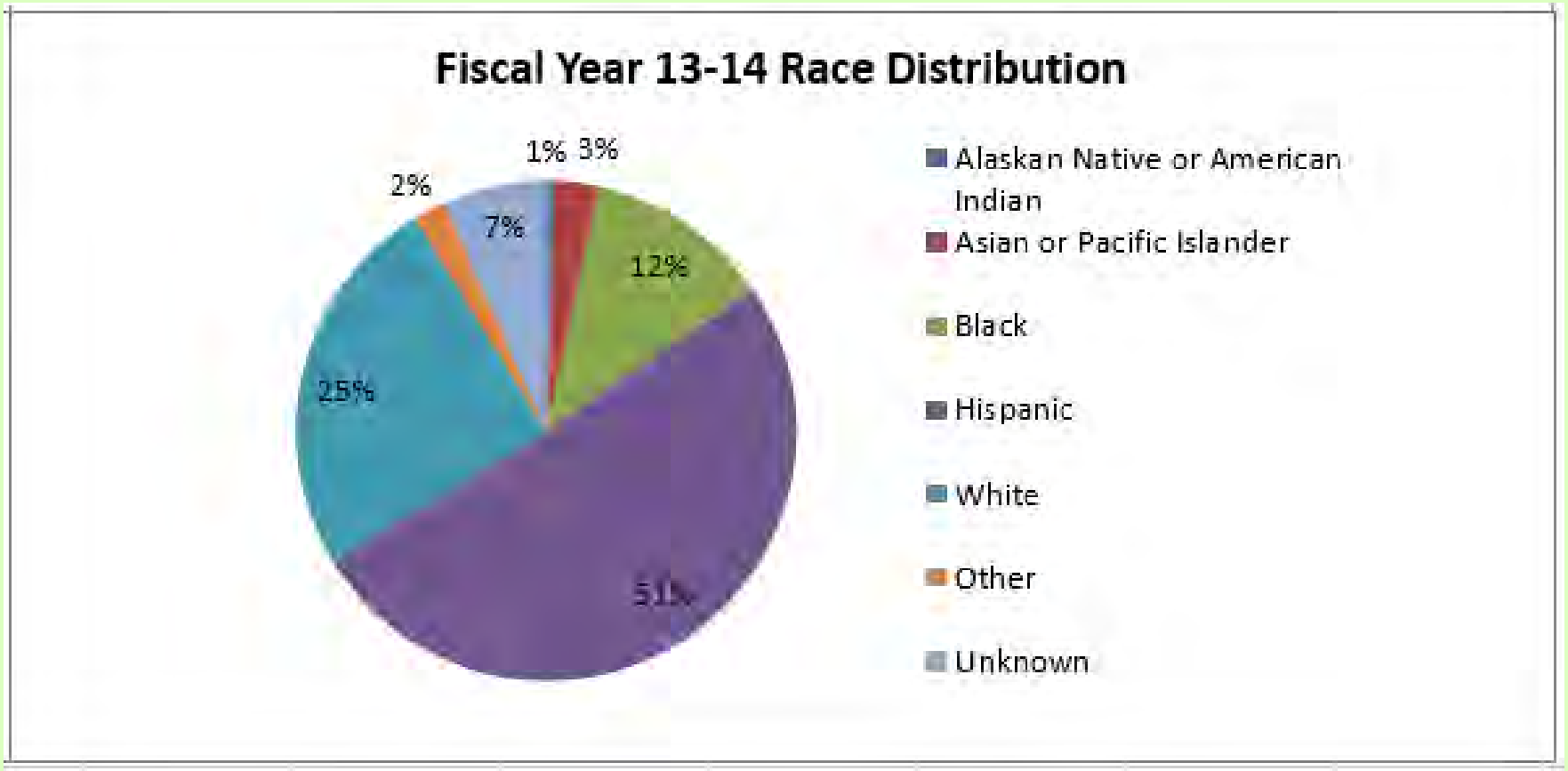
Statewide: Count of Medi-Cal eligible Children/Youth: 6,032,290.

Unique count of children and youth who received Specialty Mental Health Services: 263,567 (data for age ranges shown below)



Data: Demographics of Medi-Cal 'Eligible' Children/Youth receiving Specialty Mental Health Services in CA

Statewide FY 2013-14: Unique count of children and youth who received Specialty Mental Health Services: 263,567



California Mental Health Planning Council

Service Penetration Rates for Children/Youth Receiving at least one MH service/year in CA, 2013-2014

	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**263,567**	**6,032,290**	**4.4%**
Children 0-5	32,722	1,889,338	1.7%
Children 6-11	90,290	1,758,991	5.1%
Children 12-17	110,364	1,554,966	7.1%
Youth 18-20	30,191	828,995	3.6%
Alaskan Native or American Indian	1,470	21,940	6.7%
Asian or Pacific Islander	7,676	486,270	1.6%
Black	31,577	453,195	7.0%
Hispanic	133,834	3,440,659	3.9%
White	65,829	925,679	7.1%
Other	5,437	214,444	2.5%
Unknown	17,744	490,103	3.6%
Female	115,776	2,978,409	3.9%
Male	147,791	3,053,881	4.8%

Engagement: measured by Service Penetration Rates for those Receiving at least 5 or more Services/Year in CA

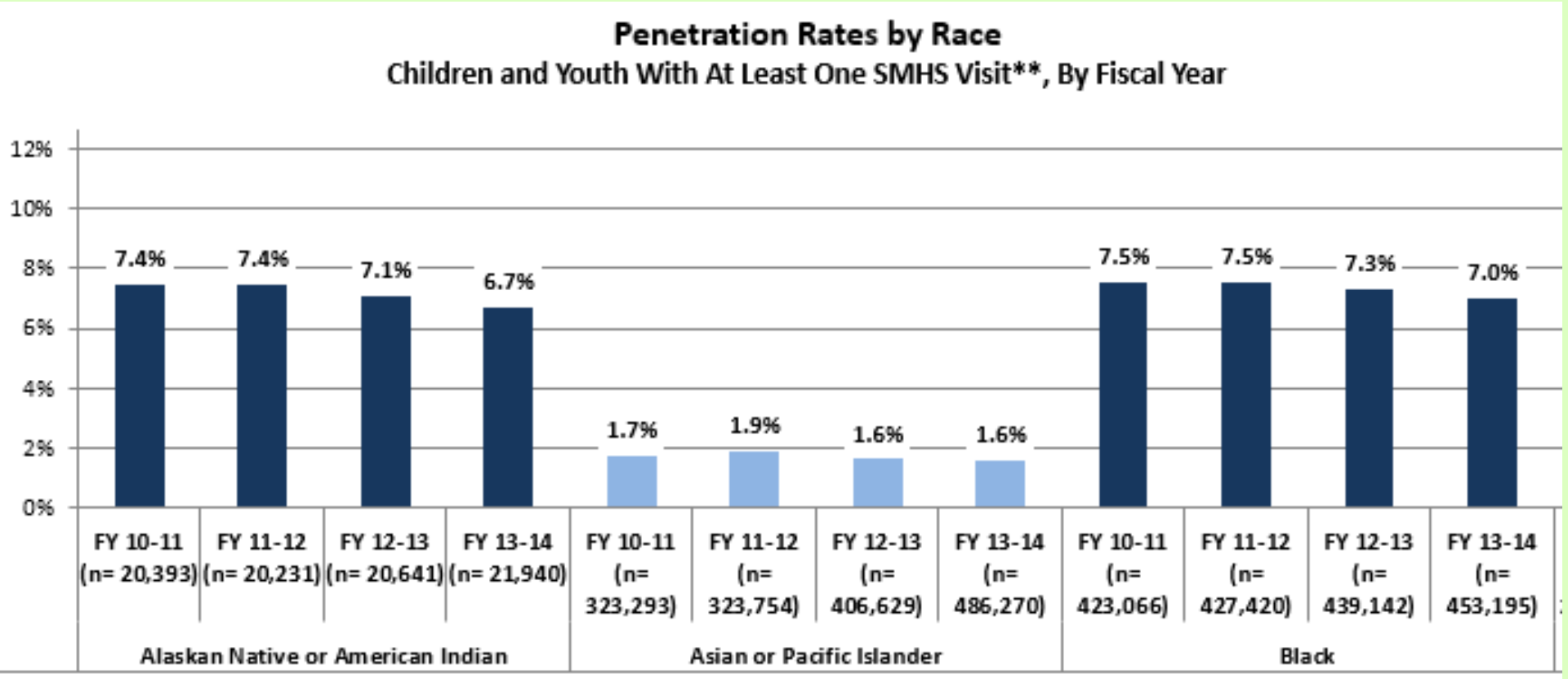
- Statewide Data for Child/Youth, FY 2013-2014: Five or More Visits/Year

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**202,070**	**6,032,290**	**3.3%**
Children 0-5	21,735	1,889,338	1.2%
Children 6-11	71,912	1,758,991	4.1%
Children 12-17	87,255	1,554,966	5.6%
Youth 18-20	21,168	828,995	2.6%
Alaskan Native or American Indian	1,075	21,940	4.9%
Asian or Pacific Islander	5,845	486,270	1.2%
Black	24,264	453,195	5.4%
Hispanic	102,031	3,440,659	3.0%
White	50,714	925,679	5.5%
Other	4,195	214,444	2.0%
Unknown	13,946	490,103	2.8%
Female	87,831	2,978,409	2.9%
Male	114,239	3,053,881	3.7%

California Mental Health Planning Council

Changes over Time of Penetration Rates by Race in CA

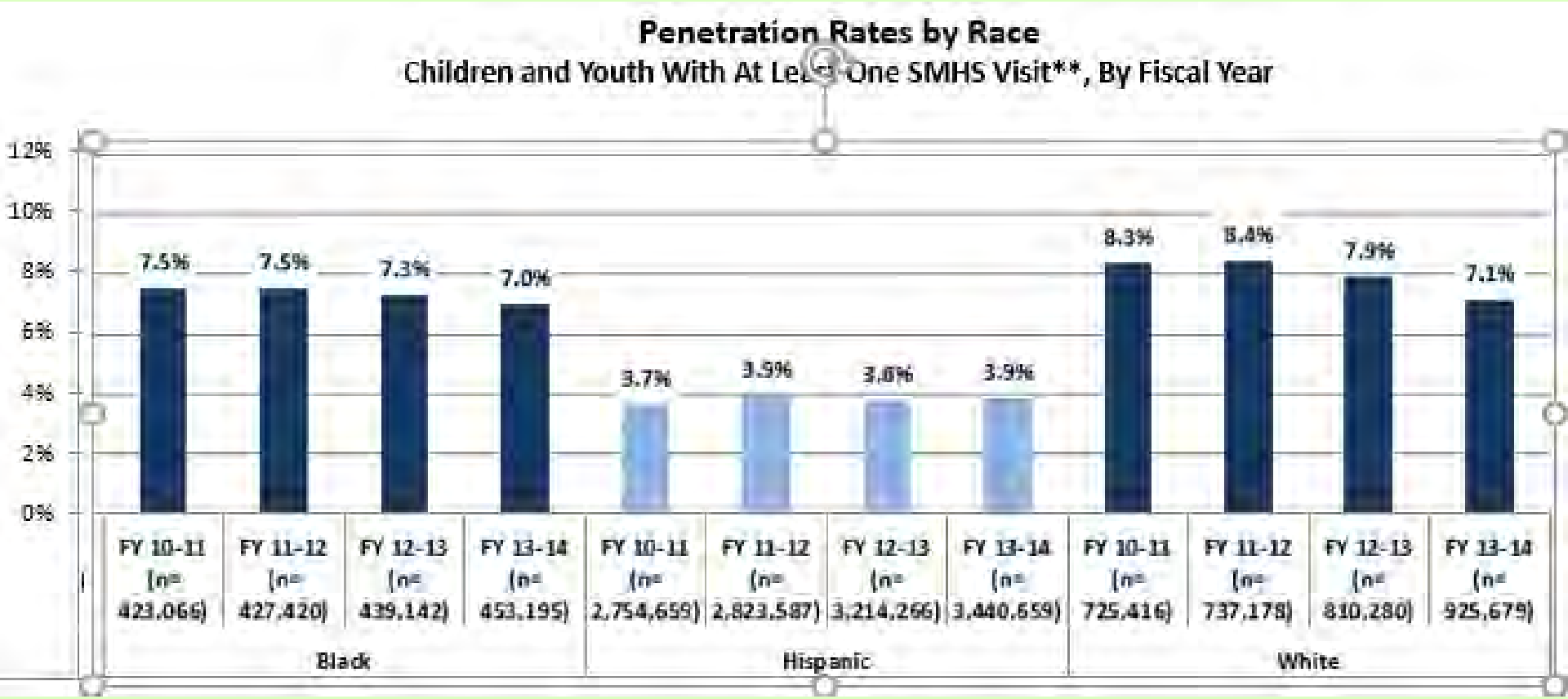
Data, Part 1:



California Mental Health Planning Council

Changes over Time of Penetration Rates by Race in CA

Data, Part 2:



Access: Timely Follow-up Services after Child/Youth Hospitalization

- **QUESTION 2A:**

  Do you think your county is doing an effective job providing timely follow-up services after a child or youth is discharged from a mental health hospitalization? Yes ___ No____.

