MENTAL HEALTH COMMISSON
MHSA-FINANCE COMMITTEE MEETING MINUTES
October 21, 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 1:31 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Cmsr. Graham Wiseman, District II Presenters: Gabriel Eriksson, LCSW, Chief Executive Officer, EMBRACE Mental Health (formerly COFY) Brent Ringwood, Director of Multisystemic Therapy and Behavioral Services, EMBRACE Mental Health (formerly COFY) Other Attendees: Cmsr. Alana Russaw, District IV Cmsr. Barbara Serwin, District II Cmsr. Rhiannon Shires, District IV Angela Beck Jennifer Bruggeman Carolyn Goldstein-Hidalgo Teresa Pasquini Jen Quallick, Supv. Candace Andersen's office	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: None	
IV. CHAIR COMMENTS: • NAMI Contra Costa Board meeting it was discussed that the Crisis Stabilization Unit (CSU) for Youth at the Miller Wellness Center (MWC) is being set up but MWC has closed down. MWC is a vital bridge between psych emergency services (PES) and the clinics in the different regions of the county. Having that closed leaves a big hole. The question is how long will this be? Three weeks? Three months? MWC needs to be open and portable units set up so it can keep operating during construction. There will be follow up with the Supervisors and if Jennifer (Bruggeman) can follow up with Dr. Tavano. (Jennifer Bruggeman) Did you say this was announced at the NAMI board meeting that it was closed? Without a contingency plan? (Cmsr. Dunn) it was stated the Miller Wellness Center. (Cmsr. May) I pushed for this too, but they should have found another location for a temporary site during construction. Many patients are referred to MWC clinic after being released from PES for follow up and prescription refills until they are connected with an appropriate clinic in the community. There should be a plan during construction. I would also like to add that I sent an email to Dr. Tavano regarding grant money available with no	

response, so I resent it again through our executive assistant (EA), Angela Beck, to distribute it to Dr. Tavano and everyone to keep updated on the various grants and money becoming available this month, in order to complete process to submit for the funding. (Cmsr. Serwin) I think this a general commission question and I will speak with the chair to send out an email to Dr. Tavano regarding the MWC services now that the residential treatment center is being worked on. I don't want to make an assumption there is not a backup plan. (Jennifer Bruggeman) We did understand MWC would have to close in order to accommodate the construction of this Youth CSU. I can't imagine there isn't some contingency plan in place but sounds like it is not known/wasn't made clear and it sounds like a good plan for Commissioner Wiseman wants to send a communication to Suzanne. I would be happy to reach out, as well. In terms of representing the commission it make the most sense for the Chair to send an email to clarify. (Teresa Pasquini) Just would strongly encourage you all to include the CEO of the hospital and the medical director of PES. This falls under their purview and it would be good to make an inquiry to all involved.	
V. APPROVE minutes from September 16, 2021, MHSA-Finance Committee meeting: Cmsr. Leslie May moved to approve the minutes as written. Seconded by Cmsr. Douglas Dunn. **Vote:** 3-0-0 **Ayes:** D. Dunn, L. May, G. Wiseman. Abstain: None	
VI. RECEIVE Community Options for Families and Youth, Inc. (COFY) Program & Fiscal Review discussion and documentation for its Transition Age Youth (TAY) Full Service Partnership, Gabriel Eriksson, LCSW, Chief Executive Officer, EMBRACE Mental Health (Formerly COFY) Founder and former Chief Executive Officer (CEO) for Community Options for Families and Youth (COFY), David Bergesen retired in October 2020. I, Gabriel Erikkson, was promoted from Chief Operating Officer (COO) to CEO in November 2020. Brent Ringwood was promoted to Director of Multisystemic Therapy (MST) and Therapeutic Behavioral Services (TBS). COFY is now EMBRACE Mental Health and there are a lot of big changes, including the name. COFY was such a long name and hard to remember. We set out to come up with a name to reflect our services in the mental health industry. Multisystemic Therapy (MST) Full Service Partnership (FSP) • MST is an intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior. • The MST approach views individuals as being surrounded by a network of interconnected systems that encompasses individual, family, and extra familial (peers, school, community) factors. • Intervention may be necessary in any one or a combination of these systems and using the strengths of each system to facilitate positive change. • Family sessions are provided over a three to five-month period.	MHSA Plan Update Power-Point presentation screenshare during meeting.

