MHSA-FINANCE COMMITTEE MEETING
MINUTES
September 16, 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 1:34 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Absent: Cmsr. Graham Wiseman, District II Presenters: Jessica Donohue, Executive Director, Seneca Contra Costa & Solano Counties Programs Byron Iacuaniello, Clinical Director, Youth Homes TAY Programs Other Attendees: Jennifer Bruggeman Angela Beck Jen Quallick, Supv. Candace Andersen's office	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: • National Alliance on Mental Illness (NAMI) Contra Costa is holding a Suicide Prevention Awareness at Contra Loma Regional Park, Antioch, California, this Saturday from 9:30 to 11:00 am. There is an admission charge, but state you are with NAMI and the $5.00 parking fee will be taken care of by NAMI. • The Mental Health Commission (MHC) Retreat is Wednesday, October 6 from 3:30 to 6:30 pm.	
V. APPROVE minutes from August 19, 2021, MHSA-Finance Committee meeting: Cmsr. Leslie May moved to approve the minutes as written. Seconded by Cmsr. Douglas Dunn. **Vote:** 2-0-0 **Ayes:** D. Dunn, L. May. Abstain: None	
VI. RECEIVE SENECA Family of Agencies Contra Costa Program & Fiscal Review, Jessica Donohue, Executive Director, Seneca Contra Costa & Solano County Programs The Mental Health Services Act (MHSA) review of START program was in 2017. The MHSA review of the program was due just before COVID hit (Spring of 2020).	Program review brochure shared on screen. No PowerPoint presentation.

We are definitely looking forward to the next opportunity to do a whole program review. It is a really valuable experience to look at all the data as a whole and get feedback from our participants and staff. We have been significantly below our goal of 75 youth and is tied to staffing turnover and clinician turnover, including several folks on medical leave and COVID. It has impacted our staff, as well as the competitiveness of our salaries. We need to be able to increase our reimbursement rates so we can directly pay our staff higher salaries because it is the only way we will be able to attract and retain quality clinicians and staff.

Short Term Assessment of Resources and Treatment (START)

The START program is Seneca's full service partnership (FSP) program that is partially funded by MHSA and partially funded by EPSDT (Early and Periodic Screening, Diagnostic and Treatment). We began the program in 2013 and is designed to be the children's crisis FSP. The program began with the goal of addressing the flow into psych emergency (PES) that children often make where they are brought to PES (via 5150 or 5585) and then returned home without a true mental health intervention or any real linkage to resources. The goal of the program is actually to outreach to youth who have gone to PES and are not yet connected to mental health service in Contra Costa County (CCC) to ensure they are aware of and supported to connect with those resources in CCC so there is no need to return to PES, in order to help provide resources to divert unnecessary visits to the hospital.

Seneca's primary approach to care and model of treatment is based on unconditional care. We don't dismiss or eject children from Seneca services for the behaviors that brought them into services. That model is really to say that we don't give up on kids and families. We know these clients and their families have complex histories that have brought them to our care and we are continuously trying to be creative and think to 'what haven't we tried yet?' and continue to try different interventions until we find the one that works.

The START program is family driven and a strength-based service planning modality. We want to always leverage family's strengths and competency so we are, not only looking at what hasn't worked, but what has worked. What can we capitalize on to help families find stability and success. The program is highly individualized and is flexible to provide more or less intensive support. Some families have external resources to get to appointments or afford basic needs, other families are really struggling with external factors and impacts the family stability. We have the ability to support families really intensively or in a more 'hands off' way, depending on the particular family needs might be.

Cultural competence is one of MHSA's values and Seneca's, as well. We don't believe we can achieve complete competency as it is an ongoing process of awareness of our own potential bias and our own identity and working with families to understand what makes them unique and how we can tailor services to work for their family based on their own backgrounds (cultural, regional, socio-economic, gender, religious, etc.).

Interagency Collaboration is another key focus of the program and directly linking/working in partnership with both the county behavioral health programs and other community providers. We have facilitated connections for older youth to youth homes and other programs in other regions of the county (West, East, Central, South) and other recreational, therapeutic, community-based supports.

It is important to us that we are connecting and integrating with other community partners in CCC. We serve children of all ages through their 18th year (until they turn 19). Generally, they are seen at a PES first, then work with youth and families for approximately a six (6) month period.

