MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
April 7th, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. B. Serwin, Mental Health Commission (MHC) Vice-Chair, called the meeting to order @ 4:32 pm Members Present: Vice-Chair, Cmsr. Barbara Serwin, District II Cmsr. Candace Andersen, District II Cmsr. Michael Coyle, District IV Cmsr, Douglas Dunn, District III Cmsr. Laura Griffin, District V Cmsr, John Kincaid, District II Cmsr. Kate Lewis, District I Cmsr. Kathy Maibaum, District IV Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Kira Monterrey, District III Cmsr. Alana Russaw, District IV Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent: Chair- Cmsr. Graham Wiseman, District II Presenters: Dr. Suzanne Tavano, (Director, Behavioral Health) David Seidner (Mental Health Program Chief, Detention Health Services) Dr. Jessica Hamilton (Medical Director, Detention Health Services) Aisha Banks (Improvement Advisor, Clinical Informatics) Other Attendees: Colleen Awad Angela Beck Jaspreet Benepal Gigi Crowder Lisa Finch Florene Freasier Kennisha Johnson Lynda Kaufmann Enid Mendoza Supervisor Karen Mitchoff Teresa Pasquini Dom Pruett (Supv. Candace Andersen's ofc) Jill Ray (Supv. Candace Andersen's ofc) Kristine Suchan Robert Thigpin Genoveva Zesati	Meeting was held via Zoom platform
II. PUBLIC COMMENT: None	
III. COMMISSIONER COMMENTS • (Cmsr. John Kincaid) Comment regarding meeting agenda packet documents. Very thorough and informative and a big Thank You for all the trouble.	

• (Cmsr. D. Dunn) Looking forward to delving into the issue/need regarding the recent police shootings of those with severe mental health issues in Antioch and Danville in my update of what the Mental Health Services Act (MHSA)-finance subcommittee does and our goal for the committee for the remainder of this year. • (Cmsr. L. May) Thank you Commissioner Dunn, am looking forward to having that discussion. Also, looking over the agenda and the missing items, specifically the addendum to the Mental Health Commission (MHC) Chair for attendance and to discuss the appointment of commissioners and the roll the MHC plays in recommending members to serve on the commission. (RESPONSE) Thank you Commissioner May. If you recall, the last Executive Committee meeting we determined that we did not have enough information and would continue the discussion at the April meeting. (Cmsr. Anderson) If I could add, I did meet with Chair Wiseman last week, regarding the appointments. I came up with some draft language that has been sent to county counsel and presented to the next Executive Committee meeting. • (Cmsr. K. Maibaum) Requesting receipt of meeting packets earlier than one day prior to the meetings. Emails were sent Friday (well over the 96-hr mandatory posting). Did not see or receive initial email but checked commissioner distribution list and all new commissioners are on both lists.	
IV. CHAIR COMMENTS/ANNOUNCEMENTS: None	
V. APPROVE March 3rd, 2021 Meeting Minutes • March 3, 2021 Minutes reviewed. **Motion:** J. Kincaid moved to approve the minutes as written. Seconded by G. Swirsding. **Vote: 14-0-0** **Ayes:** B. Serwin (Vice-Chair), C. Andersen, M. Coyle, D. Dunn, L. Griffin, J. Kincaid, K. Lewis, K. Maibaum, L. May, J. Metro, K. Monterrey, A. Russaw, G. Stern, G. Swirsding Abstain: None	**Agenda and minute can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. "Get to know your Commissioner" – Introducing our two newest commission members: Michael Coyle and Kathy Maibaum (District IV) • Cmsr. Michael Coyle, District IV – Executive Director, To My People, Inc., which provides psychiatric telehealth services for the financially vulnerable and marginalized. That practice should be up and running in the next few months. It has been ongoing for a few years and we just moved from St. Louis to the East Bay just before COVID started and am very new to the area and sequestered from meeting everyone. This opportunity to apply for the Commission came across my desk and I am very happy to be a part of it, as a consumer. Not only serving those that are having mental health difficulties, but I can speak firsthand for some of the journey I have been on and happy to share those views in addition to looking at it from a larger perspective of providing telehealth services for mental health (MH) patients. • Cmsr. Kathy Maibaum, District IV – Very happy to be involved and introduced to the opening by NAMI, where I am a volunteer. Recently completed family-to-peer specialist (16 classes over 8 weeks of training). Just really want to fill the advocacy role. I am a parent with a son that has a mood disorder and that is how I am representing the commission (Family Member) and to those who are not advocate for themselves and very happy to be here.	