  If no, please describe your concerns or recommendations briefly.

  QUESTION 2B:

  After a hospitalization or MH crisis, what are the main strategies used to engage and ensure prompt follow-up for outpatient care in transition-aged youth? Please list briefly.

  QUESTION 2C:

  What are the main strategies used to help parents/caregivers of children access care promptly after a child's hospitalization or other mental health crisis? Please list briefly.

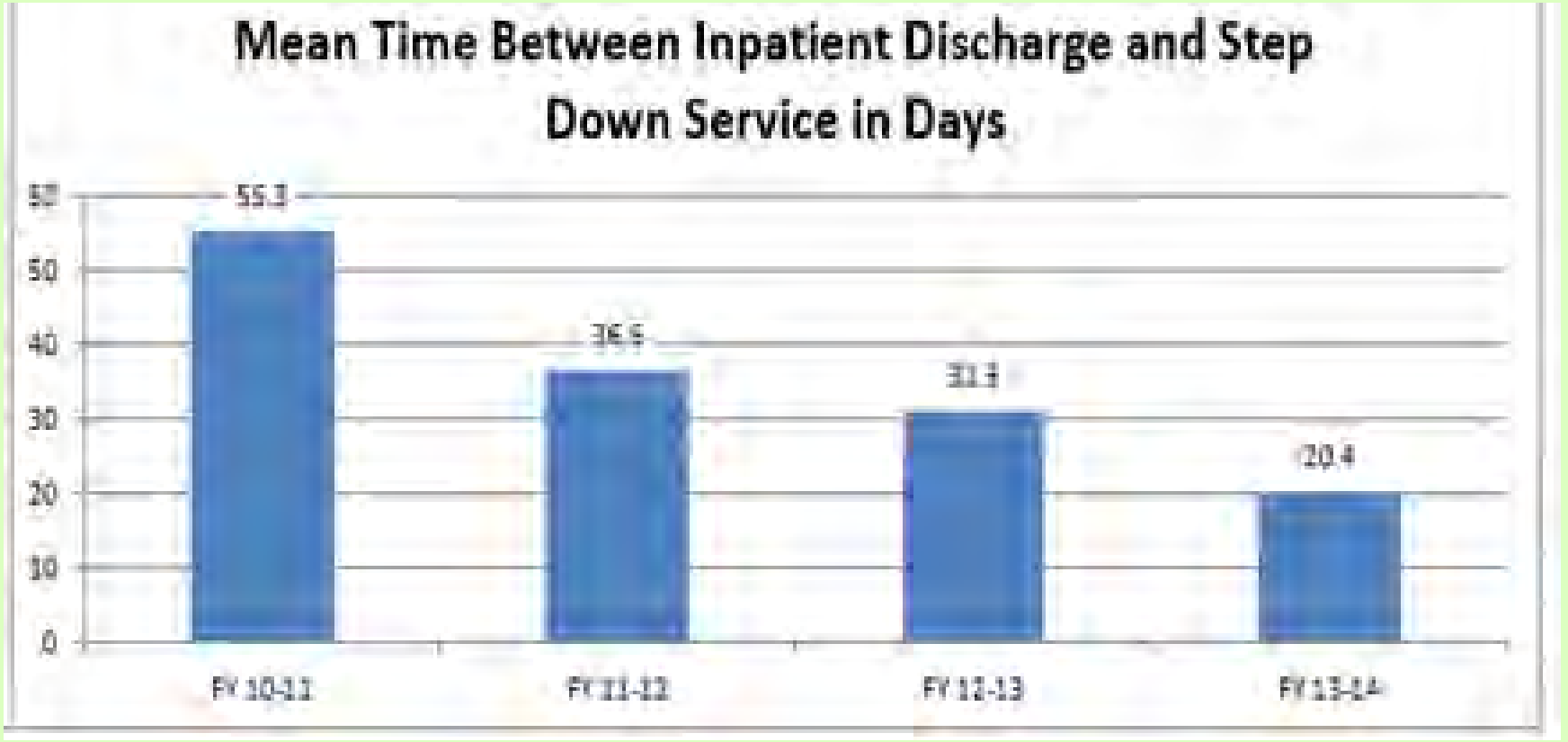
  QUESTION 2D:

  The follow-up data shown are based on services billed to Medi-Cal. Please list some non-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH crisis.

California Mental Health Planning Council

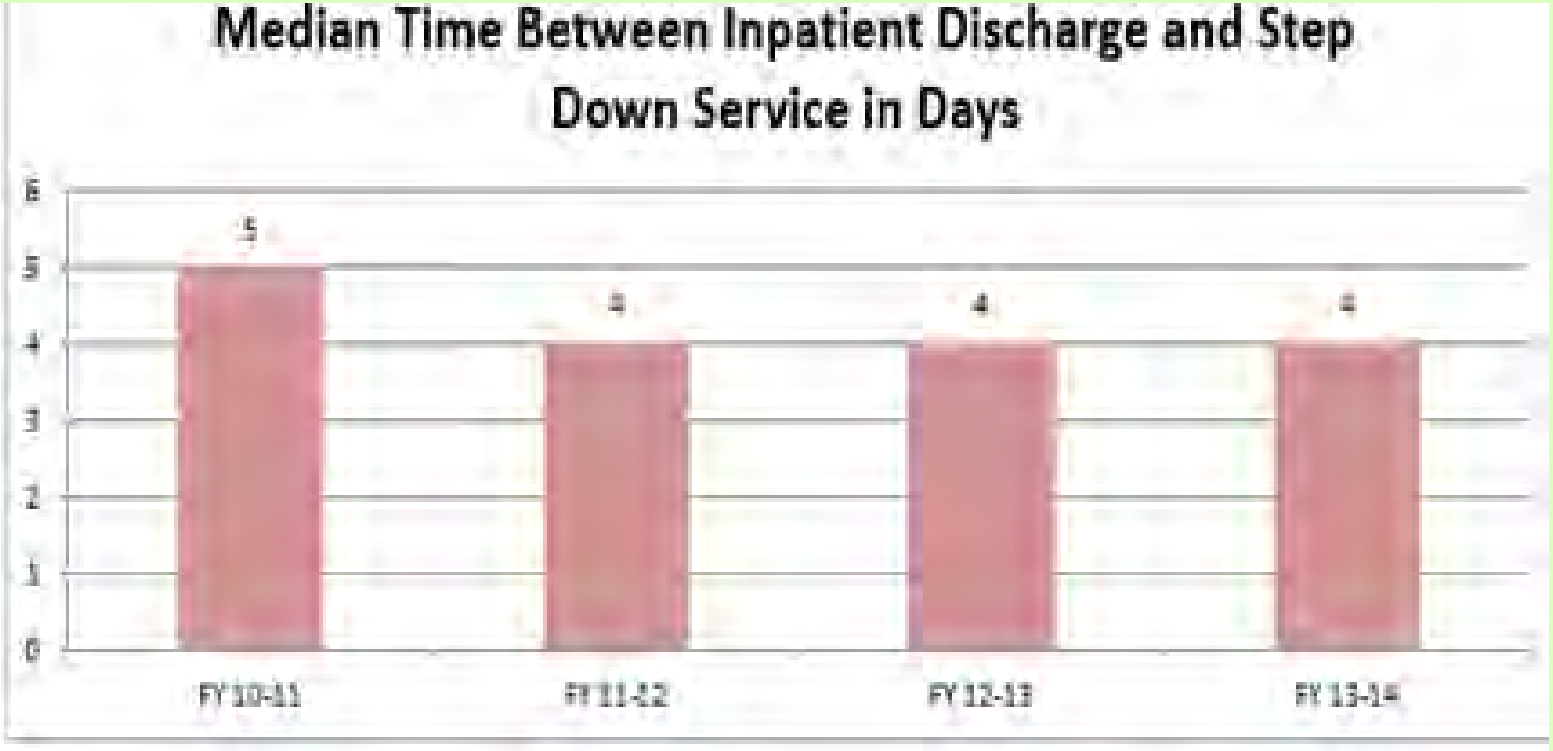
Average Time Between Discharge and Follow-up Services

Your County: Los Angeles



Median Time Between Discharge and Follow-up Services

- Your County: Los Angeles
- “Median” time may be a more realistic indicator for most clients of how long it takes to get follow-up services after discharge from the hospital.



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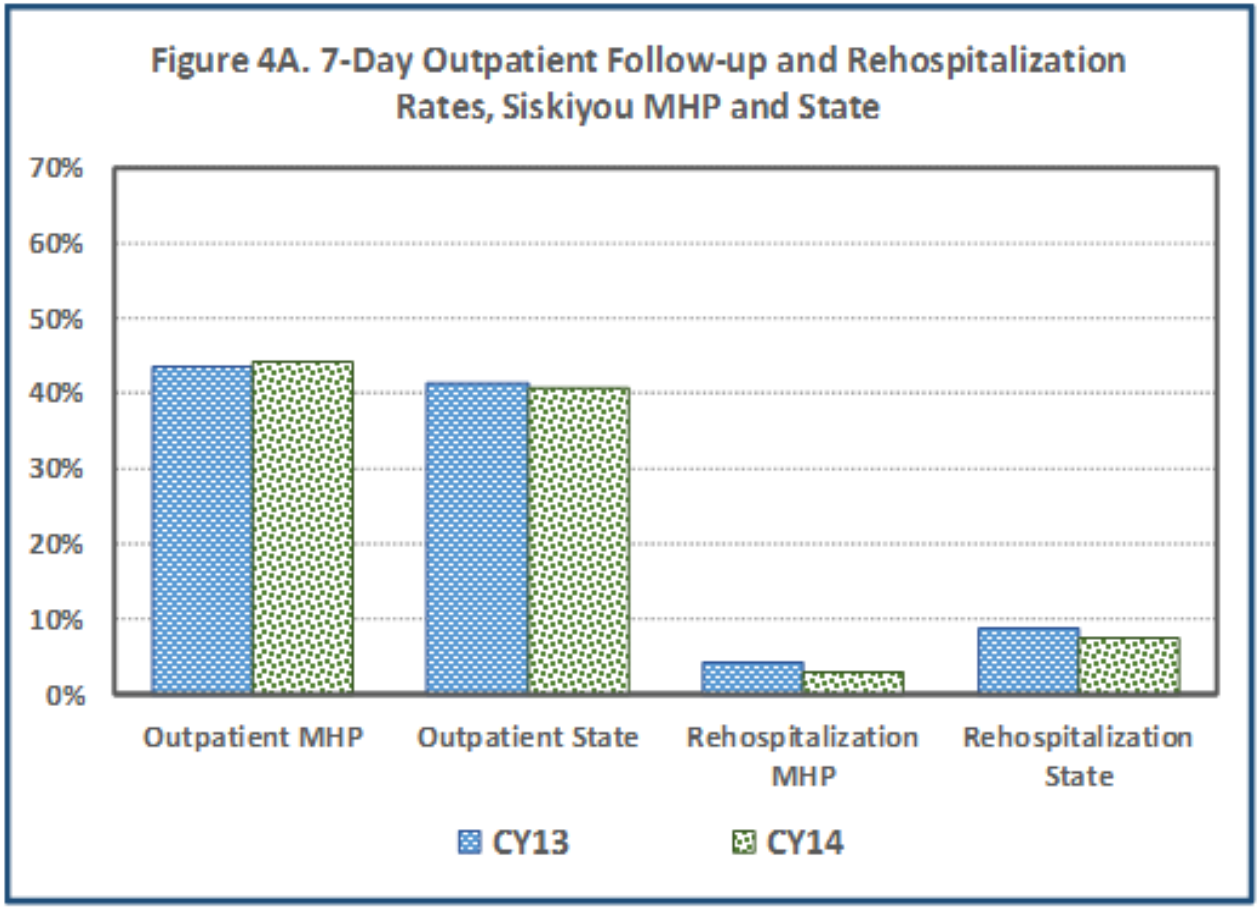
Federal QI Measure of Follow-up Services 7 Days after Discharge

Siskiyou County, CY 2013 and CY 2014 (All age groups, CALEQRO)