The original intention of the START program was that we would work with youth and families for three to six months. Over the last several years, we have seen the length of treatment has actually extended. It used to be around four and a half (4-½) months and that is now closer to 6 months. It is a shorter term intervention with the goal assessing what led the client and the family to the point of crisis and what are their general needs (support needed) and what resources might be useful. We don't provide direct psychotherapy but link to those services for the families to connect with longer term support.

We do brief counseling and every youth in the program is connected to a personal service coordinator that is a clinician. We have a support counselor that is a bachelor's level counselor that works on coping skills and strategies with youth, safety planning, other community skill building and work on linking youth to resources in the community. There is also a family partner in the program who has lived experience and caring for a youth that has psychiatric needs. Currently, we do have bilingual clinicians, family partner and support counselor in the program. We are really happy and proud to be able to support families in their preferred language (Spanish or English).

As an FSP, we also have 24-hour support for our youth and families enrolled in the program and it is their own separate line. They can access support by phone and in person, as needed.

<u>Mobil Response Team (MRT)</u>

Seneca operates Contra Costa's Mobile Response Team (MRT), which is our youth crisis provider. We serve any youth under the age of 18, often to the age of 22 if they are still in care (still dependents). Anyone can access our support line through our 800 number at any time of day and we have clinicians in field, Monday through Friday between 7:00am and 11:00pm and on weekends from 9:00am to 9:00pm. Seven days a week, the line is always available. Even if it is not an infield response hour, you can still reach someone from Seneca who can provide crisis intervention and support by phone.

The team is staffed with all clinicians and are working on hiring peer support personnel and is on our list of goals for this year. We currently have 11 clinicians on the team and are working on hiring one more. We are much more fully staffed than we have been in the last two years and have Spanish speakers everyday of the week (currently five of eleven staff are bilingual). We will go wherever we are needed, therefore we meet families at their homes. During COVID, it has been tricky but we are still doing COVID screening questions by phone before going out in person to ensure our staff and families stay safe and healthy. Staff is fully outfitted in personal protective equipment (PPE) to go out in person as zoom is problematic for crisis support.

This time of year, we ramp up outreach to schools as they have cut their contracts with school resources offices and local police departments and we want to make sure schools have the MRT line easily accessible. If there are any ideas around that, we are always wanting to do presentations to different schools and organizations to ensure they are aware that MRT is out there in the community

and available. We do provide same day crisis response for anyone who needs. Our availability and how quickly we can get to folks is always dependent on where are teams are in the county at any given moment and can be a challenge for those wanting immediate response, especially with the traffic in CCC. The MRT planning process, we are definitely talking with Gerold (Leoniker) and our county partners regarding how might be able to fully regionalize to ensure we are able to get to any region to the county in 20 minutes or less. Right now, our average response time is just under 45 minutes to anywhere in the county. However, when a family is in crisis, 45 minutes can feel too long. That is something to be aware of, we always encourage calling as early as possible in the escalation curve so we try to intervene before it has reached the peak of their crisis and truly unsafe.

Questions and Comments:

- (Cmsr. Douglas Dunn) You talked about how the START program tries to get connection with youth homes and other FSPs, non-Seneca programs for referral. Coming into the program, do you get a lot of referrals from Seneca's MRT program? (RESPONSE: Jessica Donohue) The referral stream is typically where MRT and START are linked. When kids are seen at PES, everyday a list of youth who have been seen at PES and are not yet connected to other services in CCC are sent to MRT. The clinicians in MRT do the outreach to families to let them know they are actually eligible for the start program. They do the screening and eligibility assessment for START. MRT conducts the outreach and meets with the family, informs them of the services available to them, so that in the future, they wouldn't need to go to PES but actually call MRT in crisis and would identify eligibility for the START program.
- (Cmsr. Leslie May) What about youth receiving sexual assault counseling? As we know, there is a lot of human trafficking, there is a lot of sexual assault of our population, especially the youth population. Once the youth are placed back in that environment, they require intense therapy. Do you have people in the organization that are trained on that level, or do you work with an outside agency that is trained whose sole purpose is to work with victims of sexual assault and/or trafficking. (RESPONSE: Jessica Donohue) MRT and START are more brief interventions and not designed to provide individual therapy, we are connecting them with resources in the community, such as Community Violence Solutions or even the District Attorney's (DA) office – Victim's Assistance Unit where they can be connected with resources that have the expertise in that intervention. We have general skills and training on working with youth and families but our job is to help them feel safe enough to engage in the longer term counseling.
- (Cmsr. Leslie May) Right. I just think there are some subjects we don't talk about here and this is something that is a lot more prevalent, I'm learning more about just how prevalent it is in our county. Where are the services that intervene and help the children with ongoing support, because that is severe trauma that can continue well into adulthood and needs to be addressed. Thank you. (RESPONSE: Jessica Donohue) I definitely agree with you. It is an area that we actually don't (in CCC) have enough support surrounding the early intervention. Community Violence Prevention does provide groups or case management, but we are not quite there on the preventative side and having outreach teams to kids at high-risk. I think we could do better as a community.