VII. Committee Reports

I. Executive Committee – Cmsr. Barbara Serwin

Executive Committee covers a lot and are mostly administrative issues, discussion regarding by-laws and potential changes having to do with attendance and membership.

II. Justice Systems Committee – Cmsr. Geri Stern

Justice Systems Committee has been spending the last several months taking a deep dive into Conservatorship and the challenges. We have had number of very important speakers. Some from the Public Defender's office, from the deputy at the public guardians office, the psychiatrist from psych emergency services (PES) speak. It has a really interesting educational experience as to what the roadblocks for obtaining conservatorships are and the challenges for those conservatees to actually get treatment. We are focused on (in the near future) looking at some of the mental health issues in the detention facilities and to see if there is a way to collect data to identify ways to treat mental illness in the community before it gets to the point that someone has to be detained in jail.

III. Quality of Care Committee – Cmsr. Barbara Serwin

Quality of Care Committee has been working in depth since last April (since COVID hit), the committee has been working on developing a robust site visit program. All commissioners will participate over the year and will be targeting approximately 10-12 site visits of a full-range (MHSA and non-MHSA facilities). We are motivated and feel great about this. We have looked surrounding counties to see what they are doing and determined we really wanted to model our program on the San Francisco site visit program, which is very much consumer focused. The consumer's perspective on the program services they are receiving and specific sites and leaving the administrative pieces to BHS / MHSA reviews. We have developed questionnaires for adults, children, youth and parents and family (caregivers) that we intend to interview with. We have been able to test the adult questionnaires with the SPIRIT team and are conducting a test site visit with HUME Center on April 23rd.

IV. MHSA-Finance Committee – Cmsr. Douglas Dunn

MHSA-Finance Committee performs financial oversight and recommendations for spending of the entire $225 million Contra Costa Behavioral Health Services (CCBHS) budget. We also look at funding streams and carefully observe resulting BH-related programming. There are four major departments:

◊ Alcohol and Other Drugs (AOD)	$40.0 mil
◊ Older Adult (ages 59 and above)	
◊ Adult (ages 18-59)	$92.5 mil
◊ Children and Adolescents (up to 18)	$92.5 mil

Funding Streams:

◊ Federal Financial Participation (FFP – Medicare/Medi-Cal)	$75.0 mil
◊ Realignment (1991 & 2011)	$71.4 mil
◊ Mental Health Services Act (MHSA)	$61.3 mil
◊ County General Funds	17.3 mil

Programs Financial Oversight

Mental Health Services Act Program & Fiscal Reviews: Review and discussion program reviews of all 85+ programs funded by Mental Health Services Act (MHSA funds). Also discuss the efficacy of the programs funded by MHSA.

- Juvenile Justice:
  - ◊ Per 2020 legislation signed by Gov. Newsom, Juvenile Justice—over a 4-year period, from Jul1, 2021-June 30, 2025, Contra Costa to take over all functions done by the closing Dept. of Juvenile Justice (DJJ). The Committee began delving into the numerous financial and other issues at its March 18 meeting with Dr. Dan Batiuchok, the departing Juvenile Hall Mental Health Program Manager and Children and Adolescent Program Chief, Gerold Loenicker. At its April or May meeting, the

Committee will delve further into the numerous issues with Juvenile Justice Probation Officer, Esa Ehmen-Krause. • Future Issues: ◊ Costs of and funding for a full 24/7 countywide adult Mobile Crisis Response Team (MCRT). This is in direct response to police shootings under very questionable circumstances in Walnut Creek, Antioch, and Danville. ◊ How to get the Commission, esp. the MHC-Finance Committee, involved in a timely manner in the county health services/behavioral health services budget process. So far, progress has been sorely lacking. • Need for more committee members: ◊ This committee currently has 2 listed and 2 ex-officio members. We need 3 more members. This committee currently meets the 3rd Thursday of the month from 1:30-3 PM. This meeting time can be changed if needed to get more members.	
VIII. RECEIVE presentation on the 9/29/20 County settlement with the Prison Law Office regarding improvements at the Martinez and West County jails, including in the area of mental health, required medical and mental health plans to improve treatment of inmates, and improvement already made to date, David Seidner, Mental Health Program Chief, Detention Health, and Dr. Jessica Hamilton, Medical Director, Detention Health Services The negotiations for the Prison Law Office Settlement started in 2017. • Consent decree approved by the Court February 2021 • Medical and mental health remedial plans • Many improvements began in 2017 ◊ Value Stream Mapping ◊ Rapid improvement events based on feedback from VSM Detention Health Services is part of Contra Costa County Health Services (CCCHS) and our **mission** is to **care** for and improve the **health** of all people in **Contra Costa** County with special attention to those who are most vulnerable to **health** problems. We know many of our most vulnerable community members pass through the detention system. At Detention Health, we see this as an opportunity to help improve their health and their quality of life. We refer to this as **ONE CARE** offering one level of care regardless of if you are incarcerated or homeless or housed. We are to deliver one level of Patient Centered Care: • Prioritized Mental Health improvements • Improved identification of care needs at intake ◊ Standardized screening tools and process ◊ Increased privacy (especially at intake) • Improved identification and treatment of substance use disorders • Increase staffing to provide consistent care across disciplines including psychiatry, mental health clinicians, physicians, nurse practitioners and nursing staff • Intentional, strategic improvements to address patient needs Track Levels of Mental Health Care is the backbone of our delivery system. It is a significant paradigm shift in how the services are organized, how individuals are identified and how care is delivered. • Strength Based and Recovery Model • Ongoing assessment of the individual's mental health needs ◊ Identification of risk factors ◊ Support adjustment to detention environment • Psychiatrist's order for Track Levels of Mental Health Care • Coordination and Case Conference with Health and Custody staff Suicide Prevention Program	The Detention Health Update presentation to the Mental Health Commission was shared as a PowerPoint presentation during meeting.