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE



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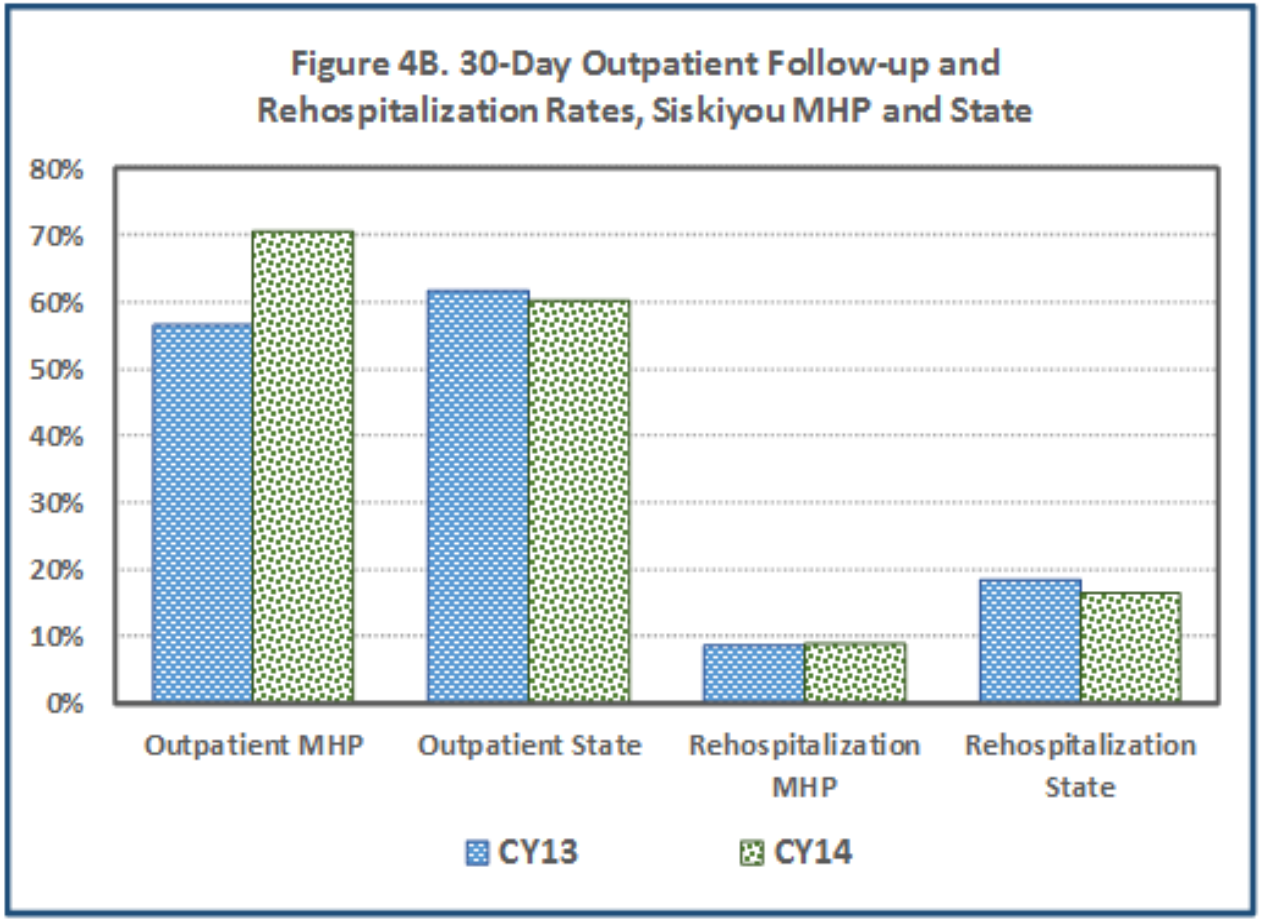
Federal QI Measure of Follow-up Services 30 days after Discharge

Siskiyou County, CY 2013 and CY 2014 (All age groups, CALEQRO)

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE



California Mental Health Planning Council

Any Questions ?

California Mental Health Planning Council

Foster Children and Youth Mental Health Needs

- **QUESTION 3A:**

  What major strategies are used in your county to provide mental health services as a priority for foster youth?

  Please list or describe briefly.

  QUESTION 3B:

  Do you think that your county does a good job of coordinating with your county department of social services or child welfare to meet the MH needs of foster care children and youth?

  Yes____ No____. If no, please explain briefly.

  QUESTION 3C:

  Do you have any comments or suggestions about strategies used to engage foster youth and provide mental health services?

  Yes___ No____. If yes, please list or describe briefly.

California Mental Health Planning Council

How Many Foster Youth Received Specialty Mental Health Services?

Figure 5. Percentages of Foster Youth Who Received Specialty MH Services

Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2011, 2012, and 2013. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

California Mental Health Planning Council

Lesbian, Gay, Bisexual, Transgender and Questioning Youth

- **QUESTION 4A:**

  Does your county have programs which are designed and directed specifically to LGBTQ youth? ___ Yes ___ No.

  If yes, please list and describe briefly.

  QUESTION 4B

  Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes___ No____.

  If yes, please list or describe briefly.

  QUESTION 4C:

  Do you have any comments or suggestions about services or how to address unmet needs for LGBTQ youth in your community?

  Yes___ No____. If yes, please list or describe briefly.

California Mental Health Planning Council

Children and Youth with Substance Use Disorders

QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Y____ N____

If yes, please list or describe briefly.

If no, what is the alternative in your county?

QUESTION 5B:

Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes___ No___.

Please explain briefly.

Youth that Began Treatment for Substance Use Disorders FY 2013-14

.

Numbers of Youth that Began Substance Use Disorder Treatment, FY 2013-2014

California: Statewide

Age < 18: 14,957 **Age 18-25: 23,614**

Your County: Los Angeles

Age <18: 4,592 **Age 18-25: 5,089**

Justice System-Involved Youth with Behavioral Health Needs

QUESTION 6A:

Does your county provide mental health or substance use disorder treatment services or programs to justice system-involved juveniles while they are still in custody? Yes___ No___.

If yes, please list briefly. Please indicate (if available) the main funding[30] sources for these programs.

QUESTION 6B:

Are the mental health and substance use services provided to non-custodial youth involved with probation or diversion programs different from those services provided to youth in the general community? Yes___ No___

If yes, please list briefly. Please indicate (if available) the main funding source for these programs/services.

QUESTION 6C:

Do any of these programs engage the parents/guardians of juveniles involved with the justice system?

Yes___ No___. If yes, please list briefly.

California Mental Health Planning Council

Numbers of Youth Involved in Justice System

Table 3. Numbers[27] and Types of Juvenile Arrests, California, 2014

Total population[28] age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

For state of California: 27,651 juvenile felony arrests, 2014.

For your county: Los Angeles 6,906 juvenile felony arrests, 2014.

California Mental Health Planning Council

Prevention of Suicide, Attempts at Suicide, and Thinking About It

- **QUESTION 7A:**

  Does your county have programs that are specifically targeted at preventing suicides in children and youth under 16 (ages 6-16) in your community?

  Yes____ No_____ If yes, please list and describe very briefly.

  QUESTION 7B:

  Does your county have programs that are specifically targeted at preventing suicides in transition aged youth (ages 16-25) in your community?

  Yes____ No_____ If yes, please list and describe very briefly.

  QUESTION 7C:

  Do you have any further comments or suggestions regarding local suicide reduction/prevention programs?

  Yes____ No_____. If yes, please list briefly.

California Mental Health Planning Council

Thoughts of Suicide: an Early Indicator of Youth at Risk

Survey data (below) show the percentage of public high school students who reported seriously considering attempting suicide in the prior 12 months in California. [37]

Table 5. Public High School Students Reporting Thoughts of Suicide, 2011-2013

California	Percent	
Grade Level	Yes	No
9th Grade	19.3%	80.7%
11th Grade	17.5%	82.5%
Non-Traditional	19.4%	80.6%
All	18.5%	81.5%

Data from your county are shown on the next page (if available).[38] Some counties or school districts either did not administer the surveys or else did not report their results.

Risks for First-Break Psychosis and Its Prevention

- **QUESTION 8A:**

  Does your county have services or programs targeted for first break psychosis in children and youth, and transition aged youth (TAY)?

  Yes_____No____

  QUESTION 8B:

  If yes, please list by age range(s) targeted and describe the program or services briefly. Also, please include the major funding source, (i.e., MHSA, SAMHSA Block Grant, Realignment I/II, Medi-Cal, etc), if the information is readily available.

  QUESTION 8C:

  Do you have any further comments or suggestions about local programs targeted for first break psychosis in children and youth?

  Yes_____No____. If yes, please describe briefly.

California Mental Health Planning Council

Full Service Partnership Programs for Children and Youth

- **QUESTION 9A:**

  What are the most urgent child or youth problems in your county? (For example, homelessness, problems with school or work, arrests, incarcerations, use of emergency MH services or psychiatric hospitalizations, out-of-home placements for children, substance abuse, teen pregnancy/parenting, etc.).

  QUESTION 9B:

  Do the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community?

  Question 9C:

  Do you have any other comments or recommendations regarding your local FSP programs or other types of "wrap-around" services?

  Yes ___ No___. If yes, please describe briefly.

FSP Outcomes Data for Children

- **Table 7. Children, ages 0-15.**

  N=5,335 completed at least 1 year of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 year	Change in Client Outcomes at 2 years
Mental Health Emergencies	89% ⇩	--
Psych. Hospitalizations	49% ⇩	--
Out-of-Home Placements	12% ⇩	--
Arrests	86% ⇩	--
Incarcerations	40% ⇩	--
Academic Performance	68% ⇧	--

California Mental Health Planning Council

FSP Outcomes Data for Transition-Age Youth

- **Table 8. Transition Age Youth (TAY) ages 16-25.**

  N= 4,779 completed at least 2 years of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 Year	Change in Client Outcomes at 2 years
Mental health emergencies	84% ⇩	86% ⇩
Psych. hospitalizations	41% ⇩	57% ⇩
Emergency shelter use	20% ⇩	53% ⇩
Arrests	81% ⇩	86% ⇩
Incarcerations	45% ⇩	49% ⇩

California Mental Health Planning Council

Final: Questionnaire about how you completed this Data Notebook

- Please review before starting work.

What process was used to complete this Data Notebook? Please check all that apply.

___ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

____MH Board completed majority of the Data Notebook

___ County staff and/or Director completed majority of the Data Notebook

___ Data Notebook placed on Agenda and discussed at Board meeting

___ MH Board work group or temporary ad hoc committee worked on it

___ MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

California Mental Health Planning Council

Any Questions ?

California Mental Health Planning Council

Thank you to contributors to our Data Notebook Project, 2013-2016

- Susan Wilson, Chair, Project Workgroup Chair (CMHPC)
- Jane Adcock, Executive Director, CMHPC
- Linda Dickerson, Ph.D. and other staff (CMHPC)
- Lorraine Flores (CMHPC)
- Karen Hart (CMHPC)
- Amy Eargle, Ph.D., CDCR (CMHPC)
- Monica Nepomuceno, CDE (CMHPC)
- Noel O'Neil (CMHPC) and other county BH directors
- MHSA Coordinators Committee (CBHDA)
- Adrienne Shilton, M.S. and Debbie Innes-Gomberg, Ph.D.
- Beryl Nielsen, CALMHB/C (Napa MHB)
- Herman Debose, Ph.D., CALMHB/C (Los Angeles MHB/C)
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Where to send your Data Notebook?

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Thank you for your participation!

California Mental Health Planning Council

- Break Time -

CONTRA COSTA COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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CONTRA COSTA COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2016): 1,123,429

Website for County Department of Mental Health (MH) or Behavioral Health:

www.cchealth.org

Website for Local County MH Data and Reports:

www.cchealth.org

Website for local MH Board/Commission Meeting Announcements and Reports:

www.cchealth.org/mentalhealth/mhc/

Specialty MH Data[1] from CY 2013: see MHP Reports folder at http://www.calegro.com/

Total number of persons receiving Medi-Cal in your county (2013): 200,963

Average number Medi-Cal eligible persons per month (2014): 192,684

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 47.3 %

Adults, 18 and over: 52.7 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 13,786

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 38.2 %

Adults, 18 and over: 61.8 %

[1] Downloaded from the website, www.calegro.com. If you have more recent data available, please feel free to update this section within current HIPAA compliant guidelines. CY = calendar year.

[2] Serious Mental Illness, term used for adults 18 and older.

[3] Severe Emotional Disorder, term used for children 17 and under.

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INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. For example, the topic for our 2016 Data Notebook reviews behavioral health services for children, youth, and transition age youth (TAY)[4].

Each year, mental health boards and commissions are required to review performance data for mental health services in their county. The local boards are required to report their findings to the California Mental Health Planning Council (CMHPC) every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information.

The Data Notebook is developed annually in a work group process with input from:

- the CA Mental Health Planning Council and staff members,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB),
- consultations with individual Mental Health Directors, and
- representatives of the County Behavioral Health Directors Association (CBHDA).

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates[5] to review performance data for their local county mental health services and report on performance every year,
- function as an educational resource on behavioral health data for local boards,
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

The Data Notebook is organized to provide data and solicit responses from the mental health board on specific topics so that the information can be readily analyzed by the CMHPC. These data are compiled by staff in a yearly report to inform policy makers, stakeholders and the general public. Recently, we analyzed all 50 Data Notebooks received in 2015 from the mental health boards and commissions. This information represented 52 counties[7] that comprised a geographic area containing 99% of this

[4] See various definitions of the age ranges for these groups depending on data source, Table 2, page 8.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W.I.C. 5772 (c), regarding annual reports from the California Mental Health Planning Council.
[7] Sutter and Yuba Counties are paired in one Mental Health Plan, as are Placer and Sierra Counties.

state's population. The analyses resulted in the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function. Data reporting provides evidence for advocacy and good public policy. In turn, policy drives funding for programs.