• (Cmsr. Leslie May) Regarding staffing and salaries: Tap the semi-retired and retired because they wouldn't mind. They are not even worried about the salary because they have retirement. They don't mind picking up a little extra money but don't have to be locked in on 40 hours a week, etc. They are willing to work and why are agencies not going to AARP and looking for part-time staff. Retired workforce has, not just book knowledge but lived experience and are much more self sufficient on the clinical reports and diagnosis side. That would help with coverage of staff. (RESPONSE: Jessica Donohue) That point along with the clinical interns, specifically in the FSP programs, it is really challenging to have part-time employees because you don't know when the crisis is going to come up for a family. If it is not during a time where that clinician works, the other full-time employees end up picking up the slack or help cover that caseload. So, it is really important to have folks available five days a week. In some programs that is a great idea. • (Cmsr. Douglas Dunn) For MRT, unless it's a Medicare only insurance situation, that's when you can serve and MRT. Is that the same for the START program? (RESPONSE: Jessica Donohue) Great question. START is actually only folks with MediCAL or uninsured. MHSA portion helps us serve the uninsured youth and families in both START and MRT. However, with MRT we serve anyone in crisis, even if they have private insurance and they are in crisis, we will go out and will help them with follow up back to their private insurance provide but anyone can call MRT in crisis. Example, often times with schools, they don't necessarily know in the moment if that child has coverage or what their insurance coverage is. That's okay, we will go out anyway and find out later. MHSA also helps us with that flexibility, especially in certain areas of the county where there are lower percentages of MediCAL. • (Cmsr. Douglas Dunn) Has Seneca received feedback from the Crisis Response Rapid Improvement Event (RIE) regarding the need for 24/7 in person service from the county going forward at the MRT level (not the MCRT level, but the MRT level)? (RESPONSE: Jessica Donohue) We haven't talked about that lately. A couple years ago when we expanded the MRT, in partnership with the county, we actually doubled the size. At that time, we modeled out what it would cause to provide 24/7 in person response and also looked at our data, in terms of how many calls are we getting between that 11:00pm and 7:00am time. The need is really low and it remains really low. We made a decision at that time that it didn't make sense for the cost to actually maintain in person support availability in those over night hours. That is how we designed the hours we have now. There are very few cars and generally, when we see needs in that overnight time, it is either a young person who is psychotic or not sleeping (substance use) and often actually do need emergency intervention and not necessarily a mental health need that can be stabilized.	
VII. RECEIVE Youth Homes Program & Fiscal Review discussion and documentation for its Transition Age Youth (TAY) Full-Service Partnership (FSP), Byron Iacuaniello, Clinical Directory, Youth Homes TAY Programs. Youth Homes is a non-profit agency in Contra Costa County (CCC) and have been around almost 60 years (2025 will be 60 years). Youth Homes started off as a residential group home for children in child welfare and have expanded on this.	Youth Homes Power-Point presentation screenshare during meeting and can be