- Joint training cofacilitated by health and custody trainers. All staff in contact with those in custody are trained.
- Health and Custody collaboration for suicide prevention. All staff "see something, say something" to ensure safety for all.
- Continued support during suicide precautions and after

Current State

- Significant improvement efforts prior to recent court approval
- Continuing improvement efforts amidst pandemic
- Robust multidisciplinary COVID response
- 0 COVID positive patients currently incarcerated
- 0 COVID related hospitalizations or deaths
- Vaccinations underway since January 2021

Comments and Questions:

- (Cmsr. J. Kincaid) I noticed in documentation we received there was repeated reference to the mental health expert who will be assessing improvements in the program, but nowhere does it say who that mental health expert is. There was another term "QI" and there is no definition. (RESPONSE Dr. Hamilton) We have a series of experts to evaluate various aspects of care within the facilities and we will have appointed monitors, as well. I am not sure how much of that information I can share (unsure how much is confidential). QI refers to Quality Improvement. (Cmsr. J Kincaid) Is the mental health expert a paid consultant? An organization? A person? Why would that be confidential? (RESPONSE) Our expert that came in to review the care provided is Roberta Stahlman, a psychiatrist, but don't know how much I can discuss moving forward. (Cmsr. J. Kincaid) I see that referred to over several years, early in the negotiations there was a mental health expert. The title has been referenced over and over, is that the same person? (RESPONSE) Yes.
- (Cmsr. L. May) Is this person from this community or are they from another community. We should have someone from CCC that is making these recommendations and ensure diversity. This should be a diverse panel of experts evaluating, not just one person. Is she from this county, or someone that has been contracted that is outside of the community? (RESPONSE Dr. Hamilton) I can comment that our VSM event, which preceded this whole process, it involved many members of the community and a broad spectrum of organizations within the county. I do not know the details of Dr. Stahlman's background or upbringing.
- (Cmsr. G. Stern) Can you explain/expound on the need for confidentiality of this person and where in the law was it written that we are not allowed to know too much about the process and who the staff member is? (RESPONSE Dr. Hamilton) That is a good question for our county counsel.
- (Enid Mendoza) I was not involved, but I can speak to is more of the process and the involvement of the MHC. From what I understand, the consent decree is going to be monitored by court experts and the (PLO), follow up and reporting where the county will be preparing status reports every six months. I see the report being provided by Dr. Hamilton and David Seidner, it is informational for the MHC and more specific details of status or monitoring would be more appropriate for the MHC to tune in to when the updates are available or go before the Board. (Cmsr. G. Stern) Where was it documented that this is so confidential that we can't know too much about it? (Enid Mendoza) I can't speak to the confidentiality, but it is possible there is a lot of internal and it is not the forum to present details. <FOLLOW UP> to look into this further and work with Dr. Hamilton and David Seidner.
- (Dr. Tavano) To speak on behalf of Dr. Hamilton and David Seidner, consultation with county counsel is needed to get clarification around the boundaries or limitations of confidentiality and probably were told to limit the presentation to what is publicly know due to the settlement agreement. In terms of the limitations, the reason for confidentiality and limitations, county counsel would be good to weigh in. The limitation is what has already been shared publicly.