- These sessions are based on nationally recognized evidence-based practices designed to decrease rates of anti-social behavior, improve school performance and interpersonal skills, and reduce out-of-home placements.

Program & Fiscal Review was completed late 2019/early 2020 and met all standards in all except two areas, deemed "partially met": (1) number of individuals served; and (2) outcomes achieved.

- Our goal of "individuals served" has been somewhat unrealistic
  - Population served leads to longer treatment episodes: average 5 months
  - A fully trained clinician can at best complete 1 case a month = 12 / year
  - 8 FTEs: 96 completed cases; numbers for reviewed period: 93, 103, 97
  - Program was reduced from 8 to 4 clinicians in 2018; funding shifted to FFT
- Recruiting issue exacerbated by pandemic; but making progress.

MST Program Implementation Review covering January 1, 2021 to June 30, 2021.

The purpose of the review was to provide an overview of the implementation of MST to date by the Community Options for Families Youth team; with the intent to identify areas of program development seen as organizational strengths and those areas that may benefit from further discussion and evaluation.

- Program Data: Staffing and Cases
  - Total FTE for active therapists: Actual 2, Target 2-4
  - Current census (open case) at the end of the report period (7)
  - Average number of cases per therapist: Actual 4.72, Target 4-6
  - Cases served during the report period (20)
  - Estimated annual service capacity (30.40)
- Case Review
  - Total number of cases discharged during the report period (13)
  - Referrals closed without services during report period (1)
  - Percent of cases completing treatment: Actual 91.67%, Target 85%
  - Percent of cases closed by mutual agreement (84.62%)
  - Percent of cases discharged due to lack of engagement (0%), Target <5%
  - Percent of youth placed: 7.69%, Target <10%
  - Percent of youth placed for event prior to MST (0%)
  - Percent of cases removed by administration: 7.69%
  - Percent of cases removed by funding/referral source (0%)
  - Percent of cases moved out of service area (0%)
- Ultimate Outcomes
  - Total number of cases with opportunity for full course of treatment during the report period (12)
  - Avg length of stay in days for youth with opportunity to have full course of treatment: Actual 113.25, Target 120
  - Percent of youth living at home: Actual 83.33%, Target 90%
  - Percent of youth in school/working: Actual 75%, Target 90%
  - Percent of youth with no new arrests: Actual 91.67%, Target 90%
- Instrumental Outcomes
  - Percent with parenting skills necessary to handle future problems: Actual 75%, Target 85%
  - Percent with improved family relations: Actual 75%, Target 85%
  - Percent with improved network of supports: Actual 83.33%, Target 85%

- Percent with success in educational/vocational setting: Actual 75%, Target 85%
- Percent of youth involved with prosocial peers/activities: Actual 83.33%, Target 85%
- Percent of cases where changes have been sustained: Actual 83.33%, Target 85%

- Improvement Efforts
  - Hire the right clinicians
    - ◊ Higher pay: increased by 25% over last year
    - ◊ Better recruiting protocols: best platforms, better ads and interviews
  - Retain good clinicians
    - ◊ Provide more thorough training and development opportunities
    - ◊ New position: Director of Training & Development
    - ◊ Higher pay, better benefits, growth opportunities, plus other incentives
    - ◊ Prevent burnout: focus on wellness, boundaries, messaging, workload
  - Targeting most appropriate population for the model
    - ◊ Focus on younger youth: received approval to work with 11-year-olds
    - ◊ Collaboration with and referral to/from FFT (Functional Family Therapy) and MDFT (

Questions and Comments:

- (Cmsr. Leslie May) What was the anticipated target population? Outcomes achieved, how many individuals did you actually serve? In terms of finances, is there information that shows how much money you received to achieve those goals at that time? (RESPONSE: Gabriel Erikkson) Target 100, the years reviewed that were served (2015/2016) 93, (2016/2017) 103, and (2017/2018) 97 – The review was for the three previous years. In the report we received, it looks at the PES episodes and during this year were decreased and that is a positive change. The juvenile assessment and consultation service (JACS) the numbers in this report suggest a significant decrease, yet it states we had a positive change. There seems to be a mistake because if you look at Lincoln, it changes from 45 to 34 and shows a decrease. It is the PES that had a big drop. We have our data tracking that I will show you. But I wanted to answer the question about outcomes not being the same.
- (Cmsr. Alana Russaw) Are you providing services while the kids in custody or only in the community? (RESPONSE: Brent Ringwood) Both. We want our service to be preventative, but quite often a kid is referred and mandated by the court to participate in our program and sometimes we are even named in the probation report specifically and it is a term of the client's probation. They are referred while detained, before detained, before even on the radar for juvenile justice, we don't turn anyone away. There is a lockout period and when the MHSA funds kick in. MediCal (and other programs) don't reimburse us for periods of time where the kid is detained, but we still want to provide services and not abandon anyone. We just write non-billable notes during that time and are reimbursed down the line. We get to continue to engage the family and treatment for that period of time.
- (Jennifer Bruggeman) Briefly, thank you for the presentation. I just wanted to acknowledge the error on the FSP report. I think you are right, I noticed this must be a draft version and I will ensure this is corrected moving forward.

(RESPONSE: Brent Ringwood) Thank you, that is the one Windy sent and stated it was final but had not removed the 'draft'. If there is an updated version, it would be much appreciated.

- (Cmsr. Douglas Dunn) Going through the review, I noticed you stated pay had been a major issue and through your own internal resources raising it 25%. I know the county is speaking to Cost of Living Adjustments (COLA) in renewal of contracts. (Jennifer Bruggeman) This was announced in one of our recent meetings the MHSA contracts are allowed to include a 3% cost of living increase. Last year, due to COVID and all that was going on, we were not allowed to do so.
- (Cmsr. Douglas Dunn) How does this compare to other counties and their COLA? (RESPONSE: Brent Ringwood) After this review, Warren Hayes brought to our attention that MHSA could fund some of the training. Cmsr. Russaw mentioned the training could be expensive for these models. Thanks to Warren and Michelle and Windy, money was set aside to cover the training and consultation fees, included in our last contract. In addition to rate increases the county has offered, those combined have helped us to increase pay to the clinicians.
- (Cmsr. Leslie May) I am really happy to see you are addressing the higher pay and retaining the right clinicians. How many clinicians do you have working directly with children? What is the pay range? What is the ethnical breakdown of clinicians? Multi-lingual? And the last question is what is the workload average for each clinician? (RESPONSE: Brent Ringwood) MST we have three full time clinicians, one of which is on maternity leave right now. 35 total employees and approximately 27 clinicians. The range varies as we have trainees ($55k/yr) and associate level ($60k+/yr). For licensed clinicians ($80k/yr). Two of our three MMC (managed mental care) programs are Spanish speaking, and have a large number of Spanish speaking clinicians and recently obtained a Farsi translator. We also work with other translators. The average workload for each clinician is normally five, six if you are superhuman, and four if they are really intense cases for the MST program, it varies. The FFT program is 12 to 15 (less intense) and it varies depending on the model.
- (Cmsr. Douglas Dunn) What about ethnic and cultural diversity within staff? (RESPONSE: Gabriel Erikkson) This is something we look to when hiring. I don't have a percentage, but we have African-American, Asian, Latino staff. I'm Swedish, by the way, and an immigrant.
- (Teresa Pasquini) I wanted to thank you for the presentation and to be reacquainted with some of the children's programs in our county. I am one of the creators of the program and fiscal review format. I know I did review before the meeting and are we continuing those? Do we know? These are invaluable and what you have presented today shows it was a tool for improvement and it should continue. What is the long-term effect of this program and is the county tracking these youth into their adulthood? In terms of they have successfully completed the program, but did this program prevent the need for higher end services in the future?
- (Jennifer Bruggeman) The program and fiscal review had to cease in March 2020 due to COVID and we do absolutely plan to resume as soon as it is safe to be on site. (Teresa Pasquini) What about tracking? (Jennifer Bruggeman)

Great question, don't know to what extent that is happening currently, but it is a great point. (Brent Ringwood) MST does do phone follow up with families that have been in service as far as six months out. The challenge with collecting that data is are these families interested in answering the phone one more time for someone asking for a survey after you have done several. Tracking is done for as long as possible.	

