MHSA-FINANCE COMMITTEE MEETING
MINUTES
May 20, 2021 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Douglas Dunn, District III called the meeting to order at 1:33 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Absent: Cmsr. Graham Wiseman, District II Presenters: Jan Cobaleda-Kegler, PsyD, Mental Health Program Chief Natalie Dimidjian, PhD., Program Manager Forensic Mental Health Maria Scannel, LCSW, MCRT Program Supervisor Other Attendees: Guita Bahramipour Angela Beck Jennifer Bruggeman Enid Mendoza Dom Pruett Stephanie Regular Cmsr. Barbara Serwin, District II	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: • Alarming word from fellow advocates in Southern California, the Department of State Hospitals (DSH), (1) wants to stop admitting anyone that is under an LPS Conservatorship to state hospitals; and (2) do not want to have persons that are incompetent to stand trial to go to state hospitals until there is a Murphy Conservatorship. Persons have to be incompetent to stand trial for two consecutive years, before they can be considered for Murphy conservatorship in a state hospital stay. This has staggering implications and, again, my advocate friends, the state has a $100 billion surplus; and the DSH want to do this. I understand it's tied up with the ACL lawsuit with the DSH, having to do with the waitlist of persons to get into the state hospital that are waiting for an incompetent to stand trial bed. They are just not available. This is going to put real pressure on the Contra Costa County (CCC) jail system. I am just saying, Leslie, for you and me, because county employees can't advocate, but we can. We need to advocate that this DSH decision is reversed. There is money to change it right now. (RESPONSE: Cmsr. May) There is money there, available. I heard about this approximately three weeks ago. What is happening, they are trying to link it with the criminal justice money. Remember all that money came in, all of a sudden…all the	

criminal justice equity and they are trying to link it with that. (D. Dunn) the problem (philosophically) I have is under this DSH proposal, it would merely become an ancillary "arm" of the state prison system (i.e., CA Dept. of Corrections & Rehabilitation).	
V. APPROVE minutes from April 15, 2021 MHSA-Finance Committee meeting: Cmsr. Douglas Dunn moved to approve the minutes as written. Seconded by Cmsr. Leslie May. **Vote:** 2-0-0 **Ayes:** D. Dunn, Leslie May.	

VI. DISCUSS/RECEIVE Presentation of funding and programming needs for multi-location 24/7 county-wide adult Mobile Crisis Response Teams (MCRTs). Presenters: Marie Scannel, PhD., Program Manager, Forensic Mental Health, and Natalie Dimidjian, LCSW, MCRT Program Supervisor.
Mobile Crisis Response Team (MCRT) is a specialty mental health service in the Adult System of Care to serve Medi-Cal and uninsured adults with chronic mental illness in all regions of Contra Costa County. (Natalie Dimidjian)
• The MCRT is designed to have mental health providers respond in the community to serve adults who are experiencing a psychiatric crisis. The program is designed to respond to calls in the field to de-escalate the crisis, provide stabilization, and prevent psychiatric hospitalization. If the situation cannot be de-escalated in the field, the MCRT will assess for 5150 criteria, and if criteria are met, the Mental Health Clinical Specialist can initiate a 72-hour 5150 involuntary hold.
• In addition to responding in the community to the immediate situation that led to calling the MCRT, the team provides a 30-day period for follow up during which they focus on linking individuals to a variety of services to help them stabilize and prevent ongoing crisis experiences.
• Staffing:
  • 3.5 Mental Health Clinical Specialists
  • 3.5 Community Support Workers
  • 1 Nurse Practitioner
  • 1 FT Senior Clerk
  • 1 FT Program Supervisor
• Hours:
  • Monday-Friday: 8:00am-10:30pm
  • Saturday & Sunday: 8:30am-5:00pm
  • Holidays: 8:30am-5:00pm
• Funding:
  • $1,860,204 (FFP and MHSA)
MCRT Calls per City (charts presented exhibited the number of calls received from each city in each county region between July 1, 2019, and April 30, 2021). The MCRT received 3,607 Calls, of which 3,041 were calls within the county:
• West County
  • 686 calls (23%)
  ◊ Crockett – 8 calls
  ◊ El Cerrito – 37 calls
  ◊ El Sobrante – 60 calls
  ◊ Hercules – 17 calls
	MCRT PowerPoint presentation screenshare during meeting.