- (Gigi Crowder) When I do any training, especially regarding the criminal justice system, I would look at the county and the demographics and want to find out, part of this building a better place for people who live with Mental Health challenges to get treatment, does this include how to better serve individuals from ethnic and cultural communities? It is my understanding that African Americans make up only 10% of the population in CCC but in the Criminal Justice/Mental Health system, you will see those numbers increase to 50% (at last count). How do we start working on this disparity? This county deemed (in November) that racism was a public health crisis and this is the most glaring example of it for me because I don't believe in jailing people who live with mental health challenges in the first place, then to have so many African Americans show up there who live with mental health challenges creates a disconnection with efforts we are moving toward. So, if either of you can answer whether there are any plans in place to improve the disparities. (RESPONSE D. Seidner) It is a very critical part of our case conference and multi-disciplinary treatment approach, diagnosing correctly, understanding implicit bias and how that conforms the DSM5 and psychiatric medication. Our psychiatrists raise this issue very frequently. I do want to speak to the work of the team. It is an incredible part of our work to have the discussion. Are we there yet? No. Is it something we need to work to? Yes. Again, the focus is recovery, if we make treatment recommendations that become restrictive, we need to have a reflective auditing process. Are we seeing trends? Are these certain groups getting less restrictive intervention or and these groups getting more invasive interventions? We do have emergency medication and are participating in involuntary medications with the court. Reviewing the make up of the people we serve and calling out institutional racism and implicit bias is very much a heated conversation among the treatment team. Again, because the psychiatrists have a lot of power in deriving care, they really champion this topic. It is a part of our case conference and our QI Program takes into account oversight and monitoring surveillance of trends, as an example, court ordered meds over time, who are the individuals pursued court ordered meds? That is one area where quality overlaps with operations and teasing out bias. Did I explain that clearly?
  (Gigi Crowder) I am happy to hear it is being looked at, but it has been going on for so long, it might be well to share the name publicly, subject matter experts around ethnopharmacology because African-Americans metabolize their medications at different rate, so they are more prone to being overmedicated and therefore, unwilling to take the meds. Then there are practices that have put in place where the populations are over-representing African-Americans that have proven to be promising. If you would like that subject matter experts that are working on this, I can share the information with you. (D. Seidner) Thank you so much and to the MHC and everyone, our energy has started on this journey "standard word" consistency, predictability. Is it happening on a consistent basis? The next phase is quality and the deeper dive, is this meeting the needs of the people we are serving? As you look at the consent decree, the length of time, it is built into the process. What we are sharing is what is standing up. You are absolutely correct – the quality and depth of the work is a continual process. It is not a 'one and done' process, it is ongoing.
- (Teresa Pasquini) I share the frustration around the confidentiality and lack of transparency, but understand. I was a member of the executive team at the county hospital that oversaw detention health at the beginning of this process. I was not included in those conversations. I was included in almost every conversation except for the THAT conversation. I did participate in the leadership role in the VSM and the RIE and, shared before, how happy I was to see this work moving forward; however, in retrospect I am disappointed that the community has been left in the dark in terms of the planning and advocacy around the $70mil investment (the large budget investment) that our community is going to have in this area and now directed to detention health and jails. I did support the sheriff's grant process and took a lot of heat from the community for

doing that and regret it now. It saddens me we are in a county that is now investing so much in detention health and struggling to keep people out of jail. One of the greatest disparities is the seriously mentally ill population and are over-represented in jail. I encourage the commission to do whatever you can to keep track of this process and I will be tracking at both the Board and Commission level, as somebody who's son has been jailed and failed in our county and state. (RESPONSE D. Seidner) Yes, there is a large expenditure for the increase in psychiatry hours (night/day), the fact we have the necessary amount of psychiatry on site at MDF seven days a week and five days a week at West County. What that has led to improvement in care. When I started in 2017 to where we are in 2021, individuals that are severely mentally ill and acute are getting treatment and access of care, the timeliness of treatment is almost real time. Individuals are being seen daily and immediately for acute crisis, which was not the case. The psychiatrists guiding the are actively involved in suicide precautions, the treatment planning. Where we were prior to the investment to where we are now (just in psychiatry) has decreased a lot of codes. The care for those that are the most ill, has intensified greatly. (Teresa Pasquini) Family advocacy needs to be included and addressed in the presentation and moving forward in care decisions.