VII. RECEIVE update on the California Incompetent to Stand Trial (IST) Workgroup & Working Groups developments, Commissioner Douglas Dunn, Chair, MHSA-Finance Committee
State Level IST Solutions Workgroups: Three are set to wrap up this week and next week.
• Working Group 1: Early Access to Treatment and Stabilization for Persons Found IST on Felony Charges (FIST)
  • FOCUS: Identify short-term solutions to provide early access to treatment and stabilization in jail or via Jail Based Competency Treatments (JBCTs) in order to maximize re-evaluation, diversion or other community based treatment opportunities and reduce length of stay in state hospitals
• Working Group 2: Diversion and Community-Based Restoration for Felony ISTs (FISTs)
  • FOCUS: Identify short-term (4/1/2022), medium-term (1/10/2023)and long-term (01/1/2024 & 01/10/2025) strategies to implement Diversion and Community-Based Restoration programs
• Working Group 3: Initial County Competency Examinations
  • FOCUS: Reduce the number of individuals found Incompetent to Stand Trial by strengthening the quality of the initial county competency evaluation (aka Alienist Evaluations).
Remaining IST Solutions Workgroup Meetings
• Tuesday, October 12, 2021: 3 - 5 PM
• Friday, November 5, 2021: 10 AM – 12 noon
• Friday, November 19, 2021: 11 AM – 1 PM
You can google CA IST Solutions Workgroup, to register for each of the remaining Working Group as well as the larger Workgroup meetings.
<u>Mental Health Commission (MHC) —Wed. Sept. 1, 2021, 4:30-6:30 PM</u>
• Main Content: Passed a very important MHSA-Finance Motion:
  • Asked CCBHS to establish and build out a complete non-jail county based "system of care (including housing and wraparound treatment and services for its 65-75 person, at least IST population by:
  ◊ Being prepared to competitively bid for its "maximum fair share" of $2.2B in one-time competitive state grant building funds to construct, acquire, and rehabilitate new facilities to expand the community continuum of behavioral health treatment resources. This state funding will not be available until early to late 2022. 5 year maximum time to build period.
  ◊ Over $850M in one-time state funds to expand the behavioral health work force.
NOTE: This is the only mentally ill population for which new state BH funding is NOT guaranteed. At the same time, the Dept. of State Hospitals (DSH) is	

pushing as much as possible to the counties, the responsibilities for care for this most vulnerable population.

KEY FINANCIAL ISSUES for Contra Costa Behavioral Health Services

- Upcoming Financial Penalties if Short, Medium, and Long-Term Goals NOT met - *Not Yet in Effect*
  - The DSH can refuse admission of person, esp. an LPS Conservatee (including Murphy) to any of its 5 facilities, AND/OR
  - Charge 150% of the current daily bed rate (at least $754/day x 1.5=$1,131/day) for each new admittee.

Needs Assessment for the 65-75 person IST Population

Misdemeanor Incompetent to Stand Trial (MIST) (5-10 persons currently)

- Need: Programs and Housing to place them other than the county jail via Mental Health Diversion (MHD).
  Blockages and Questions:
  - Staff Training: So far, staff of the contracted adult Full Services Programs (FSP) [(Hume Center and MHS, Inc.]) are not Forensic Assertive Community Treatment (FACT) trained. These training and resulting increased salaries will increase the need for ongoing additional Mental Health Services Act (MHSA) funding.
  - Are these persons considered too "disruptive" to be blended into the existing FSP and AOT programs populations (650 persons)?
  - If so, should a separate program with separate housing and FACT trained staff be established via MHSA funding for this currently 5-10 person population?
  - If not, do we attempt to "blend" these persons into slightly larger FSP programs, including slightly expanded existing housing and upgraded FACT trained staff?
  - Do we need to slightly increase each FSP program size to accommodate this small population? I believe we do.

Felony Incompetent to Stand Trial (FIST) (currently 55-60 persons)

- Needs: Specialized FACT trained staff, housing, services and programming
- Training: Major need for very specialized and "mission driven" FACT trained staff
- Housing: Required need for in-county Institute of Mental Diseases (IMD) Mental Health Rehabilitation Center facilitie(s).