- ◊ Pinole – 52 calls
- ◊ Richmond – 374 calls
- ◊ Rodeo – 19 calls
- ◊ San Pablo – 119 calls

- Central County
  - 1414 calls (46%)
    - ◊ Clayton – 20 calls
    - ◊ Concord – 634 calls
    - ◊ Danville – 61 calls
    - ◊ Lafayette – 38 calls
    - ◊ Martinez – 237 calls
    - ◊ Moraga – 22 calls
    - ◊ Orinda – 28 calls
    - ◊ Pacheco – 13 calls
    - ◊ Pleasant Hill – 101 calls
    - ◊ Ran Ramon – 80 calls
    - ◊ Walnut Creek 180 calls
- East County
  - 941 calls (31%)
    - ◊ Antioch – 473 calls
    - ◊ Bay Point – 124 calls
    - ◊ Bethel Island – 5 calls
    - ◊ Brentwood – 66 calls
    - ◊ Discovery Bay – 20 calls
    - ◊ Oakley – 78 calls
    - ◊ Pittsburg – 175 calls
- MCRT Crisis Assessment Outcome
  - West County
    - ◊ For cases where MCRT was dispatched, in 49% of instances, staff were able to de-escalate the situation/crisis.
    - ◊ In 29% of instances, client was 5150'd - PES.
    - ◊ And in 16% of occurrences, client was not present when MCRT staff arrived.
  - Central County
    - ◊ For cases where MCRT was dispatched, in 50% of instances, staff were able to de-escalate the situation/crisis.
    - ◊ In 32% of instances, client was 5150'd - PES.
    - ◊ And in 13% of occurrences, client was not present when MCRT staff arrived.
  - East County
    - ◊ For cases where MCRT was dispatched, in 54% of instances, staff were able to de-escalate the situation/crisis.
    - ◊ In 29% of instances, client was 5150'd – PES.
    - ◊ And in 13% of occurrences, client was not present when MCRT staff arrived.
- MCRT Average Travel Time:
  - Average Travel time to West County (159 calls): 63 minutes
  - Average Travel time to Central County (309 calls): 67 minutes
  - Average Travel time to East County (193 calls): 73 minutes
  - Average Travel time to South County (51 calls): 87 minutes

The Rapid Improvement Event (RIE) started back in the fall in response to the community and recognizing we needed a crisis response for the needs of our members, especially a non-police crisis response. The Health Service Department (HSD) set up a process, these improvement events. The second one just took place at the end of April. The AIM of this project is: Anyone in CCC can access timely and appropriate behavioral health crisis services anywhere, anytime. The workgroup has identified four priority improvement areas

- Single phone number – right now it is 911, 211, Access line, 988* (the Miles Hall Number) or through other agencies. Right now, there is a committee to tackle the single phone number issues.
- Mobile 24/7 response
- Non-Police Mobile Crisis Team
- Alternate Destination – this addresses the issue of when the team goes out and they deescalate a crisis? The person doesn't need to go to PES (psych emergency), they don't need to go to the hospital, but do need some downtime, maybe a place where they need to get centered and still themselves away from home. This can also include sober centers, and the like.
    - The model the team came up with is called the Community Mobile Crisis Collaborative Integrated Response Model (Slide 4 Flow Chart). The plan is to have a Behavioral Health Virtual Hub that will process these calls. All calls will come in and processed by a crisis counselor. This is being done now, but this would be on a bigger scale. The virtual hub will take calls from all over the county and the MCRT is dispatched. Crisis is de-escalated and route the customer to the hospital or a safe place / alternate destination. After which, a long-term treatment plan will be determined. The goal being: decreased use of Jail, Emergency Room and PES.
- Behavioral Health Virtual Hub Team NEXT STEPS:
    - Develop a 24/7/365 Centralized Crisis Call Virtual Hub
        - ◊ Call answered by a trained mental health professional
        - ◊ Based on the Substance Abuse and Mental Health Services Administration (SAMHSA) **Best Practices**
        - ◊ Offers air traffic control (ATC) quality coordination of crisis care in real-time
        - ◊ The HUB will provide seamless coordination from the customers crisis entry to follow up care
- Crisis Assessment Triage Decision Tree used to process the crisis call (Slide 10 flow chart) NEXT STEPS:
    - Test and time triage tool to be utilized for Virtual Hub and Collaborative Mobile Responses