Resources: Where do We Get the Data?

The data and discussion for our review of behavioral health services for children, youth, and transition age youth (TAY) are organized in three main sections:

1) Access, engagement and post-hospitalization follow-up,
2) Vulnerable populations of youth with specialized mental health needs, and
3) Mental Health Services Act (MHSA) –funded[8] programs that help children and youth recover.

We customized each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide reference data are provided for comparison for some items. A few critical issues are highlighted by information from research reports. County data are taken from public sources including state agencies. For small population counties, special care must be taken to protect patient privacy; for example, by combining several counties' data together. Another strategy is "masking" (redaction) of data cells containing small numbers, which may be marked by an asterisk "*", or a carat "^", or LNE for "low number event."

Many questions request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. Basic information for that discussion may be obtained from local county departments of behavioral health or mental health.

This year we present information from California Department of Health Care Services (DHCS), information about some Mental Health Services Act (MHSA)-funded programs, and data from "KidsData.org," which aggregates data from many other agencies. These and other data resources are described in more detail in Table 1, below.

[8] Mental Health Services Act of 2004; also called Proposition 63.

Table 1. Who Produces the Data and What is Contained in these Resources?

CA DHCS: Child/Youth Mental Health Services Performance Outcomes System,[9] http://www.dhcs.ca.gov	Mental health services provided to Medi-Cal covered children/youth through age 20, as part of the federally defined EPSDT[10] benefits. Focuses on Specialty Mental Health Services for those with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI).
CA DHCS: Office of Applied Research and Analysis (OARA)	Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the "Cal-OMS" data system.
CA DOJ: Department of Justice yearly report on Juveniles. Data at: www.doj.ca.gov	Annual data for arrests of Juveniles (<18) for felonies, misdemeanors, and status offenses, with detailed analysis of data by age groups, gender, race/ethnicity, county of arrest, and disposition of cases.
External Quality Review Organization (EQRO), at www.CALEQRO.com	Annual evaluation of the data for services offered by each county's Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.
KidsData.Org, A Program of Lucile Packard Foundation for Children's Health, see www.KidsData.org	Collects national, state, and county statistics. CA data are from DHCS, Depts. Of Public Health, Education, and Justice, Office of Statewide Health Planning and Development, "West-Ed," and others.
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: National Survey on Drug Use and Health (NSDUH), which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.
County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the "Measures Outcomes and Quality Assessment" (MOQA) database.

[9] See recent reports at: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

[10] EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

How Do the Data Sources Define Children and Youth?

Although it may be common to refer broadly to children and youth collectively as "youth," discussions of data require precise definitions which may differ depending on the information source and its purpose. For example, "minor children," also called juveniles, are defined by the legal system as those under the age of 18. Others may define subcategories by age to describe psychological or biological[11] stages of development. Many systems are based on requirements for state reports to the federal government. Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the various public data sources that are available to us.

Table 2. Categories used by Different Data Resources for Children and Youth

Category	EPSDT MH Services	CA EQRO	MHSA Programs	JUSTICE System	SMHSA, NSDUH, Federal datasets
Children (or Juveniles)	0-5	0-5	0-15	0-17	
	6-11	6-17	--	--	6-11
	12-17 (Youth or 'Teens')	--	--	--	12-17
Adults	18-20	>18	(varies)	>18	>18
Transition Age Youth (TAY)	N/A[12]	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

[11] Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.
[12] N/A means not applicable, because this category is not available under this system or data source.

How Can Local Advisory Boards Fulfill their Reporting Mandates?

What are the reporting roles mandated for the mental health/behavioral health boards and commissions? These requirements are defined in law by the state of California.

Welfare and Institutions Code, Section 5604.2 (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 Section 5650.

(3) Advise the governing body and the local mental health director as 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 a mental health board.

The structured format and questions in the Data Notebook are designed to assist local advisory boards to fulfill their state mandates, review their data, report on county mental health programs, identify unmet needs, and make recommendations. We encourage all local boards to review this Data Notebook and to participate in the development of responses. It is an opportunity for the local board and their supporting public mental health departments to work together on the issues presented in the Data Notebook.

This year we present information about important topics for children and youth. Each section is anchored in data for a current topic, followed by discussion questions. A final open-ended question asks about *"any additional comments or suggestions you may have."* Ideas could include a program's successes or strengths, changes or improvements in services, or a critical need for new program resources or facilities. Please address whatever is most important at this time to your local board and stakeholders and that also may help inform your county leadership.

We were very impressed with the level of participation in 2015, having received 50 Data Notebooks that represent data from 52 counties. Several examples of good and even exemplary strategies were evident in these reports. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff to produce the Data Notebook. In several counties, the responses were developed by an *ad hoc* committee or special work group of the local board and staff and then presented to the local board for approval. In other counties, the responses in the Data Notebook were developed by staff and presented to the local boards for approval. In a few counties, responses were prepared by staff and submitted directly to the CMHPC.

In an August 25, 2015 letter, the County Behavioral Health Directors Association (CBHDA) endorsed the expectation that "the process of gathering this data should be collaborative between the Advisory Boards and the Mental Health Plans (MHPs)." They also stated that "then the process would be more natural to the actual dynamic that exists in the counties." The California Mental Health Planning Council fully supports these statements and finds them consistent with the spirit and intent of the statutes.

This year we encourage every local board to look at and participate in developing the responses to questions outlined in the Data Notebook. We hope this Data Notebook serves as a spring-board for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

The final page of this document contains a questionnaire asking about the strategies you employ to complete this year's Data Notebook. Please review these in advance, before beginning this work.

Thank you very much for participating in this project.

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ACCESS TO SERVICES: Youth, Children, and their Families/Caregivers

Access: Outreach and Engagement with Services

One goal of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color and LGBTQ[13] youth. If children, youth or their families are not accessing services, we may need to change our programs to meet their mental health needs in ways that better complement their culture or language needs. These values also guide the county mental health plans that provide specialty mental health services (SMHS). These services are intended for those with serious emotional disorders (SED) or serious mental illness (SMI).

As you examine data on the following pages, consider whether your county is serving all of the children and youth who need specialty mental health services. The standard data collected does not provide much detail about all the cultural groups that live in each county. The rich diversity of California can present challenges in providing services in a culturally and linguistically appropriate manner, as we have residents with family or ancestors from nearly every country.

From data the counties report to the state, we can see how many children and youth living in your county are eligible for Medi-Cal and how many of those individuals received one or more visits for mental health services. There are several ways to measure service outreach and engagement that help us evaluate how different groups are doing in their efforts to obtain mental health care.

The simplest way to examine the demographics of a service population is to look at "pie chart" figures which show the percentage of services provided to each group in your county. Figure 1 on the top half of the next page shows the percentages of children and youth from each major race/ethnicity group who received one or more SMHS visits during the fiscal year (FY). The lower half of the figure shows the percentage of each age group that received specialty mental health services (SMHS, in the graphs and tables). The gender distribution is not shown because it is fairly stable year over year across the state as a whole: about 45% of service recipients are female and about 55% of recipients are male.

Following Figure 1, more detailed data are shown in Figures 2 and 3, describing the Medi-Cal eligible population of children and youth, the percentages of each group that received specialty mental health services, and changes in those numbers over time for the fiscal years 2010-2011 through 2013-2014.

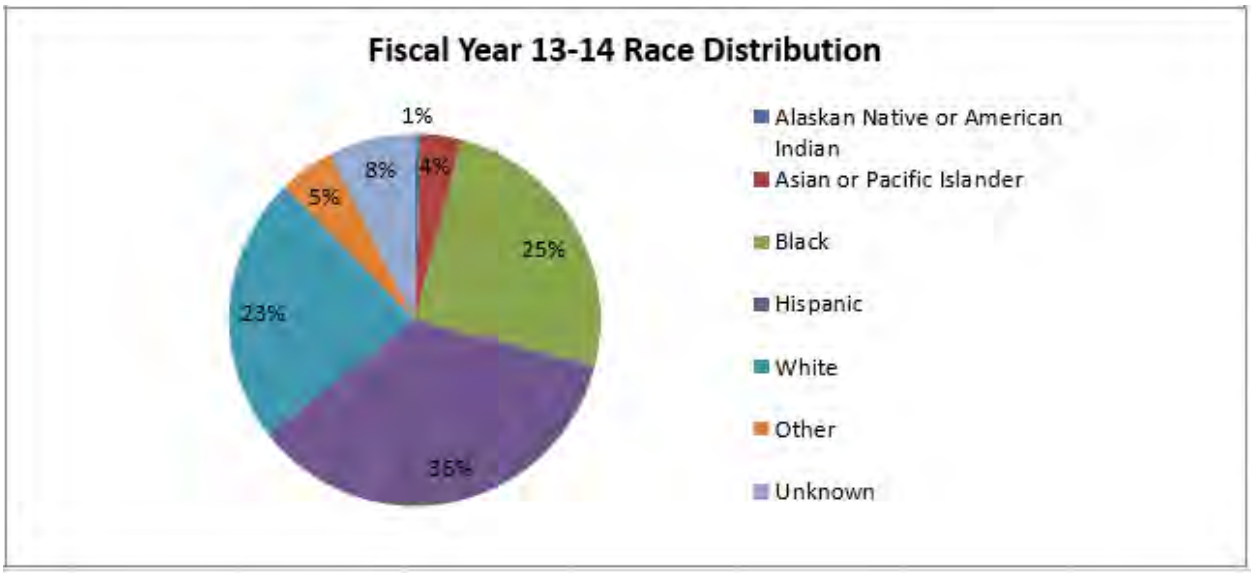
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

Figure 1. Demographics for Your County: Contra Costa (FY 2013-2014)

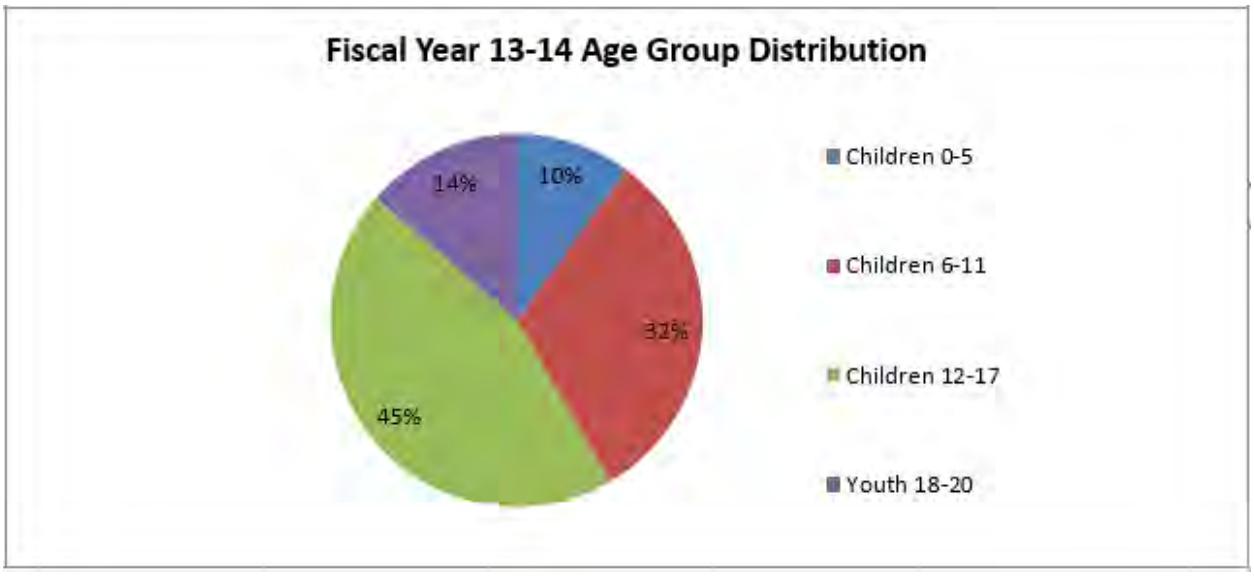
Unique numbers of children and youth who were Medi-Cal eligible: **112,499**

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **5,964**.

Top: Major race/ethnicity groupings of children and youth who received one or more specialty mental health services during the fiscal year.



Below: Age groups of children and youth who received one or more specialty mental health services.



Client access and engagement in services is a complex issue and is somewhat difficult to measure. One way to measure client engagement is "penetration rates." Service penetration rates measure an individual's initial access and engagement in services provided by the local mental health plan. Figure 2 on the next page shows data that illustrate two common ways to measure penetration rates:

- One way is to count how many children and youth came in for at least one service during the year, as shown in the data in the top half of figure 2. These data may provide information about outreach and at least initial access to services for child/youth clients of different ages and race/ethnicity groups.

- Another way to measure the penetration rate is to consider how many had sustained access to services for at least five or more visits, as shown in the data in the lower half of figure 2. This is sometimes referred to as the "retention rate." This measure is often used as a proxy (or substitute) for client engagement. Here, we measure how many came in for five or more services during the year.

Figure 2: in the table at the top of the page, the first column of numbers show how many children/youth received at least one specialty mental health service. The second column shows the number who were certified Medi-Cal eligible in each group. The final column at the right shows service penetration rates, which are calculated by dividing the number who received services by the total number who were Medi-Cal eligible.