- (Cmsr. G. Swirsding) Trying to find a psychologist/psychiatrist in West County is very difficult. There are a lot of consumers (myself included) that took a long time to find someone that would take Medicare/MediCal/MediCaid). Not aware of the reason, but in order to get treatment you have to go to Central County or San Francisco. In our part of the county, the churches have been really effective. They have picked up a lot of our consumers to get help in finding therapists for people here. There is a real shortage of Mental healthcare workers. It is very hard, especially if you don't drive and have severe mental illness, it is hard to receive care. ZOOM has been helpful but many do not have the ability to connect
- (Cmsr. A. Russaw) I wanted to speak on case discussion and trying to keep race and ethnicity on top of the priority list. I feel that it also needs to be reflected in the staff that is hired as well so patients can feel a level of comfort or understanding from the individuals treating them as well. Secondly, COVID vaccinations, does that include staff and constant testing? (RESPONSE Dr. Hamilton) Everyone who comes into the detention facilities is tested and quarantine and regularly testing patients and staff. Staff vaccinations started mid-December and patient vaccinations started in January.
- (Cmsr. L. May) What was the total settlement amount that was or is going to be paid? $43.7 million? (RESPONSE Cmsr. B. Serwin) That is what the post-settlement with the Prison Law Office memo to the Board of Supervisors from David Twa.
- (Cmsr. A. Russaw) I did want to ask David to speak to the diversity within the staff and how that is being captured. (RESPONSE David Seidner) I would like to share the makeup of the mental health team without being disrespectful, bear with me. I would say the majority of those on the MH team are people of color. I am not able to give the breakdown, but we do have mixed diversity of our workforce between sex, age and ethnicity. This has come up frequently as an incredibly important and powerful that people helping reflect the population being served. Respecting my team and speak to it in general terms. More than half of our team is made up of various backgrounds.
- (Cmsr. B. Serwin) What level of people in detention have mental health issues? Is it tracked at intake? What is your typical caseload? (RESPONSE D. Seidner) There are two levels - Pre-COVID/COVID. Our duty is to serve, help and protect individuals within the institution. We are not bound by the same structures as BHS. We have a variety of individuals we serve based on the spectrum of what they need. We are not diagnostic driven so we can have individuals who are Track 4 (our least restrictive level) that have chronic mental illness and are

thriving well in West County and are participating in their care and stable on their medication. 'Ballpark' numbers, typically West County (Richmond) the caseload runs a little over 200 and have been as high as the mid-200s to almost 300 individuals. Typically, these are Track 3 & 4, who are participating in their care are seeing the psychiatrist(s) and mental health clinical specialists regularly and are able to navigate a more dorm setting. West County is more of a campus setting / lower security. At Martinez Detention, our population has been pretty stable at approximately 200 individuals and it is the medium to maximum security. Those distinctions are informed by custody, health doesn't inform that location. The census at MDF is under 200 presently and fluctuates between 150-160, the percentage on the mental health caseload fluctuates and upwards of 30% (possibly 35%). The percentage of new cases identified at intake is typically 35 -40%. Those numbers have been pretty stable over the last couple of years and our identification has been consistent since we have implemented the track program. • (Cmsr. B. Serwin) I was going to ask the number of FTE's that have been added and are going to continue to be added. It makes more sense as it is such a high number. My one last question is: Funding for the medical and mental health care provided in detention, how is that funded? Or are you aware of that? (RESPONSE Dr. Tavano) People detained (Juvenile Hall or Adult facilities) even if they go in with MediCal benefits, we are prohibited to claim against it during the duration of detention. It puts a huge financial strain on the system. Once the person crosses the door into any of the detention facilities, their MediCal benefits cannot be accessed for their care. It is largely county costs that are covering the services. In terms of the settlement agreement, I couldn't speak to that but in general. (Cmsr. Andersen) It is coming from the general fund. It is a lot of money we needed to reach the settlement. There was a lot of negotiations, other counties that had to enter into settlement agreement with the PLO have paid substantially more than we have. Our goal to figure out, working with the PLO, how could we provide the highest level of care to those individuals. It is a lot of money and it will be an impact on our budget. This is not where we want to be helping people, it is not the ideal. We need to continue to look at 'what are we doing to divert people prior to them ending up in jail?' How do we provide those supportive services? Upon release, what supportive services and housing do we have? This is just a very small segment of time in which we have custody of an individual to try to help them turn their lives around. • (Enid Mendoza via chat) CY Detention Budget can be found, starting on page 323, at https://www.contracosta.ca.gov/DocumentCenter/View/64835/2020-21--Recommended-Budget?bidId=	
IX. RECEIVE update on the first Crisis Intervention Rapid Improvement Event (RIE), Aisha Banks Improvement Advisor, Clinical Informatics, Kenissha Johnson, East County Child and Adolescent Services, Commissioner Barbara Serwin, Mental Health Commission Rapid Improvement Event 1 (RIE) Report Out: April 2, 2021 presentation included many various slides including a long list of Sponsors, Leadership and guests participating and providing background on the process. AIM Statement: *"Anyone in Contra Costa County can access timely and appropriate behavioral health crisis services anywhere, anytime."* The current State Value Stream Map was presented (from November 2020), which was created to illustrate the journey that a person or family member takes through a crisis as best we could tell at that time from calling for help, all the way through crisis response, post-crisis. 'Waste' identified are listed in blue post it notes , which signify the different areas of waste that we have identified that are not of value to the consumer experience. Over 95 areas of 'waste' were identified include a few that follow:	The Crisis Intervention Rapid Improvement Event Update presentation to the Mental Health Commission was shared as a PowerPoint presentation during meeting.