Mobile Crisis Collaborative Response Team (Slide 13 flow chart Model)

- Short-term NEXT STEPS:
    - At least 25 Mental Health only responses before next Rapid Improvement Event
    - Pilot use of police radios for clinicians for improved immediacy of response and communication among team members
    - Analyze data from responses
    - Consistently administer follow up surveys:
        - ◊ Law Enforcement
        - ◊ Clinicians

- ◊ Community Support Workers
- ◊ Community Members

- Long-Term NEXT STEPS:
  - Pilot option of having an EMT as team member
  - Further refinement of triage assessment
  - Pilot use of crisis support worker (mental health specialist)
  - Law Enforcement be a member of c-response team ("task force" model)
  - Streamlined transportation modalities

Alternate Destinations:

- Future State Alternate Destinations Model (Slide 17, Flow Chart)
  - Co-Occurring Treatment facilitates
  - Crisis Residential
  - Crisis Receiving and Stabilization Center ('No Wrong Door')
  - Drop-in Clinic/In-Home Support
  - Sobering Center
  - Respite
  - Shelter
- Creating Alternate Destinations NEXT STEPS:
  - Expand and Create Children and Adult services in all regions:
    - ◊ Peer-Operated Respite
    - ◊ Sobering Center
    - ◊ Crisis Stabilization Unit
    - ◊ Crisis Residential Facilities
    - ◊ Co-Occurring Treatment facilities
    - ◊ Shelter and safety for those living with Mental Illness
    - ◊ Drop-in Clinic/In-Home Support
- Data Measures
  - Percent of HUB calls answered, screened, and routed to the appropriate source within 3 minutes
  - Mobile Crisis Collaborative Response Team answers all calls within 30 minutes
  - Reduce avoidable 5150s by 25%
  - Community Satisfaction and Customer Experience targeted at the 75th percentile
  - Reduce cost per crisis by 20%
  - 80% of all crises have follow up care services (wrap-around)
  - Team Satisfaction targeted at 80% (satisfied – very satisfied)

MCRT Budget Questions (Jan Cobaleda-Kegler) From Board of Supervisors Approval of FY 2021-22 Recommended Budget Actions:

- How are we funding the Mobile Crisis Response Team? Right now, it is funded by the Mental Health Services Act (MHSA) and pull down Federal Financial Participation (FFP).
- Are Mobile Crisis Services funded in FY 2021-2022? The MCRT provides crisis intervention response to adult clients experiencing mental health crisis seven days a week, Monday through Friday from 8 a.m. - 10:30 p.m. and Saturday, Sundays, and Holidays from 8:30 a.m. -5:00 p.m. There are currently 3.5 teams, each consisting of a mental health clinician and peer. These teams coordinate crisis response and 5150s, with law enforcement agencies as needed, and County emergency services. Approximately 1600 calls were received in FY 2019-20, and the call volume continues to increase monthly.

The goal is to decrease 5150s, reduce psychiatric emergency services (PES) visits, and refer clients to the appropriate services in their communities. Funding sources include Medi-Cal, AB 109 Realignment, and Mental Health Services Act Prop 63 revenues.

- Additionally, as referenced in slide 26 of the Health Services Department's Recommended Budget Presentation, the American Rescue Plan Act allows California to provide community-based mobile crisis intervention services. These services will provide multidisciplinary mobile crisis team to an individual who is outside of a hospital or facility and experiencing a mental health or substance use disorder crisis. Services must be available 24 hour per day, year-round and members of the team must include at least one behavioral health care professional trained in trauma-informed care. The State option will be available for a 5-year period, with an enhanced federal match for costs set at 85%. For the remaining 15% the Department would either need to find State funding or support from Measure X revenues.
    - Community Crisis Services: The American Rescue Plan Act allows California to provide community-based mobile crisis intervention services:
        - ◊ Provided by a multidisciplinary mobile crisis team to individual outside hospital/facility experiencing a mental health or substance use disorder crisis
        - ◊ Services must be available 24/7/365
        - ◊ Team includes behavioral health care professional trained in trauma-informed care
        - ◊ State option available for 5-year period
        - ◊ Enhanced federal matching for costs set at 85%

The Department will continue to work with a sub-group of the Public Managers Association. Current work includes seeking a single regional model, in coordination with cities, inclusive of a funding plan and a sustainable plan to provide non-police behavioral health community-based crisis services 24/7, 365 days per year.

