MENTAL HEALTH COMMISSION
QUALITY OF CARE COMMITTEE MEETING MINUTES
FEBRUARY 17th, 2022 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Quality of Care Committee Chair, Cmsr. Barbara Serwin, called the meeting to order @3:32 pm. Members Present: Chair- Cmsr. Barbara Serwin, District II Cmsr. Laura Griffin, District V Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Gina Swirsding, District I Presenters Jan Cobaleda-Kegler Gerold Loenicker Ade Gobir Carolyn Goldstein-Hidalgo Mark Tiano Chris Celio Amelia Wood Nick Berger Other Attendees: Cmsr. Douglas Dunn, District III Cmsr. Rhiannon Shires, District II Angela Beck Jennifer Bruggeman Edgar Martinez Dawn Morrow (Supv. Burgis Ofc.) Teresa Pasquini Jen Quallick (Supv. Andersen's Ofc) Lauren Rettagliata	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Teresa Pasquini) I am still concerned about our conservatorship office and the staffing level. I know that Cmsr. Stern's committee has been addressing to this, but I received an email over the weekend informing me that my own son's conservator of the past 12 years has left his position and was unable to inform my son. So, after being with someone for 12 years who is responsible for where you live and placed, there was no goodbye or warm handoff to the next person. I will honestly say that I broke down and cried. I can't express enough how difficult it is to have your child publicly conserved and try to establish a relationship, be in charge of their life and work together as a team. I did that and had deep respect for my son's conservator. I think this is the second conservator that literally walked off the job. My son will be okay but actually worry about those who don't have families and just to have their conservator disappear is NOT okay. • (Lauren Rettagliata) I can only second what Teresa has to say, as I have a son that has appointed a conservator but not been conserved. I have the understanding that the office is completely understaffed. When you have	

people who are a danger to themselves, the community and cannot take care of their own needs; we really need to ensure the office is there. It is the last rung on the ladder before you fall over the cliff. • (Edgar Martinez) I have worked in three different healthcare centers, treatment-based agencies, community health settings and I worked as a case manager and worked with those conserved. It was very interesting but very difficult. I have dealt with conservators that just didn't know what to do or have any type of direction, so some of my clients were adults with both physical and developmental disabilities. To me, as a community member, it is really concerning. • (Amelia Wood) I would just like to back what the three people before stated.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Gina Swirsding) I want to echo Teresa. If it wasn't for the staff, who still help me from way back, I would likely not be here. It was their care and persistence of helping me when I needed help. They still do so today. I attend a day program and I will call them when I feel 'off' and they know when I need an opening and call me in. It is the same staff from 1989. It is THAT care that makes a difference. • (Cmsr. Leslie May) I totally agree, as well. I received a call for someone approximately a month ago and this person's conservator was unable to be reached for over two months. They stated they have left messages but hasn't returned calls. There was nothing I could do because I am unfamiliar. I wanted to bring up something else that concerns me. The new Delta Landing facility has finally opened a few days ago in Pittsburg at the Motel Six, and I received a call today from a parent that was very upset because their child goes to MLK Junior High School on Carion Court in Pittsburg. This Motel Six is on 2101 Loveridge Road, so it is a little bit better than a half-mile away. However, she said that she went buy there and saw staff going in, they told her it is for single parents, no children. So single parents that have been homeless, but also sex offenders. She asked what are they doing? There is a ruling (law) that they should be 2,000 – 2,640 feet away from the school but there are other places such as Walmart, where the kids congregate. The mental health services building is on Loveridge and not sure if they treat children at that facility. I just want to make everyone aware that it has opened and there now seems to be issues with the population living in that facility it is a BACS program?	
IV. CHAIR COMMENTS: • I am really pleased with the way that our guests today from Mental Health Services (MHS), Hume Center, Gerold Leonicker, and the Wellness in Schools Program (WISP) and how accommodating they were in work their schedules to attend this meeting. I changed things around about, also Jan Cobaleda-Kegler. I just want to thank them for their flexibility.	
V. APPROVE minutes from the January 20th, 2022 Quality-of-Care Committee Meeting. Cmsr. Leslie May moved to approve the minutes. Seconded by Cmsr. Gina Swirsding. **Vote:** 5-0-0	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

Ayes: B. Serwin (Chair), L. Griffin, L. May, J. Metro and G. Swirsding.

Abstain: none

VI. UPDATE on Site Visits

- Crestwood Our House Visit
- Hope House Update
- Harmony Home Update

Cmsr. Serwin has been in communication with BJ Jones at Hope House. Our initial conversation, he only had two clients and were getting ready to leave. We discussed touching base again this week and we have been playing phone tag. He was very amenable to the site visit and I am hoping that goes well. The next step is to get a few candidate dates.