Our organization empowers youth and young adults who have experienced complex trauma and have mental health needs. Youth homes are nationally accredited through the Council on Accreditation (COA) and are members of the Children's Home Society of America (CHSA). We emphasize a Trauma-Informed approach to care and are focused on healing, resiliency, empowerment and skills building. <u>Youth Homes Continuum of Care:</u> • Transition Age Youth Full Service Partnership • Aftercare • Stepping Stones Workforce Development • Enrichment Programs • Resource Family Program • Family Pathways • Therapeutic Behavioral Services • Short-Term Residential Therapeutic Program <u>TAY Full Service Partnership</u> • Provide comprehensive, intensive mental health service for youth and their families in home and in the community. ◊ We are community based and out there in the community, in homes. ◊ We have two different office locations but are not fully staffed and are used for team meetings and other indoor space. ◊ COVID has brought challenges, but we are still navigating and offering a hybrid, heavily focused in person but do provide telehealth services as appropriate and needed. • Target youth ages 16-25 with serious and persistent mental illness who are currently un-served or underserved, including those struggling with substance use, homeless or at-risk of homelessness, stepping down from long-term institutional care, or experiencing their first episode of psychotic break. • Cover East and Central Contra Costa County. • Current contract cap of 30 FSP clients, typically have around 25-27 clients at any given time. • <u>Who we are:</u> • Multi-disciplinary team of dedicated professionals committed to supporting this population • Six (6) Clinicians (licensed or license eligible) • Three (3) Paraprofessionals (Life Skills Coach and Youth Advocate) • Psychiatrist • Workforce Development Program Manager (*hiring/open) • <u>How we help:</u> • Holistic and individualized approach to care which gives our young people the best chance to lead happy, healthy, and independent lives. ◊ Therapeutic Interventions ◊ Intensive Skill Development ◊ Building Connections ◊ Support and Advocacy • <u>What we do:</u> • Counseling/Psychotherapy and Medication Management	found in the agenda meeting packet under: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

- Assistance in finding a safe and affordable place to live, or assistance in remaining in the present home
- Help with educational opportunities and academics
- Aid in securing financial and health benefits
- Treatment for addictions, such as alcoholism, drugs and other substances
- Support in finding employment, vocational training, and/or volunteer opportunities
- Provide workshops and groups for skill building and socialization
- Support 24/7 Crisis Intervention

- Full Service Partnership Outcomes Report
  - Pre- and post-enrollment utilization rates for 32 Youth Homes FSP participants in the program (2019-2020)
    - ◊ PES Episodes – Pre-enrollment (124), Post-enrollment (62)
    - ◊ Inpatient episodes – Pre-enrollment (34), Post-enrollment (14)
    - ◊ Inpatient days – Pre-enrollment (330), Post-enrollment (188)
    - ◊ DET Bookings – Pre-enrollment (11), Post-enrollment (5)
  - Pre- and post-enrollment utilization rates for 9 KETs enrolled in the program (2020)
    - ◊ Productive Meaningful Avg Hrs./week pre-enrollment (14.67), post-enrollment (5.56) – trending in the wrong direction and trying to find out why (not providing service or the right services or not logging it).
    - ◊ Homeless persons/at risk of homelessness – pre-enrollment (8), post-enrollment (0)

- <u>Needs and Areas of Future Focus:</u>
  - Multilingual
  - Specialist vs generalist
  - Psychiatric Nurse on Staff
  - Robust system for internal evaluations
  - Qualitative Key Performance Indicators (KPI)
  - Retention and recruitment

Questions and Comments:

- (Cmsr. Douglas Dunn) In addition to your presentation, I did look over the program fiscal review detail and made some notes. I am aware the TAY population is 16 to 25. Here in CCC, the FSPs serve detained population 18-25; why is that? (RESPONSE: Byron Iacuaniello) I do not. We have actually had clients that came in and are younger, they just go through children's (rather than adult) and I am not sure why that is.
- (Cmsr. Douglas Dunn) Partially met issues around staffing and in my detailed email, I let you know that I think it has to do with pay scale and lack of Cost of Living Adjustment (COLA). Along with COVID, prior to that, we were going to make major strides in that area, as well as expanding all the FSPs up to assertive community treatment (ACT) standards, which means it would be easier to let you have a psychiatrist and a full-time psychiatric nurse. Those plans (due to COVID) have been put on hold. Hopefully by 2022/23, some progress can be made. (RESPONSE: Byron Iacuaniello) If that is a possibility, it would certainly be appreciated and would help immensely.
- (Jennifer Bruggeman) What you said was exactly right, Cmsr. Dunn. We had hoped to add additional funding prior to COVID, we thought the MHSA fund had much more money that needed to be spent. So, one of the plans (that

Warren had) outlined was to bring all our FSP up to ACT fidelity, unfortunately COVID hit and all turned on its head. As you know, we are late again renewing our upcoming contracts. The Commission and other stakeholders have been advocating for all of our contractors to receive that COLA that was missed last year due to COVID. We hope to have good news on that in a few days for the 2021/22 contracts.