Questions and Comments:

- (Cmsr. Leslie May) We need more locations. If I had a magic wand, I would like there to be more locations spread out throughout the various regions so the response times would be shortened significantly / reduced travel time. What are the direct phone numbers? (RESPONSE: 1-833-443-2672).
- (Stephanie Regular) Is there a continued phone contact while the team is in route? (RESPONSE: Natalie) No, when the call comes in, we gather the demographics and get the call situation, presenting issue, current crisis and gather information on any existing mental health services and determine at that point if the call warrants a field visit. Typically, we end the call and let the caller know 'yes we will be responding'; we can be out in an hour (depending) on other calls that are taking place, usually the team is able to communicate with each other about what is pending and give some level of an ETA. At that point, we call dispatch non-emergency line, if we are requesting law enforcement for safety issues. (Marie Scannel) Stephanie, if it is a real immediate emergency, like someone is actively suicidal with a knife, then the team calls 911 and stays on the phone until response personnel are there.
- (Cmsr. Douglas Dunn) What is the level of training is pre-supposed for those handling the calls in virtual HUB? (Response: Jan Cobaleda-Kegler) I would say

those with experience working with crisis, especially with mental health crisis. Those who are licensed-eligible and licensed. I believe we have crisis counselors that don't have to be licensed but who definitely have experience with working those who have mental crisis and issues. In many of our programs, we have community support workers who are very skilled and work in partnership with some of our licensed clinicians that go into the jail and do groups, and lead groups in the clinics. We would want that level of experience/education working in the HUB. The people in the HUB are going to be listening, processing, and trying to troubleshoot how to respond to the crisis. They have to have the ability to do that.

- (Cmsr. Leslie May) My questions are regarding a warming center, sober center, and sub-counselors, they could also be part of this. I am wondering, though, there is a population of that people are not tapping, that is those finished with their master's programs and trying to get hours. Mobile crisis, you get all issues all at once. It is hands on training, learning how to recognize and de-escalate many situations at once. It is a high level of pressure and energy. There are a lot of people that are trying to get their hours, as well as many trying to their licensing. (Response: Jan Cobaleda-Kegler) That is a really good idea Leslie. There are a lot of licensed-eligible folks that want to get experience. It is a great place to get experienced working with people in those kinds of situations.
- (Cmsr. Douglas Dunn) To follow on, Jan, with what Leslie was just asking, I saw the crisis triage slide. How are community support workers from family perspective and the peer perspective, slated to be used in the crisis triage set up? (Response: Jan Cobaleda-Kegler) We will still be using them. Our community support workers provide a lot of lived experience and peer provider support to family members and loved ones to those having the crisis. (Natalie Dimidjian) The CSWs on the team have been really valuable and are picking up the calls when they come in to the 800-line. They are doing some level of triaging, as well. All of our CSWs come with, at least a minimum currently, of two (2) years' experience in the mental health field. They have gotten very skilled and, over the last couple of years, in managing the calls coming in and knowing when it is appropriate to send the call to a clinician for further evaluation. Our CSWs are doing a lot of work with family members, in terms of supporting family members who may have been involved in the crisis, helping with navigating the mental health system and providing phone numbers (PES, 4C, 4D, etc.). The triage in the slide that Jan displayed, is the current MCRT triage that you were able to view. We will likely (maybe) do some refining following the rapid improvement events (suggestions, efficiency help, necessity of a site visit?).
- (Cmsr. Douglas Dunn) One of the slides, Concord, Richmond & Antioch are the highest call cities. Within that, what seem to be the busiest days and hours where the demand for MCRT is highest? (Response: Natalie Dimidjian) That's next on our request for data. To get a better understanding. We do not have the raw data to tell you what the busiest time is, but I can just speak to experience her in the office (hearing the phone ringing and going to voicemail because there is no one available to answer the call). Currently, the busiest is in the morning right at 8:00 am to 1:00 pm. We get a lot of calls. Six (6) months ago, the busiest was between 10:00 am and 4:00 pm. It seems to have shifted a bit earlier.