The second table of Figure 2 shows data for those with more sustained engagement in accessing services. The first column of numbers show how many children/youth received five or more services during the fiscal year. The middle column, showing numbers who were Medi-Cal eligible, is identical to the middle column in table in the upper half of the page. The column at the far right shows the percentage in each group who received five or more services. Clearly, these numbers are much smaller than the corresponding rates in the data table shown above.

Figure 3 on the subsequent page shows a set of bar graphs: these graphs show changes over four fiscal years in service penetration rates by race/ethnicity, for children and youth who had at least one visit for services. Each group of bars shows the changes over time for one major race/ethnicity group. The final bar in each group illustrates the time point for FY 2013-2014 that was presented in more detail in figure 2. The "take home story" of figure 3 is the overall trend leading up to the most recent year's data. Please note that these data show the trends that occurred in the years following passage of the Affordable Care Act (2010).

Figure 2. Data Tables for SMHS Visits and Service Penetration Rates
Your County: Contra Costa (FY 2013-2014):

Top: Children and youth who received at least one specialty MH service during year.

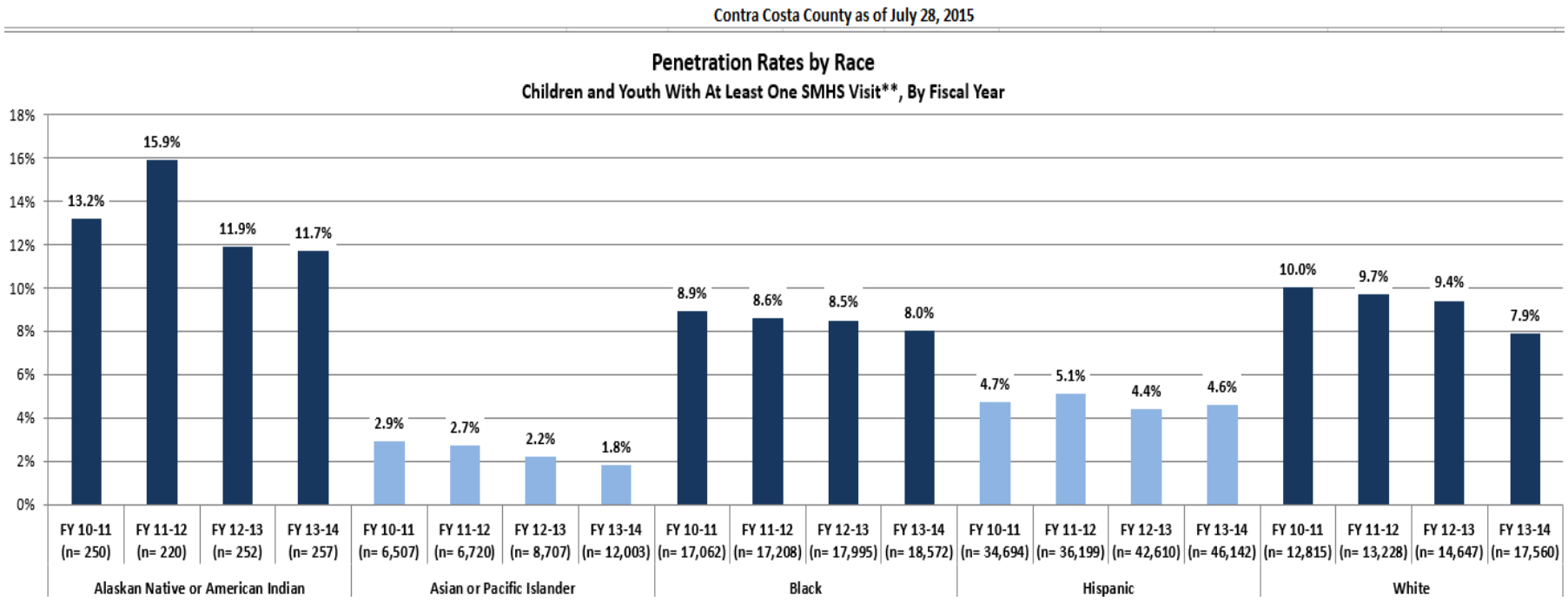
	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**5,964**	**112,499**	**5.3%**
Children 0-5	605	34,866	1.7%
Children 6-11	1,877	33,489	5.6%
Children 12-17	2,669	29,095	9.2%
Youth 18-20	813	15,049	5.4%
Alaskan Native or American Indian	30	257	11.7%
Asian or Pacific Islander	217	12,003	1.8%
Black	1,484	18,572	8.0%
Hispanic	2,117	46,142	4.6%
White	1,384	17,560	7.9%
Other	284	11,585	2.5%
Unknown	448	6,380	7.0%
Female	2,769	55,667	5.0%
Male	3,195	56,832	5.6%

Below: Children and youth who received five or more specialty MH services during year.

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**4,863**	**112,499**	**4.3%**
Children 0-5	509	34,866	1.5%
Children 6-11	1,612	33,489	4.8%
Children 12-17	2,188	29,095	7.5%
Youth 18-20	554	15,049	3.7%
Alaskan Native or American Indian	24	257	9.3%
Asian or Pacific Islander	170	12,003	1.4%
Black	1,201	18,572	6.5%
Hispanic	1,781	46,142	3.9%
White	1,094	17,560	6.2%
Other	215	11,585	1.9%
Unknown	378	6,380	5.9%
Female	2,234	55,667	4.0%
Male	2,629	56,832	4.6%

Figure 3. Changes Over Time in Service Penetration Rates by Race/Ethnicity, for Children/Youth with at Least One Specialty Mental Health Service During Fiscal Year. (FY 10-11 through FY 13-14).

Your County: Contra Costa



Understanding the changes observed above should take into account the expansion of the total Medi-Cal eligible population, which resulted in a statewide increase of nearly 12% in FY12-13 relative to the previous year. The expansion occurred in stages during 2011 to 2013 as the state began to implement the changes mandated in the federal Affordable Care Act (2010). Families with incomes up to 138% of the federal poverty level became eligible for Medi-Cal. Also, children and families previously enrolled in "CHIP," federal Children's Health Insurance Program transitioned to Medi-Cal.

Please consider the following discussion items after examining the data above regarding access and engagement in mental health services.

QUESTION 1A:

Do you think the county is doing an effective job providing access and engagement for children and youth in all of your communities?

Yes ___ No____. If yes, what strategies seem to work well?

QUESTION 1B:

What strategies are directed specifically towards outreach and engagement of transition-aged youth in your county? Please list or describe briefly.

QUESTION 1C:

Do you have any recommendations to improve outreach or services to specific ethnic or cultural groups of adolescents or transition-aged youth?

Yes ___ No____. If yes, please list briefly.

QUESTION 1D:

What are your main strategies for assisting parents/caregivers of children with mental health needs? Please list or describe briefly.

Access: Timely Follow-up Services after Child/Youth Psychiatric Hospitalization

The goals of timely follow-up services after psychiatric hospitalization are to promote sustained recovery and to prevent a relapse that could lead to another hospitalization. Children and youth vary greatly in their path to recovery. Sometimes a subsequent hospitalization is needed in spite of the best efforts of the healthcare providers, parents/caregivers, and the clients themselves.

"Step-down" is a term used by some mental health care professionals to describe a patient's treatment as "stepping down" from a higher level of care intensity to a lower level of care, such as outpatient care. Another example of step-down is when a hospital patient is transferred to crisis residential care or day treatment for further stabilization to promote a smoother transition to outpatient care.

Figure 4 on the next page shows data for the overall population of children and youth under the age of 21 who were discharged from a psychiatric hospitalization. In the upper half of the figure are data showing trends from one fiscal year to the next. The columns in this table show the overall percentages of clients with follow-up services within 7 days and those who received such services within 30 days. These time frames reflect important federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries.

The lower half of Figure 4 shows graphs of the median and mean (average) times for outpatient follow-up (stepdown) services following discharge from child/youth psychiatric hospitalization. These are two important measures that can be used to evaluate whether timely follow-up services are provided. But, because some clients do not return for outpatient services for a very long time (or refused, or moved), their data affects the overall average (mean) times in a misleading way due to the large values for those "outliers." Instead, the use of median values is a more reliable measure of how well the county is doing to provide follow-up services after a hospitalization.

A related concern includes how we help children and youth handle a crisis so that hospitalization can be avoided. Although we do not have data for mental health crises, similar follow-up care and strategies are likely to be employed. Your local board may have reviewed the range of crisis services needed and/or provided in your community for children and youth. Many counties have identified their needs for such programs or facilities to provide crisis-related services.[14]

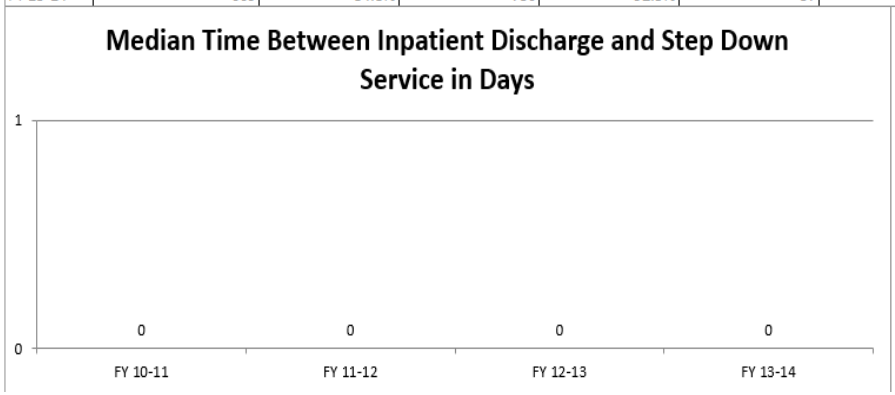
[14] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

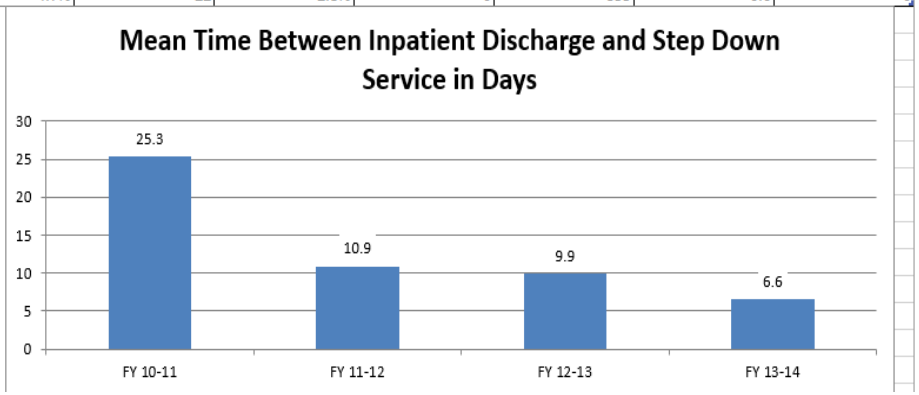
Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization. (2010-2014).

Your County: Contra Costa

Contra Costa County as of July 28, 2015

Service FY	Count of Inpatient Discharges with Step Down within 7 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 7 Days of Discharge	Count of Inpatient Discharges with Step Down within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 Days of Discharge	Count of Inpatient Discharges with a Step Down > 30 Days from Discharge	Percentage of Inpatient Discharges with a Step Down > 30 Days from Discharge	Count of Inpatient Discharges with No Step Down**	Percentage of Inpatient Discharges with No Step Down	Minimum Number of Days between Discharge and Step Down	Maximum Number of Days between Discharge and Step Down	Mean Time to Next Contact Post Inpatient Discharge (Days)	Median Time to Next Contact Post Inpatient Discharge (Days)
FY 10-11	511	74.3%	581	84.4%	91	13.2%	16	2.3%	0	1599	25.3	0
FY 11-12	515	92.0%	538	96.1%	^	^	^	^	0	1057	10.9	0
FY 12-13	617	87.4%	654	92.6%	37	5.2%	15	2.1%	0	703	9.9	0
FY 13-14	669	84.8%	730	92.5%	37	4.7%	22	2.8%	0	355	6.6	0





When examining the post-hospitalization data above, take special note of the percentages who received follow-up services within 7 days after discharge, within 30 days after discharge, or later than 30 days. These time frames reflect federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries. On lower left side graph, the median time for follow-up is the most useful measure of this outcome. Zero days would indicate that clients were seen as outpatients on the same day as the hospital discharge. Also take note of mean time (average) from discharge to step-down services (right side graph).

^ = Data redacted due to small numbers and HIPAA and privacy regulations.

QUESTION 2A:

Do you think your county is doing an effective job providing timely follow-up services after a child or youth is discharged from a mental health hospitalization? Yes ___ No____.

If no, please describe your concerns or recommendations briefly.

QUESTION 2B:

After a hospitalization or MH crisis, what are the main strategies used to engage and ensure prompt follow-up for outpatient care in transition-aged youth? Please list briefly.