- Only one team for the county based in Martinez
- Long travel times to other regions
- Not everyone receives a referral or gets connected to follow up services
- Redundant intake interviews
- The correct people are not sent to help the person or family in crisis.

These and many others were identified and we are continuing to work on and find ways to improve. The improvement priority areas coming out of that event were:

- Single phone number
- Mobile 24/7 Response
- Non-Police Mobile Crisis Team
- Alternate Destinations

In this RIE, the task was "How do we do PLAN-DO-STUDY-ACT (PDSA) cycles? Small tests of change, what are we trying to test and observe? What are the tasks going to be? What can we do on a small scale? Once we Do, Study (analyze) the results and Act (refine) adjustments, is it working? Then repeating the cycle until we get to the results that are acceptable.

Single Phone Number/Mobile 24-7 Team

- **Problem Statement:** There are 19+ telephone numbers for the public to access crisis mental health support. The uncoordinated multiple entry points limit access by creating barriers for an appropriate and timely response.
- **Goals:** By January of 2022 75% of individuals who call a single phone number for a mental health crisis will have 24/7 access to services and a mobile response within 45 minutes.
  Community Perspective: "I would like a direct line for a dispatcher. So that a mobile response could be contacted directly. Also, more mobile response so that they're not flying from San Pablo to Discovery Bay." – Healthcare Worker

TEST OF CHANGE:

- **Who would you call during a mental health crisis?**
  - **Problem**: The community does not know who to call FIRST for a mental health crisis other than 911.
  - **Test of Change**: We asked residents who they would call during a mental health crisis.
  - **Results:** Of the 34 people asked - 12% would call family member; 33% don't know who to call; 18% would call their doctor; 3% would call the suicide hotline; 9% would call 211; 25% would call 911.
    - ◊ Approximately 75% were not aware of the available community resources.
    - ◊ Community outreach is needed to market who to call besides 911.
- **What is the current system?**
  - **Problem:** Uncoordinated entry points for crisis support
  - **Test of Change:** Interviewed two existing call centers and two mobile response teams
  - **Results:** A centralized hub is more effective for a mobile crisis response
    - ◊ *"I would like the county to let people know that help exists and they can call other numbers besides the suicide hotline or 911"* – Teenage Student

The HUB: All calls are routed to a call center where they are triaged and dispatched to Mobile Crisis Teams in the field.

Crisis Triage and Assessment Team

- **Problem Statement:** Mental crisis calls (regardless the source) are not consistently responded to with a mental health crisis team.
  - ◊ *Who responds to mental health crisis calls? Too often, it is just the police.*
- **Goals:** Develop two triage tools [911 diversion & mobile team assessment] and a decision tree that can provide *the most appropriate level of care* in a *timely fashion* to anyone, anywhere, & anytime.

- **Lived Experience Perspectives**
  - ◊ *"In February 2021, the Martinez Police brought my son who was threatening another with a knife into Psychiatric Emergency. Law Enforcement must spend as many hours training how to save the life of a person whose mental state is impaired as they do apprehending a person robbing a bank."*
- **Family Perspectives**
  - ◊ "Our son's first involuntary hold was a suicide by cop-type event. He was 16. I have had to call the police over 50 times in the past 19 years in order to get him medical care. He was 5150d every time, which is not easy. That usually meant that we were living on the edge, in fear of what he would do to himself or someone else. We knew that if we called too soon, he wouldn't be taken into the hospital. So, we waited and, when the time was right, my husband would stand watch while I snuck into the backroom and dialed 911 and said, "Please hurry."
    We have had to watch our son walk out of our front door in handcuffs to the waiting ambulance too many times. It is the same door that I carried him through as a baby. This illness and system were not included in the dreams for our newborn son and our family. But now that they are our reality, I have committed to partnering with anyone to fix what I call the system of luck and heroics. **All of us in this room are part of that system and we need to join our voices and start shattering silence about the chaos of care."**
- Mental Health is the 'Fourth Arm'
  - ◊ Law Enforcement
  - ◊ Fire
  - ◊ Medical
  - ◊ **MENTAL HEALTH**