Unfortunate news regarding Harmony Home, they do not want to participate in the site visit. The way it transpired is that I spoke with the owner/manager. We had a great conversation. She was very cooperative, positive and willing to participate and the next step was to send her documentation about the site visit, program description and expectations, as well as the list of steps that we would need her to walk through in order to conduct the site visit. She was overwhelmed by that and contacted me and said she was overwhelmed by this and if this is not mandatory, then I don't feel comfortable with participating. I reassured her that the steps for the small board and care would much simpler and that it was a very positive experience for the sites and we would really greatly appreciate it if she would participate. I stopped short of saying it was mandatory. My takeaway from this was that this works really well with the small board and care to connect first via phone, it immediately puts them at ease, gives a quick summary of the program and they are willing to take the next step but since I have been working on the documentation, I need to really boil it down to the very basics of the process. Right now, the documentation goes through COVID and remote interviews which involves set up of a computer system and site visit later makes it a bit confusing. It is unfortunate it has worked out this way. There is some learning and we will move on to Crestwood Our House and look at our board and cares.

Questions and Comments:

(Cmsr. Swirsding) What commissioners will be going to these sites?

(RESPONSE: Cmsr. Serwin) We can come back to that after we finish this topic.

(Cmsr. May) I am finishing the report for our visit to Crestwood Our House, Vallejo. I have everyone's information. I am pulling it together (I've been very busy) but will send to you this weekend. It will be ready for the next MHC meeting.

(RESPONSE: Cmsr. Serwin) It will first go to the committee. I will first go to the Program Manager for their review and any comments they would like to add in or explanation and then come to Quality of Care Committee for Review. I didn't mean to say Crestwood Our House would be our next site, I meant to ask Cmsr. May about an update. Then also, we were speaking to one of the other Crestwoods as another site we wanted to do this early spring (late winter).

(Angela Beck) Crestwood Pathways (in-patient) and Bridge (out-patient).

(Cmsr. Griffin) Harmony House in March was Cmsr. Wiseman, Swirsding and myself as mentor. We were going to recruit one more commissioner. That is not happening now. Hope House is Cmsr. Stern, Hudson (no longer with the

commission) and Cmsr. Serwin as the mentor. Crestwood Bridge (64 beds) we thought we needed 6, those assigned originally were Cmsr. Hudson (no longer with the commission), Cmsr. Russaw and the mentor was TBD. We haven't updated any of this yet.

(Cmsr. Serwin) Our next step is to then pass back around to recruit volunteers for hope house and Crestwood Pathways (in-patient). Angela, can we send an email? Did this work well?

(RESPONSE: Angela Beck) People did respond but not all. Survey monkey does not work well, the response is too low.

(Cmsr. Griffin) Just for clarification, is Hope House our next visit in March?

(Cmsr. Serwin) That's the goal. (Angela Beck) and then Pathways will be in April.

VII. DISCUSS plans for providing crisis residential services in response to the closure of Nierika House and Nevin House, Dr. Jan Cobaleda-Kegler, Chief of Adult and Older Adult Services, Behavior Health Systems

We have been busy regarding both with organizing stakeholder meetings, focusing on the crisis residential. I will share some flyers. We had to cancel a series of meetings and reschedule them. We settled on some dates and sent new flyers out. We put together a workgroup back in December after the contract was terminated for Nevin House, just to put some ideas together. How do we want to envision this moving forward? This is just an internal workgroup, with Fatima Matal Sol, Alcohol and Other Drugs (AOD) Chief, me, Betsy Orme, Jesse Farrar, Psych Emergency Services (PES) Substance Use Disorder (SUD) counselor, Vickie White (Peer Provider) and getting key players that interact with a lot of our clients who struggle with co-occurring. We are ready to take this out to the community and hear what the community has to say.

We have scheduled a provider stakeholder meeting for Wednesday, March 23 @ 3:00pm. The next day, Thursday, February 24th we scheduled a stakeholder meeting for peers in recovery, as well as clients, to come speak to what their vision is for positive healing co-occurring treatment. We want to hear from people as to their experience. What has worked for them in the past. What didn't work. What they would like to see happen with this program. We really have an opportunity to create something vigorous, meaningful and helpful. <Screenshare>

There are two flyers. The little one will be going out to providers and advocates of family members. We broke it down for the dates. Wednesday the 23rd at 3:00 pm for providers. Advocates and family members are Friday, March 4th @ 11:00 am. The flyers will be sent to Angela Beck to distribute to the MHC full list. Jennifer Bruggeman will have this sent out to CPAW (Consolidated Planning Advisory Workgroup) members.