QUESTION 2C:

What are the main strategies used to help parents/caregivers of children access care promptly after a child's hospitalization or other mental health crisis? Please list briefly.

QUESTION 2D:

The follow-up data shown above are based on services billed to Medi-Cal. As a result, those data do not capture follow-up services supported by other funding sources. Examples may include post-hospitalization transportation back to the county, contact with a Peer/Family Advocate, or MHSA-based services.

Please list some non-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH crisis.

VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

Foster Children and Youth

Foster children and youth comprise a vulnerable group that faces considerable life challenges. Mental health consequences may result from the traumatic experiences which led to their placement in foster care. Foster children and youth are just 1.3 % of all Medi-Cal eligible children and youth (ages 0-20). However, they represent 13 % of the total children and youth who received Specialty Mental Health Services (SMHS) in one year (FY 2013 – 2014). SMHS are services provided to children and youth with serious emotional disorders (SED) or to adults with serious mental illness (SMI). These mental health challenges affect outcomes in all aspects of their lives as has been described in recent studies[15,16] of foster youth in California schools:

The key findings for California foster youth included:

- **Time in Foster Care –** More than 43,000 (or about one of every 150 K-12) public-school students in California spent some period of time in child welfare supervised foster care.
- **Reason for Removal –** Of students in foster care, 78% were removed from birth families due to neglect, 11% physical abuse; 4% sexual abuse; and 7% other reasons.
- **Grade Levels –** Of these students in foster care, 40% were in Elementary School; 23% were in Middle School; and 36% were in High School.
- **An At-risk Subgroup –** Nearly one in five students in foster care had a disability compared to 7% of all K-12 students and 8% low socioeconomic status (SES) students.
- **School Mobility –** Among students who had been in foster care for less than one year, 48% had changed schools during the academic year.
- **Achievement Gap –** Proficiency in English language arts for students in foster care was negatively correlated with grade level.
- **Drop-out and Graduation –** Students with three or more placements were more than twice as likely to drop out as students with one placement, although this single-year dropout rate is still twice as high as that for low SES students and for K-12 students.

Conclusion: Students in foster care constitute an at-risk subgroup that is distinct from low socioeconomic status students regardless of the characteristics of their foster care experience.

[15]The Invisible Achievement Gap, Part 1. Education Outcomes of Students in Foster Care in California's Public Schools. http://stuartfoundation.org/wp-content/uploads/2016/04/the-invisible-achievement-gap-report.pdf. Also see: Child Welfare Council Report, 2014-2015 for more source material, at: http://www.chhs.ca.gov/Child%20Welfare/CWC%202105%20Report-Approved090215.pdf.

[16] The Invisible Achievement Gap, Part 2. How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. http://stuartfoundation.org/wp-content/uploads/2016/04/IAGpart2.pdf

As they reach adulthood, most foster youth will need continuity of care through Medi-Cal for services to promote mental health, independence, and connections within the community, including housing supports to avoid homelessness. Homelessness is a common outcome for foster youth who leave the system without either re-unification to their family of origin or an attachment to a permanent family.

One subgroup of foster youth has been referred to as "Katie A Subclass members," due to a lawsuit filed in federal court regarding their need for certain types of more intensive mental health services. The services included under the 2011 court settlement order are intensive home-based services, intensive care coordination, and therapeutic foster care. More recently, DHCS recognized that other children and youth also have a right to receive such services if there is a medical necessity.

The complex needs and large numbers statewide present challenges to the foster care and mental health systems. The numbers of foster youth who are receiving Specialty Mental Health Services are shown below. These data do not include those with mild to moderate mental health needs who are served in the Medi-Cal Managed Care System. Also, these data do not reflect those with disabilities who are served through school-based mental health services as part of an "Individual Educational Plan."

HOW MANY FOSTER CHILDREN AND YOUTH RECEIVE SPECIALTY MENTAL HEALTH SERVICES,[*] INCLUDING "KATIE A" SERVICES?

Statewide: (FY 2013-2014) Certified Medi-Cal eligible Foster Care Youth (age 0-20): **77,405.**

- Total Number of Medi-Cal Foster Youth who received at least one Specialty MH Service: **34,353** (service penetration rate is 44.3 %).
- Total Medi-Cal Eligible Foster Care Youth who received five or more Specialty MH Services: **26,692**.

Statewide: (FY 2014-2015) Total Unique Katie A. Subclass Members: **14,927**

- Members who received In-Home Behavioral Services: **7,466**
- Those who received Intensive Case Coordination: **9,667**
- Those who received Case Management/Brokerage: **9,077**
- Received Crisis Intervention Services: **523**
- Received Medication Support Services: **3,293**
- Received Mental Health Services: **12,435**
- Received Day Rehabilitation: **285**
- Received Day Treatment Intensive service: **63**
- Received Hospital Inpatient treatment: **19**
- Received Psychiatric Health Facility treatment: **41**
- Therapeutic Foster Care: Data not yet available.

[*] Data reports are from: http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx. The data are for fiscal years 2014 or 2015 (depending on which data are the most recent available at the time of this report).

Next, the figure below shows the percentage of foster children under 18 who received specialty mental health services. Note the trends year-to-year for your county and the comparisons to counties with populations of similar size and to the state.

There may be several explanations possible for any observed differences. For example, some counties find it necessary to place a significant number of foster youth out-of-county in order to find specialized services or the most appropriate and safe living situation.

Another explanation is that the recent expansion of Medi-Cal markedly increased the total numbers eligible for coverage. More children and youth are now eligible to receive specialty mental health services. Even if there was an increase in total numbers who received these services, there may have been a decreased percentage of total eligible persons served. Also, in some counties there are shortages of mental health professionals trained to work with children and youth or who also have bilingual skills.

Figure 5. Percentages of Foster Youth Who Received Specialty MH Services

Your County: Contra Costa

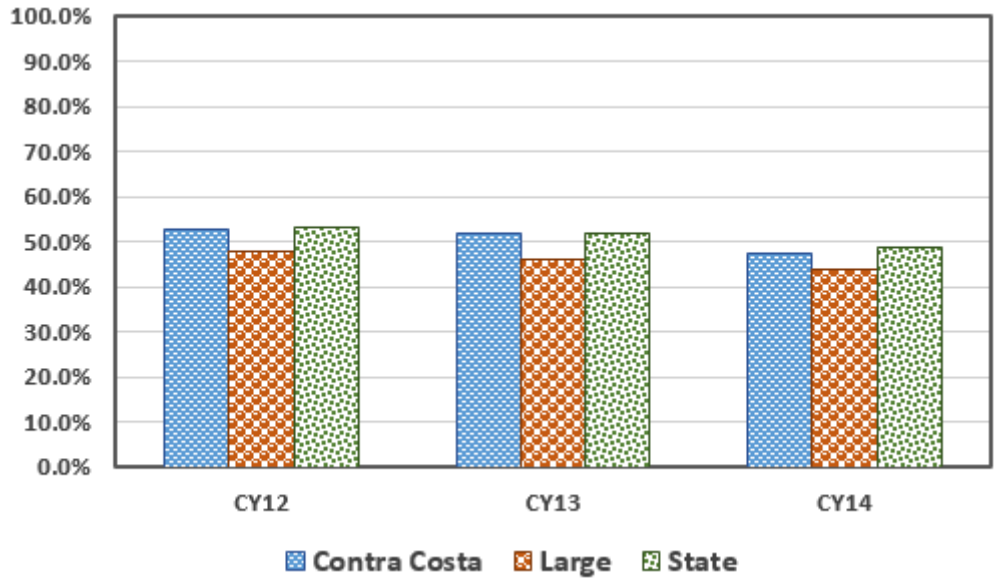


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

[17] Behavioral Health Concepts, Inc. California EQRO for Medi-Cal Specialty Mental Health Services. EQRO is the External Quality Review Organization. www.CALEQRO.com, see "Reports," and select your county to view.

QUESTION 3A:

What major strategies are used in your county to provide mental health services as a priority for foster youth?

Please list or describe briefly.

QUESTION 3B:

Do you think that your county does a good job of coordinating with your county department of social services or child welfare to meet the MH needs of foster care children and youth?

Yes____ No____. If no, please explain briefly.

QUESTION 3C:

Do you have any comments or suggestions about strategies used to engage foster youth and provide mental health services?

Yes___ No____. If yes, please list or describe briefly.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQ)

LGBTQ youth are another group which may be underserved or inappropriately served. Most counties say that LGBTQ youth are welcome to engage in their standard programs and receive services, as are all other cultural groups. However, it is essential to understand how counties are serving the specific needs and difficulties faced by LGBTQ youth. Members of the LGBTQ community access mental health services at a higher rate than heterosexuals, with some reports suggesting that 25-80 % of gay men and women seek counseling. Many individuals report unsatisfactory experiences due to a therapist's prejudice, inadvertent bias, or simple inability to comprehend the experiences and needs of their LGBTQ clients.[18]

Research and experience demonstrate that LGBTQ youth have unique needs that are most effectively provided by therapists and program directors with special training in addressing these unique populations. Outcomes are better when therapists and program leaders have received this specialized training.

Particular risks for LGBTQ youth and children include discrimination, bullying, violence, and even homelessness due to rejection by their families of origin or subsequent foster homes. Homelessness introduces great risk from all the hazards of "life on the street." In contrast, family acceptance of youth is crucial to their health and wellbeing.[19]

The Family Acceptance Project:
A promising area of research and practice is represented by the Family Acceptance Project headed by Dr. Caitlin Ryan in San Francisco, CA. She and her team developed the first family-based model of wellness, prevention, and care to engage families to learn to support the LGBTQ children across systems of care. Her research on the protective factors for LGBTQ youth has been published in peer-reviewed journals. These studies found that parental and caregiver behaviors can help protect LGBTQ youth from depression, suicidal thoughts, suicide attempts, and substance abuse.

In contrast, she found that *the LGBTQ youth who were rejected by their families were eight times as likely to attempt suicide, nearly six times more likely to have high levels of depression, and three times as likely to use illegal drugs*.

The Family Acceptance Project has assisted socially and religiously conservative families to shift the discourse on homosexuality and gender identity from morality to the health and well-being of their loved ones, even when they believe that being gay or transgender is wrong. This effort included development of multicultural, multilingual, and faith-based family education materials designed to prevent family rejection and increase family support.

"We now know that kids have their first crush at about age 10. Many young people today are now coming out between ages 7-13. Parents sometimes begin to send rejecting messages as early as age 3…. These early family experiences … are crucial in shaping [their] identity and mental health."

[18] P. Walker et al., "Do No Harm: Mental Health Services: The Good, the Bad, and the Harmful."

[19] Dr. Caitlin Ryan, 2009. Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. *Also see*: Ryan, C. (2014). Generating a Revolution in Prevention, Wellness & Care for LGBT Children & Youth, Temple Political & Civil Rights Law Review, 23(2): 331-344.

QUESTION 4A:

Does your county have programs which are designed and directed specifically to LGBTQ youth? ___ Yes ___ No.

If yes, please list and describe briefly.

QUESTION 4B

Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes___ No____.

If yes, please list or describe briefly.

QUESTION 4C:

Do you have any comments or suggestions about services or how to address unmet needs for LGBTQ youth in your community?

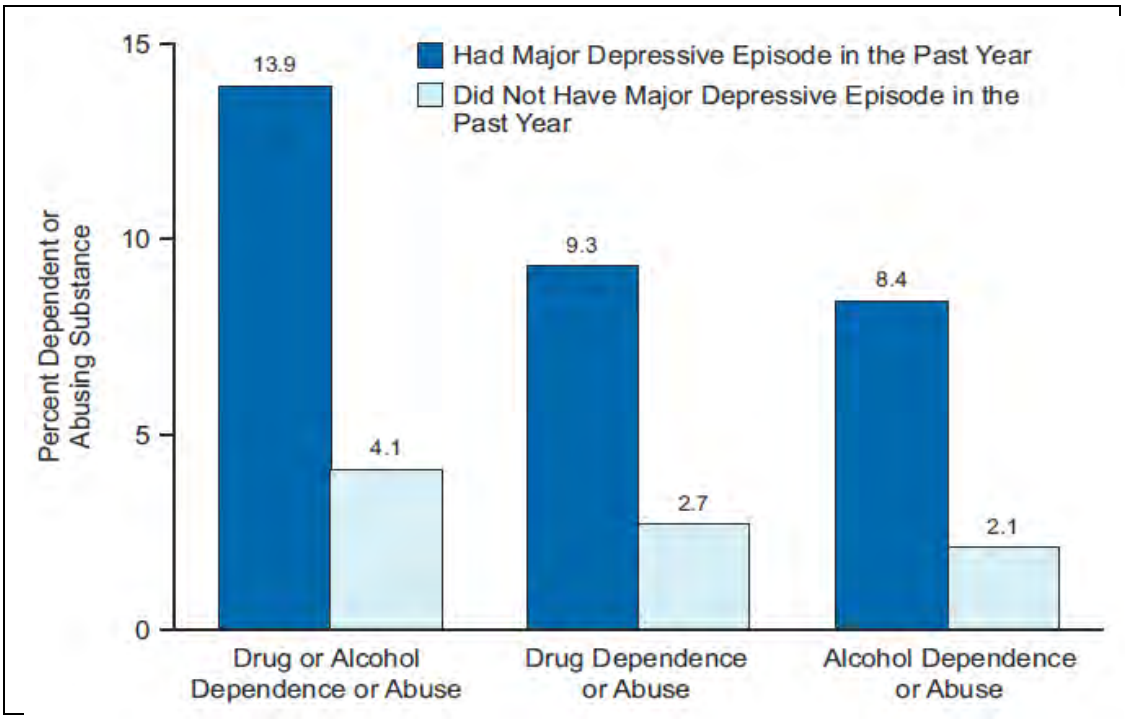
Yes___ No____. If yes, please list or describe briefly.