- (Cmsr. Leslie May) I am aware of the staffing problems, and a lot of issues at Youth Homes. Recently noticed positions open and the pay was pretty low for the exact position I was in and thought 'There is no way' and from being part of that group, a lot of non-profits are not taking advantage of bringing in students who are in their master's program. Remembering back to when I was going through my program, the first quarter in the program was just classes, studying and getting students ready. The second quarter you must find a placement and work through graduation to accumulate hours. The cap was 750 hours (in 2015); however, now it is allowed to accumulate as many hours as possible during that time. I have been observing the trends and I am aware there has been a high turnover. It isn't all about money; there are interpersonal relationship issues and people getting licensed and move on. My suggestion to you (and to every agency your size or smaller) to really contract with the California State University system, such as the Wright Institute in Berkeley (www.wi.edu/), UC Berkeley and the other (mostly) online schools to start exposing and bringing students into the social work programs or family therapist programs. There are many programs that these students are willing to come work, but not expecting the higher salary (internships). If you offer a stipend or smaller salary for them to train and get their required hours, this is a good resource to get staff in (for at least two years) and may want to remain to finish up their hours and possibly to stay with the organization. I would strongly suggest looking into the internship route. I would also suggest not 'pigeon-holing' these interns, but rather allowing them to be exposed to all areas/programs, this is beneficial to both the students and the programs for a multitude of reasons. Personally, I had to leave organizations so that I could be exposed to other populations to help us decide where we want to specialize. It is very encouraging there is a psychiatrist on staff and was available and active in the program (attending meetings, etc.). That is my feedback. (RESPONSE: Byron Iacuaniello) Thank you, Commissioner May, I appreciate that; and you are right, that is an area we haven't tapped into historically. We have two interns since I have been here, that's about it.
- (Jennifer Bruggeman) I just wanted to add that, in case you are not already aware of this, MHSA does offer through our workforce education and training component, an intern stipend program that agencies can apply for annually. It helps attract quality interns if you can offer a stipend. It's not a huge stipend. It is a competitive application process; there is a set amount of money and each year, depending on number of applicants, it is divided up.
- (Cmsr. Douglas Dunn) I noticed the last review, you spoke to maximum case load for staff. I assume that has to do with issues acquiring and keeping qualified staff. (RESPONSE: Byron Iacuaniello) That is a large part of it. In general, we try to diversify where we are getting our referral sources from, specifically for FSP, it just comes from the county and don't turn away any clients but we are trying to work on engaging the right clients. We try to have

a bit of a buffer to pick up new referrals so we don't max out the staff. We are just limited, i.e., we don't have bilingual staff so can't accommodate that type of client. I think it would just open up more doors for us. • (Cmsr. Leslie May) I know the clientele. This is what I am observing with Youth Homes and several other TAY Programs; unless you have had that client when they are younger and growing into that age group, where you really know is this person able to be 50% successful in this program. There are a lot of youth that feel they are adults and want their own apartment and independence. Once that happens (getting a taste of their independence), they stop connecting with their therapist and ICC (Intensive Care Coordinator). The TAY programs need to be overhauled. There needs to be stricter guidelines because, as a non-profit serving them and have teams together that are willing and ready, there is a tug-of-war; even if there is a court appointed attorney, etc. over this young adult, there is conflict. Court gives them two days where the county program gives them a week. There are too many discrepancies and not working together. The rules and regulations should be consistent, especially for that age group. It doesn't support the staff and their ability to properly help the clients successfully. There needs to be more stringent rules for the youth so they are unable to take advantage of not following the program. There are too many that want to be in the programs. Also, when they are housed, the locations where they are mixed in with other adults that are the homeless population with a lot of mixed diagnosis; there are too many signals for them, it is too much for their brain to absorb, especially with mixed diagnosis. Many times, they will drop off because it too much overstimulation. There needs to be a massive overhaul. (RESPONSE: Byron Iacuaniello) You are not wrong and it points to mental health in general. There is a different intrinsic motivation and value that you put on therapy if you are actually more invested. There are so many services thrown at them. They can pick and choose, so it isn't really them choosing if they really want this service. That is the difference. We do need to work on having different expectation: What is engagement? "Maybe they just are not ready for this program, come back when you are." Having a bit firmer guideline and that is something we have absolutely been talking about and trying to formulate a process for that. There needs to be more of a motivating factor for them to show up and work the program.	
VIII. Adjourned at 2:53 pm.	