We really want to hear from people about what they envision, what the program would look like to help support our clients who are struggling with these issues.

(Cmsr. Serwin) Would the groups like CPAW and the MHC come to the advocates/family members? Or is there a different one?
(Jan Cobaleda-Kegler) That is exactly who would come to this.

Jennifer Tuipulotu from Office of Consumer Empowerment (OCE) will host the one for clients, peers and recovery. That will be on Thursday, March 24th @ 4:00pm.

(Teresa Pasquini) Just curious why there would be a separate meeting for OCE for the clients and families.

(RESPONSE: Jan Cobaleda-Kegler) Jennifer is just a member of the workgroup and offered to help support to get this out there. Many of the OCE staff and CSW staff will be able to transport clients or help get them to a zoom.

(Cmsr. Swirsding) I am a consumer. Can I just listen in to the clients workgroup. (Cmsr. Serwin) Would you like to participate? (Cmsr. Swirsding) yes, I take care of some consumers that are older in my area and I would like to hear.

(Cmsr. Serwin) Was there any consideration of having the advocate meeting separate from the family members? It seems like advocate group is large and the family member group seems would have a lot of input and that it would be difficult in one meeting to recognize all that input.

(RESPONSE: Jan Cobaleda-Kegler) I am flexible. If it the feedback is that we should have two separate meetings, I'm totally flexible with it. I just feel an urgency to get these going and there is so much going on. In fairness to hearing what people have to say, we can certainly split the meetings.

(Laure Rettagliata) My question is, why are we having so many separate meetings? Aren't community planning meetings usually where the community can actually have the opportunity to hear and know what others in the community are thinking? Those that may have a different experience or mindset than they do? Are we expecting so many people that we would not be able to accommodate the number of people that come? As a family member and as an advocate, I would really like the hear the point of view coming from the providers, as well as those that have actually requested the services. We have the experience of being family members who have sought and tried to find this care. I just don't understand, I would like to see it be a larger meeting. Unless you have a feeling you will have 300 people. I think maybe having two different dates when people could participate, rather than breaking this down by classification. I think it defeats the whole purpose of a community planning meeting. We are not segmented and all part of the community.

(Cmsr. Serwin) I hear what you are saying and definitely see the wisdom of that and nod my head to you. I like the idea of two of the same meetings.

(Teresa Pasquini) I support Lauren on this. It goes back to (as you all know), I was a founding member of the Behavioral Healthcare Partnership at the hospital and spent seven years chair and running it, setting up that process. The power of that group was the fact that we had consumers, family members and providers at the same table at the same time. To create a patient and family centered process is something that is important that you include the community from the get-go so it is all created together. I also concur with Lauren. I think it just divides the community up more to have it done separately and creates a lack of transparency and trust.

(Jan Cobaleda-Kegler) I appreciate the feedback and don't want to create mistrust or anything of the sort, just was a way to split it up. We could definitely have several planning meetings and have them be open. I apologize about the problems with the flyer. We will get them corrected and out to everyone as soon as possible tomorrow.

Regarding the Crisis Residential, we are looking at details of funding and budget before we issue and RFP. (Cmsr. Serwin) What does the funding and budget look like? (RESPONSE: Jan Cobaleda-Kegler) it is in flux and we are looking at parity

with Hope House and the Hope House budget. Things like that. Also, we have a few details we are looking at and unfortunately, I wanted to bring a more finished product to this meeting but I don't have it yet. Hoping by the end of February we have a template for the RFPs, so we can issue it and get it going in March. Both programs, I am open to what others think, but I would really like to see us using the East County Region for some of these programs because East County is always a bit empty, we just don't have enough out there and I am hoping that is where we could focus our energy for both.

(Mark Tiano) I am jumping into this conversation halfway in, but what is a realistic timeline? Has your team spoken internally about what a realistic timeline is from now to opening date? Not that this written stone but what are people shooting for?

(RESPONSE: Jan Cobaleda-Kegler) I would have like to have it yesterday. We are trying to move the machine forward, get the RFP out, find a provider and start planning the program. Hopefully by June or July 1.

(Mark Tiano) I agree with you. I know those on the call providers, county representatives. For us at outpatient, it's such a valuable tool and so critical in terms of breaking the cycle of rehospitalizations and having a safe, stable short-term place for people to get their medication fine-tuning, further stabilization, individual rehab. I have nothing but positive things to say about the care clients have received at both places historically. The impact has been felt across different boards. I agree, yesterday would be nice.