Children and Youth Affected by Substance Use Disorders

Counties generally have several levels of substance use disorder programs. These include prevention, treatment, and recovery supports. Prevention refers to services that target people before a diagnosable substance use disorder occurs, and may be based in schools or the community. Treatment refers to directly intervening in a substance use disorder using clinical means and evidence-based practices by trained clinical staff. Recovery support refers to supporting long term recovery and includes secondary prevention services as well. Resources for each of these main program areas are not equally available in all counties or areas of the state. Many small-population counties have very limited types of substance use treatment programs.

Young people who engage in early substance abuse may do so because they are experiencing mental health challenges. Children and youth who experience a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who do not have depression.[20] (See next figure, 2013 data, NSDUH).

Figure 6. Past Year Substance Abuse and Depression in U.S. Youth, Age 12-17.



[20] Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf

Last year's Data Notebook (2015) included a section on substance use disorders in all groups but emphasized adults and those with co-occurring mental health disorders. Both community and school-based prevention efforts were also discussed.

Substance abuse services for children and youth were not specifically addressed last year. Therefore, our focus for this discussion is limited to treatment needs and services for children and youth. Both experience and evidence show that children and youth under age 18 are best served by substance use treatment programs which are designed specifically for their emotional and social developmental stages.

In California, many of the 30 smaller population counties (<200,000), have limited treatment options, with an emphasis on outpatient treatment or abstinence programs.[21] There is a shortage of providers and of narcotic treatment programs (NTP), which is of concern given recent trends in narcotic drug abuse in all age groups, including youth. It is unknown how many counties have substance abuse treatment programs (and what type) that are designed specifically for youth under 18 or even for TAY (ages 16-25).

For your review, we are presenting data for total numbers of youth who initiated substance use treatment during FY 2013-2014 by participating in one of these three types of treatment: **outpatient, "detox", or residential treatment programs**. (NTP services and pregnant mother programs are not included). During that year, individuals may have started treatment one or more times in either the same or another program. However, these data count only the first episode of substance use treatment for an individual within that fiscal year. Both statewide data and county data (where available) are shown.

[21]California Substance Use Disorder Block Grant & Statewide Needs Assessment and Planning Report, 2015. Presented as a collaborative effort between numerous staff at DHCS, CDPH, and the UCLA Integrated Substance Abuse Program. http://www.dhcs.ca.gov/provgovpart/Documents/2015-Statewide-Needs-Assessment-Report.pdf

Contra Costa County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	Any	None
7th Grade	10.9%	89.1%
9th Grade	25.4%	74.6%
11th Grade	37.4%	62.6%
Non-Traditional	N/R	N/R
All	24.4%	75.6%

Numbers of Youth that Began Substance Use Disorder Treatment, FY 2013-2014:

<u>California: Statewide</u>

Age < 18: 14,957 Age 18-25: 23,614

<u>Your County: Contra Costa</u>

Age <18: 249 Age 18-25: 438

QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Y____ N____

If yes, please list or describe briefly.

If no, what is the alternative in your county?

QUESTION 5B:

Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes___ No___.

Please explain briefly.

Justice System-Involved Youth with Behavioral Health Needs

Children and youth with significant emotional or mental health issues may engage in behaviors which bring them into contact with the justice system. Other vulnerable groups include homeless youth and victims of sex trafficking. They face survival challenges "on the street" and increased risk of involvement with law enforcement.

This discussion will focus on juveniles with justice system involvement. Based on the data available, it is difficult to estimate how many are in need of mental health or substance use services. However, experience at the community level suggests that the behavioral health needs of this population are considerable and many are likely to be underserved, unserved, or undiagnosed. At a minimum, needs for substance use treatment may be indicated by the data showing that one-sixth of all juvenile arrests are for offenses involving drugs or alcohol. Many others have committed offenses while impaired by alcohol or drugs of abuse.

Several factors may contribute to the circumstances which lead to youth becoming involved with the justice system, and other consequences that follow.

A recent report states that "the vast majority, between 75 and 93 percent of all youth entering the justice system are estimated to have experienced previous trauma."[22] Even more shocking, "girls in the justice system are 200 – 300 times more likely to have experienced sexual or physical abuse in the past than girls not in the justice system." [23]

The 2016 California Children's Report Card[24] defines one particularly vulnerable group as "crossover youth" (or multi-system users), because they have a history involving both the child welfare and juvenile justice systems. Often these children and youth have had multiple episodes of trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood. Parental abuse or neglect may have resulted in the child's placement in foster care or a group home, which is intended to provide for safety and well-being. In addition, the experience of removal from one's home is highly traumatic and the foster home may or may not be able to fully meet the child's needs. Studies show that these "youth are more than two times as likely to be incarcerated for low-level offenses than their justice-involved peers who are not involved in the child welfare system."

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[22] Erica Adams, "Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense." Justice Policy Institute, July 2010. http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

[23] D. K. Smith, L. D. Leve and P. Chamberlain, "Adolescent Girls' Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma." *Child Maltreatment 11.4* (2006):346-353. Print,

[24] Website: **www.ChildrenNow.org**, see report: California Children's Report Card, 2016.

The childhood experience of trauma may lead to poor emotional regulation, emotional outbursts, or disruptive behaviors in schools. Such events, in turn, can set the stage for suspension, expulsion, or other disciplinary actions in schools. Disruptive behaviors left untreated may progress to events which lead to justice system involvement. Trauma-informed strategies may better serve the needs of youth by diverting them to therapy instead of punishment or incarceration.

Historically, "students of color, LGBT students, and students with disabilities…are disproportionately impacted by suspension and expulsion."[25] Across all age groups, for similar low-level offenses, persons of color are more likely to be incarcerated and much less likely to be referred to therapy, diversion, or probation than are their white counterparts. Research shows that African American children and youth are more than twice as likely to be incarcerated for non-violent offenses compared to white youth. Thus, as a matter of equity (or fairness of access), we should consider strategies to engage youth of color in mental health and substance use treatment and diversion.

Many serious challenges are faced by justice-involved youth. The most serious are those facing incarcerated youth; they report considerable despair and suicidal ideation.

One major risk for incarcerated youth is suicide.

- One national study* reported that approximately 10 percent of juvenile detainees had thought about suicide in the prior six months.
- About 11 percent of detained juveniles had previously attempted suicide.
- The rates of completed suicides for incarcerated juveniles are between two and four times higher than for the general population.
- The general population rate of completed suicides was reported in 2010 as 10.5 per 100,000 adolescents.

*K.M. Abram, J.Y. Choe, J.J. Washburn et al., "Suicidal Thoughts and Behaviors among Detained Youth," July 2014 Juvenile Justice Bulletin, pages 1-12.

[25]"Racial Disparities in Sentencing." American Civil Liberties Union, 27 Oct. 2014. https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf; and Soler, Mark, "Reducing Racial and Ethnic Disparities in the Juvenile Justice System." Center for Children's Law and Policy, 2013. http://www.ncsc.org/~/media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers[26] for misdemeanors, felonies and status offenses. "Status offenses" are those which would not be crimes for adults, e.g. truancy, runaway, breaking curfew, etc. Additionally, unknown numbers of youth are counseled and released to a parent or guardian without formal arrest.

Table 3. Numbers[27] and Types of Juvenile Arrests, California, 2014

Total population[28] age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

These data can paint only a partial picture of the justice-involved juvenile population. Data are often lacking on who, how many, or what percentage may need behavioral health services. One goal of this discussion is to identify strategies which reach out to youth from all backgrounds. The desired outcomes are to engage individuals in treatment and diversionary programs, and to avoid detention, whenever possible.

Addressing this topic may involve challenges in seeking information from other county agencies such as Juvenile Probation. Besides county departments of behavioral health, other limited funding sources for services may include: Juvenile Justice Crime Prevention Act, Youthful Offender Block Grant, SAMHSA-funded grants, City Law Enforcement Grants, Mentally Ill Offender Crime Reduction (MIOCR) Grant Program, Proposition 63 funds (MHSA), or Re-alignment I and II funds.

[26]Data are from: www.kidsdata.org, based on compilation of data from California Department of Justice records for 2014 juvenile arrest data. Total numbers of arrests declined in 2015 to 71,923, but overall percentages broken down by type of offense were similar to those for 2014.

[27] Percentages may not add to 100% due to rounding effects. Data are from California Department of Justice reported in 2015.

[28]CA Department of Finance, Report P-3, December 2014

Data shown below:

Recent county-level arrest data are not available to us for all types of juvenile offenses. However, we present the number of felony arrests for your county,[29] keeping in mind that these comprise only 31 % or about one-third of all juvenile arrests.

For state of California: **27,651 juvenile felony arrests, 2014.**

For your county: Contra Costa **627 juvenile felony arrests, 2014.**

QUESTION 6A:

Does your county provide mental health or substance use disorder treatment services or programs to justice system-involved juveniles while they are still in custody? Yes___ No___.

If yes, please list briefly. Please indicate (if available) the main funding[30] sources for these programs.

PROGRAM: **FUNDING SOURCE:**

QUESTION 6B:

Are the mental health and substance use services provided to non-custodial youth involved with probation or diversion programs different from those services provided to youth in the general community? Yes___ No___

If yes, please list briefly. Please indicate (if available) the main funding source for these programs/services.

PROGRAM: **FUNDING SOURCE:**

QUESTION 6C:

Do any of these programs engage the parents/guardians of juveniles involved with the justice system?

Yes___ No___. If yes, please list briefly.

[29] County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children's Health.
[30] This question is asking for only the main funding sources to highlight some of these programs and their successful implementation. We recognize that counties often weave together funding from different resources. If this information is not readily available, please enter N/A.

MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS HELPING CHILDREN AND YOUTH RECOVER

California voters passed the Mental Health Services Act (MHSA) in November, 2004 to expand and improve public mental health services. MHSA services and programs maintain a commitment to service, support and assistance. The MHSA is made up of the five major components described below:[31]

- **Community Services and Supports (CSS)**—provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers. Housing is also included in this category.
- **Capital Facilities and Technological Needs (CFTN)**—provides funding for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)**—provides funding to improve and build the capacity of the mental health workforce.
- **Prevention and Early Intervention (PEI)**—provides a historic investment of 20% of Proposition 63 funding to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN)—**funds and evaluates new approaches that increase access to the unserved and/or underserved communities; promotes interagency collaboration and increases the quality of services.

Prevention and Early Intervention (PEI) Programs and Services

Twenty percent of MHSA funds are dedicated to PEI programs as an essential strategy to "prevent mental illness from becoming severe and disabling" and to improve "timely access for under-served populations." PEI programs work to reduce the negative outcomes related to untreated mental illness, including suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes.[32] Counties must use at least 51% of PEI funds to serve individuals 25 years of age and younger, according to the regulations (Section 3706). These programs provide for outreach, access and linkage to medically necessary care.

[31] Mental Health Services Oversight and Accountability Commission, December 2012. "The Five Components of Proposition 63, The Mental Health Services Act (MHSA) Fact Sheet." http://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

[32] Mental Health Services Oversight and Accountability Commission, December 2012. "Prevention and Early Intervention Fact Sheet: What is Prevention and Early Intervention?" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf

Prevention of Suicide and Suicide Attempts

Public health data for California and the U.S. show that there are risks for suicide for multiple age groups and race/ethnicity populations. In particular, youth suicide and suicide attempts are serious public health concerns. Suicide is the second leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.[33] Males are more likely to commit suicide, but females are more likely to report having attempted suicide. A recent national survey found that nearly 1 in 6 high school students (~17%) reported seriously considering suicide in the previous year, and 1 in 13 (or 7~8%) reported actually attempting it.[34]

The risks for youth suicide and suicide attempts are greatly increased for many vulnerable populations: foster youth, youth with disabilities, those who face stressful life events or significant problems in school, incarcerated youth, LGBTQ youth, and individuals with mental illness or who experience substance abuse. Among racial and ethnic groups nationwide, American Indian/Alaska Native youth have the highest suicide rates. Research confirms that LGBTQ youth are more likely to engage in suicidal behavior than their heterosexual peers.[35] Attempting to address the problem of youth suicide is both daunting and complex due to the diversity of needs and potential contributing factors for different individuals, including family history of suicide or exposure to the suicidal behavior of others. Below, we show the number of youth suicides per year by age group to gain perspective on the size of this problem in California.[36]

Table 4. California: Numbers of Youth Suicides by Age Group, 2011-2013.