  NOTE: Alameda County Behavioral Health Services (ACBHS) has at least 2 Telecare contracted locked Mental Health Rehabilitation (MHRC) facilities, Gladman (Oakland) and Villa Fairmont (San Leandro) which houses and services this population (including LPS Murphy Conservatees). CCBHS will have to do the same for this 55-65 person population.

  This population involves 3 entities:
  - The District Attorney's (DA) office through the Deputy DA of MH Litigation;
  - The Public Defender's (PD) office through its 7 person MH unit;
  - Contra Costa Behavioral Health Services (CCBHS) Forensic Mental Health (FMH) department.

  NOTE: The Deputy DA of MH Litigation does not consent at all to allowing FIST persons involved in any murder or attempted murder or manslaughter

cases be accepted into any Behavioral Health Court or MHD programs. She invariably convinces the presiding judge to have the person remain in jail. As an alternative, she may consent to allowing them to go to a non-jail locked facility MHRC treatment environment.

<u>LPS (including Murphy) Conservatees (civil LPS—regularly 120-150 persons; Murphy [incl. felony criminal justice charges—currently 5-7 persons])</u>

- In addition to contracts totaling approx.$6M with 13 IMD out-of-county facilities for 120-150 civil LPS Conservatees, CCBHS also has a $5.5M+ contract for 20 beds with the DSH, primarily Napa SH and Metropolitan SH (near LA).
- Murphy Conservatees are the most mentally vulnerable among us." In addition to be legally adjudged "gravely disabled," they have been charged by the DA's office with one of the following 3 crimes:
  - Murder
  - Attempted murder
  - Attempted grave physical and/or emotional injury.
- Up to now, per Penal Code regulations, CCBHS has sent these 5-7 persons/yr. to State Hospitals for one year at a time renewable LPS Murphy Conservatorships. Per AB 133, these generally "unrestorable" persons will very soon be sent back to their original county of origin. NOTE: The financial "kicker" in all of this is the federal Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion for persons 21-64 years of age. Because of this reimbursement exclusion, CCBHS draws down approx. $6M annually from the state provided 1991 Realignment Fund for this purpose, forfeiting the entire 50% dollar for dollar federal Medi-Cal match for LPS civil and Murphy Conservatee care. This discriminatory exclusion must be repealed!

Questions and Comments:

- (Cmsr. Leslie May) This is too much and would have loved to see this document prior to the meeting. This does need to go over the Quality of Care committee and this is where we really need to hear this information, but need the document to review before presenting because there is just too much information. I know you want to take a motion on it if there is any way to send this out and make a motion on this during the general MHC meeting. (Cmsr. Douglas Dunn) I have spoken to Chair Wiseman. November Retreat will not have any time and will be put on the December 1st MHC meeting. This information will be forwarded to the executive assistant for next meeting.
- (Teresa Pasquini) Cmsr. Dunn, you did a great job going over a lot of very complicated information. Regardless of which committee, Cmsr. Dunn has been the most immersed in this process and everyone should be acting as if their hair is on fire and not waiting for anymore procedural issues. I feel the commission should use every procedural tool in the box to raise the concerns about what is going to happen to this population. All that Cmsr. Dunn has spoken to are very complicated but also things the commission has taken positions on previously. You need to figure out your process. I just posted today that I have been invited to sit on a panel, the California Behavioral Health Directors Associations Policy Forum that is taking place next Tuesday (October 26th). Housing and Homeless forum, unfortunately not open to the public and it is pricey. I believe there will be a link after and I will be speaking on the Housing that Heals vision. I also attended the Behavioral Health

Planning Council's meeting this morning on Housing and Homelessness and heard some presentations from LA County. LA County is pretty much considered the north star on everything. They have been doing some very progressive work for the last couple of years on a variety of these issues and I will share more about that in the Quality of Care meeting (if Barbara can stay awake). • (Cmsr. Leslie May) I am not saying we should not vote on it, I would just like you to present it again with the info for us to review so that we can move it forward. (Cmsr. Serwin) It will not be able to be presented at the November full commission meeting so we should get this together for the next committee meeting and vote on it next month to move it forward.	
VIII. Adjourned at 3:01 pm.	