- 911 Triage Tool
  - 911/Dispatch
    - ◊ Is there a **Mental Health/SUD Issue**?
    - ◊ Are there **Weapons**?
    - ◊ Is there a **Medical Issue**?
    - ◊ Is there **Violence in the Moment**?
    - ◊ Are there **Credible Threats**?
  - Notify MCRT
    - ◊ If MH/SUD → always send out MH team
    - ◊ If weapons, medical, violence, credible threats
      → LE and EMS will go out with MH team available
- Call to 211/Access Line/988
  - 211/Access Line/988
    - ◊ Are there **Weapons**?
    - ◊ Is there a **Medical Issue**?
    - ◊ Is there **Violence in the Moment**?
    - ◊ Are there **Credible Threats**?
    - ◊ Is there a **Mental Health/SUD Issue**? = Contact appropriate agency (Fire, Medical, Mental Health)
  - Notify MCRT
    - ◊ Mobile Response Team responds to crisis
  - Notify Law Enforcement & EMS Backup
    - ◊ If **Potential for Weapon, Violence, Credible threats, medical**= yes
    - ◊ If potential for **Need for Transport** = yes
- 911 Diversion Test
  - **Problem:** Employ 911 triage with police dispatch to understand if mental health was identified
  - **Test of Change:** Applied mental health crisis scenarios with Concord Sgt to see if he would deploy MRCT or MRT.

- **Results:** In a little over half of scenarios a mental health crisis team would NOT have been deployed in conjunction with law enforcement.

- Triage Decision Tree Test
  - **Problem:** The current decision tree is not inclusive of all potential crisis scenarios
  - **Test of Change:** We tested the current decision tree and ask for feedback on how we can include the critical elements that would make it more inclusive.
  - **Results:** Revise the decision tree to make it more inclusive of all crisis scenarios

Non-Police Mobile Crisis Team

- **Problem Statement:** It's hard to get a consistent quality non-police response to a Mental Health Crisis in Contra Costa
  - ◊ *"You* **need** *to have a crisis at certain times of day, have certain insurance, know who to call, what to ask for, and be patient…."* Non-Police Team
- **Goal:** When "Mental Health Crisis" Rapid Responses are requested; we will provide the "least restrictive" response and start providing services within 45 minutes of the call, during expanded business hours for now, and attempt follow-up on 100% of the interactions by 12/31/2021.
- **Perspectives**:
  - ◊ **"I *thought* 911 was the only option"** –San Ramon family
    "One **common issue** that comes up with **city/county driven non-police response** projects is that they can end up either **replicating punitive structures** (like mandating care or forcing treatment) or getting stuck in a place where the **police leverage their power** to make sure they're still somehow connected into responses" – Alameda County Community Crisis Group

Reduce Police Involvement with Adult Mobile Crisis Response Team

- **Problem:** Police presence can escalate/traumatize customers. Delays time to respond.
- **Test of Change**: Change from a Police Co-Response Model to MH First when safe
- **Results:** Called dispatch in advance but not able to evaluate results based on calls today. Using MH First Model has been tested and can work
  "I had a fear *of calling 911, with my son being in AA and restrained in the past. However, here with Concord Police and MCRT, we had a positive experience and we will call again."*

Use of Technology

- **Problem:** Response times can be too long. Hard to share resources and securely connect with Customers.
- **Test of Change**: Asked customers if they had interest in virtual connections. This will also improve wait times.
- **Results:** Want to test tech next time but idea was received favorably
  "In the future, I would be open to virtual interactions"

Overall Recommendations

- Implement a Regional Call Center Hub
- Revised the MH Triage tool
- Empower law enforcement dispatch with a standardized, clear county wide protocol to utilize the mental health crisis response team
- Offer a clear alternative to 911 for mental health and substance use crises
- Review a subset of all law enforcement dispatch calls to determine what percentage could deploy the mental health crisis team
- Establish a coordinated review process that includes, law enforcement, behavioral health, emergency medical services, families for how we are doing, identify and explore possible improvements

- Establish collaborative/crossover training program for mental health, law enforcement, emergency medical services – all call takers and crisis responders

How will we know we are successful?