(Cmsr. Swirsding) It's very common for older adults when there is no COVID to be isolated, is this a problem occurring with the older adults? I feel isolated and it compounds your depression/anxiety. How are the clients doing leaving the house?

(Jan Cobaleda-Kegler) This pandemic has really affected everyone and been swept up in the energy of the pandemic. I hope you are eventually are able to get back out there and that's one of the things our older adult program goes out into the community and see the clients. Our system of care just came back to full-time in-person services. Some of what you are describing will start to ease up for people.

(Edgar Martinez) I just want to thank you for thinking about the East County side. I grew up in Pittsburg and now in Antioch. Even just working with older adults as a case manager, even if they have families, it seems they were alone. We would do home wellness check-ins. We really have to push for services out in that area and it seems there has always been a lack of resources in the area and appreciate you thinking about that.

VIII. DISCUSS the impact of the closure of Nierika House and Nevin House programs on clients in Adult Full Service Partnership (FSP) programs, Chris Celio, Director of Clinical Services and Amelia Wood, Peer Specialist, Hume Center; Mark Tiano, Program Manager, Mental Health FSP-Concord and Carolyn Goldstein-Hidalgo, Vice President, Clinical Services, Mental Health Systems

(Mark Tiano) For us, at the FSP outpatient case management team, our clients are periodically hospitalized as needed. Without a transition to crisis residential as part of the discharge, unfortunately, an in-patient hospitalization represents a brief period of safety and stabilization but very often it is a re-entry into the negative cycle of hospitalizations. That's what I spoke earlier to how valuable it is having available crisis residential beds for medication fine tuning, further

stabilization, individual coaching and it has just been a critical tool for us. I know, other parts of the system don't work as well when crisis residential isn't available and functioning. That transition is so fraught and 30-day re-admission rates increase and that crisis residential transition is so helpful with these rates. I just want to emphasize how valued it is among the out-patient case management teams. We look forward to re-opening as soon as possible.

(Chris Celio) It is a very interesting confluence of events that has made this not as bad as it could have been for clients at Hume Center. I definitely agree with Mark, Crisis Residential is a really important step along that cycle of crisis. It really gives us a soft landing and can prevent rehospitalization and can prevent a lot of conflict in the family home as well. A huge percentage of our folks live at home with their families and this can really help keep the family if they know that when things are at their worst, they can get over to crisis residential. What has really softened the blow for our folks, a lot of COVID housing has been available through project room key and we have made as much use as we could of that. There are different ways in and we are not always in control of that. Also, right before COVID hit, we had a contract extension that gave us a large amount of funding for what we are going to eventually use for a tiny home village for our FSP clients. It took a long time to purchase the land, it has been purchased and now going through city red tape to get started on the next steps. In the meantime, we have had a lot of money for housing and we have been doing a lot of extended hotel stays. We weren't quite sure how this would go. It doesn't always work. Long-term hotel stays, the dignity that comes with an extended stay has created places where people want to stay and accept treatment into their lives and be a part of our program in a very different way from a brief hotel stay. Nothing can replace crisis residential and I am excited to be a part of the process. It is a big loss and I am glad we are going to replace it and looking forward to these meetings. It is great that Hope House will receive parity on that as well. The problem coming out of COVID is most everyone is at their LAST LAST LAST wits. I am noticing our staff, everyone, it has gotten to the point that people are really frail. A lot of the homeless housing projects are also. The hotels have been closing and we are really going to be hitting that pinch points. The other thing is that clients didn't want to go into a congregate care settings during the height of COVID. It's going to get bad soon and glad we are working on the next steps.

(Amelia Wood) I would like to say that Crisis Residential is very important, it has really affected our clients and our case managers. Nevin, on the other hand, I am excited for a reboot. There were some things not really working there and for me, working with FSP clients, it was hard because they were getting kicked out for mental health issues, where that is really where they should be to get that support. I am really excited about A^3 (Anyone, Anytime, Anywhere). It might be able to replace Nevin or be a path to a better Nevin.

(Carolyn Goldstein-Hidalgo) I am (and the team) is looking forward to a rebooted, upgrade of the services and I know the changes are going to be a great thing for this county. There were definitely a lot of issues. I do think at the both the AOT and FSP level it has hit us hard. These were resources we utilized daily and weekly. Our team has had to be creative regarding a lot of services around Contra Costa and various other surrounding counties to get the level of support especially at the AOT level. It is definitely a concern from the team in addressing a lot of our client needs but we are very happy the plan is to bring back the services and make it better for all of our clients and community members. We

will continue hanging tight and providing services for all our clients and celebrate when the doors open.