California	Number		
Age	2011	2012	2013
5-14 Years	28	19	29
15-19 Years	163	129	150
20-24 Years	271	282	302
Total for Ages 5-24	462	430	481

[33] Child Trends Databank. (2015). Teen homicide, suicide, and firearm deaths. Retrieved from: http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths.
[34] Centers for Disease Control and Prevention. (2015). Suicide prevention: Youth suicide. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html.
[35] Marshal, M.P., et al. (2013) Trajectories of depressive symptoms and suicidality among heterosexual and sexual minority youth. Journal of Youth and Adolescence, 42(8), 1243-1256. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articales?PMC3744095/
[36] http://www.kidsdata.org , topic: suicides by age group and year in California.

By comparison, the number of youth suicide attempts is difficult to determine because they are combined with hospital data for self-injury. In California there were 3,322 hospitalizations for self-injury reported during 2013 for those age 24 and younger. Estimates vary, but slightly less than half of self-injury events (e.g. about 1,660) may have been suicide attempts. As with the data for suicide deaths, these numbers should be viewed with a degree of critical skepticism. Actual intent may not be readily ascertainable due to insufficient evidence, privacy concerns, or reticence of loved ones. There also may be delays in reporting or under-reporting to the state.

Reports of suicidal ideation are much more common and show that much larger numbers of youth are at risk. As an example, we may consider data for the population of high school-age young people which was about 2.1 million in 2014 for California. That means there are between 500,000 and 530,000 individuals eligible for each of the four years of high school (based on ages). Not all members of these age groups are in school, but those not in school are also at risk.

Survey data (below) show the percentage of public high school students who reported seriously considering attempting suicide in the prior 12 months in California. [37]

Table 5. Public High School Students Reporting Thoughts of Suicide, 2011-2013

California	Percent	
Grade Level	Yes	No
9th Grade	19.3%	80.7%
11th Grade	17.5%	82.5%
Non-Traditional	19.4%	80.6%
All	18.5%	81.5%

Data from your county are shown on the next page (if available).[38] Some counties or school districts either did not administer the surveys or else did not report their results.

[37] **Data Source:** California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). The 2011-2013 period reflects data from school years 2011-12 and 2012-13. District- and county-level figures are weighted proportions from the 2011-13 California Healthy Kids Survey, and state-level figures are weighted proportions from the 2011-13 California Student Survey.

[38] Source of data: http://www.kidsdata.org, topic: suicidal ideation by grade level, in California. Note on abbreviations: N/D = no data; N/R=not reported.

Costa Contra County:

Table 6. Percent of High School Students Reporting Thoughts of Suicide, 2011-13

Suicidal Ideation (Student Reported), by Grade Level: 2011-2013		
Grade Level	Yes	No
9th Grade	18.2%	81.8%
11th Grade	15.8%	84.2%
Non-Traditional	N/R	N/R
All	17.0%	83.0%

QUESTION 7A:

Does your county have programs that are specifically targeted at preventing suicides in children and youth under 16 (ages 6-16) in your community?

Yes____ No_____ If yes, please list and describe very briefly.

QUESTION 7B:

Does your county have programs that are specifically targeted at preventing suicides in transition aged youth (ages 16-25) in your community?

Yes____ No_____ If yes, please list and describe very briefly.

QUESTION 7C:

Do you have any further comments or suggestions regarding local suicide reduction/prevention programs?

Yes____ No_____. If yes, please list briefly.

Early Identification of Risks for First-break Psychosis

Sometimes, unfortunately, the first major indication parents may have about first break psychosis in a child or youth may be changes in behavior, including an unusual drop in school grades, experimenting with substance abuse, running away, or behavior that gets the attention of the justice system. PEI programs for children and youth have a goal of identifying such persons early so that they receive appropriate services.

In California, many MHSA -funded programs provide these services. Thus far, the research and evidence for improved outcomes is solid enough to support these major efforts at both the state and national level. Therefore, now there are also federal funds from SAMHSA designed to intervene early to target first-break psychosis and provide a level of coordinated care and treatment that is effective. Some counties braid together funds from more than one source to support these programs and services.

Our questions address early intervention programs, regardless of funding source.

QUESTION 8A:

Does your county have services or programs targeted for first break psychosis in children and youth, and transition aged youth (TAY)?

Yes____ No____

QUESTION 8B:

If yes, please list by age range(s) targeted and describe the program or services briefly. Also, please include the major funding source, (i.e., MHSA, SAMHSA Block Grant, Realignment I/II, Medi-Cal, etc), <u>if</u> the information is readily available.

QUESTION 8C:

Do you have any further comments or suggestions about local programs targeted for first break psychosis in children and youth?

Yes____ No____. If yes, please describe briefly.

Full Service Partnership (FSP) Programs for Children and Youth

Full Service Partnership programs (FSP) provide a broad array of intensive, coordinated services to individuals with serious mental illness. These may also be referred to as "wrap-around" services. The FSP program philosophy is to "do whatever it takes" to help individuals achieve their goals for recovery. The services provided may include, but are not limited to, mental health treatment, housing, medical care, and job- or life-skills training. Prior research has shown FSP programs to be effective in improving educational attainment, while reducing homelessness, hospitalizations, and justice system involvement. Such intensive services can be costly, but their positive impact and results outweigh the costs and actually produce cost savings to society.[39]

Overall, the data thus far indicates some very good news. These positive outcomes are leading to greater understanding of what works well for children and youth. We hope to increase resources to serve more children and youth in FSP programs.

Outcomes Data for Children and Youth (TAY) in FSP Programs

When a new client begins FSP services, data are collected to serve as a baseline for later comparisons. Next, data are collected from each client after one year of services and then again at two years. The outcomes data are calculated as a change from the number of events for each client in the year prior to beginning FSP services, compared to one year later (and again at 2 years, for TAY).

Children's FSP data are shown for only one year of service, because children usually experience more rapid improvements than do TAY or adults. Here, improved academic performance is defined and measured as the percentage of children who had improved grades relative to baseline academic performance prior to beginning FSP services.

Please examine the data in the following tables below taken from a report[40] by CBHDA released in early 2016. First, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, take note of which outcomes show improvement and those which may need further attention to improve services for client recovery and wellbeing.

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[39] Prop 63 Mental Health Services Oversight and Accountability Commission (MHSOAC). Evaluation Fact Sheet: "Full Service Partnership (FSP) Program Statewide Costs and Cost Offsets" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_Eval5_FSPCostAndCostOffset_Nov2012.pdf

[40] Data reported from the new CBHDA-designed Measurements, Outcomes, and Quality Assessment (MOQA) data system for clients in FSP programs. http://www.cbhda.org/wp-content/uploads/2014/12/Final-FSP-Eval.pdf. Data from 41 counties were analyzed. We express great appreciation to CBHDA for sharing their data with the CMHPC.

Full Service Partnership Data for Children and Youth for Fiscal Year 2013-2014.

STATEWIDE DATA:
FSP Partners included in this analysis: 41 counties[41] plus Tri-Cities group reporting, Fiscal Year 2013-2014:

- Children (age 0-15): with at least one year of service.
- Transition Age Youth (/TAY, ages 16-25): with 2 years or more of services.

Table 7. Children, ages 0-15.

N=5,335 completed at least 1 year of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 year	Change in Client Outcomes at 2 years
Mental Health Emergencies	89% ⇩	--
Psych. Hospitalizations	49% ⇩	--
Out-of-Home Placements	12% ⇩	--
Arrests	86% ⇩	--
Incarcerations	40% ⇩	--
Academic Performance	68% ⇧	--

The data the table above show that: overall, children experienced decreases in total numbers of mental health emergencies, hospitalizations, out-of-home placements, arrests and incarcerations. There was an increase in academic performance, as measured by the percentage of children who had improved grades relative to baseline during the year prior to beginning FSP services.

[41] Alpine, Butte, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Kings, Marin, Los Angeles, Mariposa, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter-Yuba, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo. Other counties do have FSP services but for technical reasons were not able to get the reports out of their data systems for this project.

STATEWIDE DATA (Fiscal year 2013-2014): continued below.

<u>Table 8. Transition Age Youth</u> (TAY) ages 16-25.

N= 4,779 completed at least 2 years of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 Year	Change in Client Outcomes at 2 years
Mental health emergencies	84% ⇩	86% ⇩
Psych. hospitalizations	41% ⇩	57% ⇩
Emergency shelter use	20% ⇩	53% ⇩
Arrests	81% ⇩	86% ⇩
Incarcerations	45% ⇩	49% ⇩

The data in the table above show that: overall, transition-aged youth experienced decreases in total numbers of mental health emergencies, hospitalizations, use of emergency shelters, arrests and incarcerations. These beneficial outcomes occurred by the end of the first year.

All of these improved outcomes continued and were sustained at the end of the clients' second year in FSP services. Two types of outcomes, psychiatric hospitalizations and use of emergency shelters, had improved even more by the end of clients' second year of FSP services, compared to the end of the first year.

The goal is to think about how the FSP outcomes data for children and youth may help inform your suggestions for improving local services or programs**.**

QUESTION 9A:

What are the most urgent child or youth problems in <u>your</u> county? (For example, homelessness, problems with school or work, arrests, incarcerations, use of emergency MH services or psychiatric hospitalizations, out-of-home placements for children, substance abuse, teen pregnancy/parenting, etc.).

QUESTION 9B:

Do the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community?

Question 9C:

Do you have any other comments or recommendations regarding your local FSP programs or other types of "wrap-around" services?

Yes ___ No___. If yes, please describe briefly.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

___ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

____MH Board completed majority of the Data Notebook

___ County staff and/or Director completed majority of the Data Notebook

___ Data Notebook placed on Agenda and discussed at Board meeting

___ MH Board work group or temporary ad hoc committee worked on it

___ MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

___ Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes___ No___

If yes, please provide their job classification _____

(c) What is the best method for contacting this staff member or board liaison?

Name and County: _____

Email_____

Phone #_____

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: _____

Email: _____

Phone #_____

Signature: _____

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Contra Costa County's Mental Health Commission Public Hearing

PURPOSE? = ***the public hearing is to enable consumers, stakeholders, representatives, advocates and any interested parties to comment on the Mental Health Services Act (MHSA), THREE YEAR PROGRAM AND EXPENDITURE PLAN.***

WHEN? - Wednesday, May 3, 2017

TIME? - From 4:30pm to 6:30pm

WHERE? – at: 550 Ellinwood Way in Pleasant Hill

****The plan is available for viewing at: http://cchealth.org/mentalhealth/***

Come join us for this event. Let others hear your comments regarding the plan. Each person will have three minutes to speak. We want to hear from you. Please confirm your attendance at: Liza.Molina-Huntley@hsd.cccounty.us. Thank you

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Contra Costa County's Mental Health Commission Hosts a PUBLIC HEARING

On the Fiscal Years 2017 to 2020
Mental Health Services Act Three Year
Program and Expenditure Plan
Wednesday, May 3, 2017♦4:30pm to 6:30pm
550 Ellinwood Way, Pleasant Hill

AGENDA

I. Call to Order/Introductions

II. APPROVE minutes from April 5, 2017

III. Opening Comments by the Mental Health Commission-Chair

A. Review of authority for Public Hearing, Welfare & Institutions Code 5848 (a) (b). A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.
The Mental Health Commission shall conduct a public hearing on the draft plan and annual updates at the close of the 30 day comment period. The Mental Health Commission shall review the adopted plan or update and make recommendations to the County Mental Health Department for revisions.
B. Review of Public Hearing purpose to confirm and complete the process.

IV. Fiscal Years2017 to 2020 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan- by Warren Hayes, MHSA Program Manager.

The plan is available for review at: http://cchealth.org/mentalhealth/

The Commission will provide reasonable accommodations for persons with disabilities planning to attend. Please contact the Executive Assistant at: 925-957-5140, at least 48 hours prior to the meeting. Thank you.

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

V. Public Comment regarding the Plan-

Members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission.
Public Comment cards are available on the table at the back of the room; please give your card to the Executive Assistant of the Mental Health Commission.
In the interest of time and equal opportunity, speakers are requested to **please adhere to a 3 minute time limit, per person**. In accordance to the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item will occur, except for the purpose of clarification.

VI. Commissioner Comments-

Members of the Commission may comment on any item of public interest within the jurisdiction of the Mental Health Commission.
Commissioner Comment cards are available at your seats. Please give your card to the Executive Assistant of the Mental Health Commission.
In the interest of time and equal opportunity, speakers are requested to please adhere to a 3 minute maximum time limit, per person. 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 will occur, except for the purpose of clarification.

VII. Develop a list of Comments and Recommendations to the County Mental Health Administration (MHA) and to the Board of Supervisors (BOS)

VIII. Adjourn Public Hearing

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 to that meeting are available for public inspection at 1340 Arnold Drive, Suite 200, Martinez, during our business hours.

The Commission will provide reasonable accommodations for persons with disabilities planning to attend. Please contact the Executive Assistant at: 925-957-5140, at least 48 hours prior to the meeting. Thank you.