- (Cmsr. Leslie May) Looking at the chart and analyzing the calls compared to the COVID pandemic and trends (March to October and since the election) the trends have gone up and stayed up through January. Many different variables corresponding to the trends calling, it will continue to escalate. These events happening are considered crisis to many people and it is affecting their mental health. There needs to be some type of statistical program to correlate the number of calls with the state of crisis that is occurring on a consistent daily basis. (Response: Marie Scannel) What you are very accurately describing is the accumulative effect of trauma. This is the trauma throughout the country that we are all experiencing day-to-day, and we are seeing it with all the people we are serving in all programs daily.
- (Leslie May) The effects of COVID are yet to be determined. Every day, there are more people with underlying effects from COVID. People who have never had a mental health crisis, acting out of character, dementia-like symptoms. This is a mental health crisis, and it will only get worse. This is something that needs to be addressed now. Not two or three years from now, but now. (Cmsr. Douglas Dunn) Just to follow up on what Leslie May has stated, I have recently come across / read article, 20% of COVID cases (1 in 5) are resulting in persons having severe mental illness that, prior to COVID, never showed. Are you running into these kinds of situations during your MCRT calls? Situations that are COVID induced psychiatric symptoms? (Response: Natalie Dimidjian) Not that I am aware of, not hearing from the team. (Leslie May) Natalie, that is a question that they need to be asking, when they receive the call: "Did you have COVID?". (Natalie) Yes we do but need to continue to follow up on that. (Marie Scannel) It is a very good point, what you are talking about with the articles, there is a study being conducted in Delaware around this issue and I think, again, it's not just with MCRT, it is in other programs too. A situation that doesn't make sense, suddenly someone in their 50's doesn't have their first psychotic episode. We need to start asking those questions more and more. I agree with what you are saying, Doug, the research is showing there is a substantial number of people showing psychotic episodes in response to the COVID virus.
- (Angela Beck) I do know they are keeping track of this through the vaccination follow up. I do not know if BHS is keeping track, but having been vaccinated at the hospital early on, we were strongly urged to register with follow up on the vaccine given and give our status daily (this was December when I registered, it is now May/almost June), and I am still contacted weekly on symptoms, known and new. The questions are regarding side-effects from the vaccine, but it is not just physical health…it is mental health questions. They are keeping track because, dependent on the severity of the COVID case, they are seeing the trend of those not ever having a psychotic break before contracting COVID are now having them. Those who have not had mental health issues are having them. Not just talking about being cooped up from the shelter in place and the whole realm of anxiety and depression…this is a new phenomenon that COVID is causing. They have to be very careful in determining if it is a response from the vaccine or COVID. Memory loss is another emergent symptom from COVID. This was being noted before anyone was able to be vaccinated. This is a trend they were aware of prior and are keeping track.
- (Cmsr. Douglas Dunn) There has been a strong push to speed up the response from 45 minutes to 20 minutes when there is a real crisis anywhere in the

county. What is your take on the number of MCRTs needed in various locations throughout the county to meet that 20-minute crisis standard? Has there been any thought given to that? . (Response: Jan Cobaleda-Kegler) This has been addressed and folded into the improvement event weeks. In between the events, there is a design team that continues to meet. They are researching and running numbers to accommodate that goal. I don't have that specific information as they are just starting to work on this and will continue on the week of June 7th. (Cmsr. Serwin) Yes, there is intensive effort going on right now to identify the assumptions and how many teams will be needed. (Jan Cobaleda-Kegler) if we had an urgent care center and MCRTs stationed in each region merely to cut the response time. For example: if you live in Richmond and there is a crisis, we should have a team stationed in west county. We should have teams stationed in each District. The corridor, as well as time of day and traffic adds to the response time. • (Cmsr. Leslie May) I just put a comment in CHAT. From what I understand yesterday, Don Brown Shelter, in Antioch, and Nierika house, in Concord will be empty before the end of the month. These are two locations that are actually (physically) there. Those are two locations that could be available for the MCRT dispatch. There are places in each district that could be used for alternate destinations. (Response: Jan Cobaleda-Kegler) Don Brown is still taking clients and available. (Cmsr. May) Both facilities will be moved to Richmond by the end of the month. (Jan Cobaleda-Kegler) Alright. Thank you.	
VII. Adjourned at 3:02 pm.	