- **Program Success:** The coordinated response should be able to reduce the number of mental health detention bookings, police interventions for mental health, reduced involuntary holds, psychiatric emergencies, and link people into ongoing behavioral health care.
  This program will save lives

Comments and Questions:

- (Dr. Tavano) The Design Teams are doing amazing work, but just for context, this county has only had an adult MCRT for just a little over two years. There has been over 600% increase in utilization over the past three months / at 20% increase in calls for MCRT. The context, we are talking about four (4) teams of two (2) people each – That's eight (8) people, covering a county of 1.2 million people and going from the Bay to the Delta and to the Benicia Bridge and down to Alameda county. It is very understandable why there delays. This program is still in its 'infancy/juvenile' form.
- (Gigi Crowder) One of the measures of success the team came up with is to ensure this program will save lives and have a coordinated response from the beginning of crisis through crisis stabilization and recovery. That is one of the things the Central HUB will help in with the non-police response. Building this will help saves lives.

<DUE TO TIME CONSTRAINTS>
It was requested by the Vice-Chair that all questions be sent through chat.
Aisha Banks and the rest of the team will follow up right away.>

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

There are number of items to cover, but specifically two or three from my report:

- County response to COVID and how we are doing: We are moving in the right direction. It is starting to feel good and hopeful. Everyday, thousands of residents are vaccinated within Contra Costa. We have been ahead by opening up the vaccine availability to all residents and others working in the county for ages 16 and above. The county exceeded its own goals of when that would happen and have implemented sooner than other counties in the state. CCC has been able to make the vaccine so much more readily available to every resident 16 and above, I must mention there are differences in making an appointment through CCHealth.org vs MyTurn (the state operated system). Since the county is ahead of the state in many ways, if you go to use MyTurn, those already in the eligible category state-wide would be able to access appointments. However, in our county, since we opened the vaccine availability more broadly and so quickly, it is still best to go through CCHealth.org to make those appointments, because MyTurn will not allow you to schedule appointments (for example) in the 16 plus age group.
- Well over 50% of the residents of CCC have had, at least, one dose of vaccine. We are definitely getting there and have moved into the Orange Tier. If we keep up the pace with the vaccinations, and everyone to continue with the mask and social distancing protocols, it will get us to community immunity. Once 80% of the county's residents are vaccinated, we will be at that point. We will be hitting that mark sooner than the original May target date.
- In terms of BHS, and the use of technology, we can see every day how many of those we serve are continuing to be vaccinated. We are putting a lot of effort into outreach and contacting them to be vaccinated. In the process of doing so, we are finding a number of clients who were receiving services have 'fallen through the COVID cracks' as they were receiving in person services and now, they are not. In person services are so important to so many and making these

clients. Making these calls, the clerks are actually able to make the appointment for them while they are on the phone, arrange for transportation, if needed, and bringing them back into the system. In a week, we were able to reach out to over 300 clients and get them scheduled.

- It is great to be part of Health Services and have highly collaborative divisions working together. Just as we were approved to be a mini-HUB to vaccinate all the Behavioral Health Providers in the county (December/January), we were approved to be a vaccination HUB at our three Adult Regional Clinics.
- We are able to track and encourage those not wanting to receive vaccinations
- As we move from Orange to (hopefully soon) the Green tier, it is opening up our in-person services. Now it is assessing who has benefited from remote services and client choice. Our goals include reducing social isolation and increasing social inclusion. If we stay providing remote services to the extent we are now, we are not meeting those goals. Clinics have stayed open with reduced hours and staggered staffing but we are now pivoting back. By May, we expect staff will still be providing some remote services but increasing in person services. Target date of June 15th.
- As schools are reopening, we will be resuming in person services in schools and redirecting some focus on youth mental health.
- BHS budget is going before the Board of Supervisors on April 20th and if all goes well. If approved as is, it looks like a flat budget for 2021/2022. No big decreases or increases overall. However, within the budget between the mental health and substance abuse (we still must divide it because the funding sources are divided), we are going down just under $1million on the mental health side, but going up approximately $1million on the substance use treatment side. Overall, it looks flat, a bit of a decrease from last year, but overall same.
- We received notification last week from CHFFA (Cal Health Facilities Financing Authority), the grant we completed ourselves with just a few people was approved. This is an initial allocation, if another county appeals or objects, the allocation might change. We think we are on track for the receiving the full initial allocation (approximately $2.4 million). Our grant application was through the CHAFFE initiative addressing youth in crisis. The project proposal had to geared toward youth and CHFFA grants are not about staff, but 'brick and mortar' so we put in a $2.8 million grant application to renovate an existing building. We received approximately $2.4 million. It will be creating a free-standing six (6) bed crisis stabilization unit for youth under 18 years old.

Comments and Questions: None

XI. Adjourned Meeting at 6:38 pm