Questions and Comments:

- (Teresa Pasquini) I really appreciate the reports from everyone and being so positive and helpful. It's just still too heartbreaking for me to feel positive yet. I do know what's possible. I know what we can do when our community comes together and what we can create. My question is about the tiny village that Chris mentioned? What's that about?
  (RESPONSE: Chris Celio) It is a tiny home village that will likely be in Antioch if all things go well with the current landlord who bought the property for us to master lease from. It will be on one site, with an office on the same site, independent living, not board and care. Amelia will be on site 5 days a week including the weekends and the rest of our staff will come through. It is not housing first, we modified with higher standards. This is a treatment village and for folks accepting treatment and an FSP placement and folks can stay for two to three years while they are working on independent living vouchers and gaining independence skills. We are hopeful. It will be open to our FSP clients. I will be a wonderful next step. The real estate end has been pretty complex and competitive so it took a long time for the land to purchased and now the city is the next step. We are trying to make sure the landlord sticks with the plan (it's his property) but we are excited and hopeful but also realistic. We need all levels of housing. This is a new tool and it won't work for everybody but recent experience tells me this is going to bring good results.
- (Lauren Rettagliata) You mentioned the really good outcomes on the extended stay places. Will you be able to share? Do you have the data on how many people have used the extended stay? What was the cost? Also, you mentioned the tiny houses and the treatment village concept, was HUME going to be the owner the property? Would you be leasing the property from someone that was distinctly separate from HUME?
  (RESPONSE: Chris Celio) Yes, there isn't money to purchase property, it is ongoing master lease funds. We weren't able to purchase but it is a completely separate person from HUME. Just a landlord that does development projects and owns a lot of different apartment building and such. He was up for it and it is separate from HUME.
- (Lauren Rettagliata) What would happen if the landlord were to suddenly decide to no longer use the property for this, is there a long-term lease agreement HUME would have on the property and, then would they then master lease it to the people in the FSP programs.
  (RESPONSE: Chris Celio) Our FSP contract is year to year, so our lease of the property would probably be year to year and if he wanted to pull the lease, it would be like any of the other leased properties out there. We'd have to go do this again. I have to imagine, based off his history, he has done a lot of Section 8 for a long time and is not one of those landlords who pulled their section 8 once property values went way up, he's actually buying more property at today's prices to do Section 8. I have as much ability to trust this person, as a lot more than a stranger. I imagine us leaving him before him leaving us. Then we would be master leasing to the consumers.
- (Lauren Rettagliata) How many people do you envision living at this treatment village? Do you know yet? Or is it in the formative stage?
  (RESPONSE: Chris Celio) Roughly 19.

• (Cmsr. Serwin) I will read Edgar's question: Has the Antioch City Council been helpful at all? (RESPONSE: Chris Celio) We have not approached them as the HUME Center, the landlord has been working his contacts with this process. It sounded like the delays were standard. There was a fire delay, the property is long and narrow; therefore, does he need to have turnaround space for a fire truck? Those type of issues.	
IX. DISCUSS Behavioral Health Services School-Based Programs presentation to the Board of Supervisors, including the Contra Costa County "Wellness in Schools Program" (WISP), Gerald Leonicker, Program Chief Children's Mental Health; Ade Gobir, Manager of WISP, Contra Costa County Office of Education (CCCOE); and Nick Berger, Senior Director, CCCOE. The Wellness in Schools Program (WISP), a collaboration between CCCOE, the school districts and CCCBHS. We applied and received a grant before the pandemic. We started to gear up and had some stakeholder meetings to assess where the biggest needs are and what schools in our districts see as their most important needs that they wanted to cover in the grant application. Mid-2020, we able to submit the grant and got notified last year that we received the grant for $6mil over four years. Our plan included a program under the umbrella of the CCCOE under the name of WISP. This Wellness in Schools Program is integrated in the context of a much larger effort to provide school-based health services and school-based mental health services. A general overview from the CCCOE, in CCC we have 18 school districts, 298 schools within the county, four (4) special education local planning (SELPAs). BHS developed partnerships with individual school districts to offer school-based mental health services in areas of high need, where there is a high concentration of MediCAL beneficiaries. BHS, CCCOE and CCHP are exploring ways to partner and collaborate to expand the support services to those schools. <Please refer to PowerPoint Presentation attached to these minutes> (Ade Gobir) The team started November 1 and have been able to reach most of the school districts. We have been making assessments, speaking to the schools and assessing where their needs are, providing linkages, assessing which schools need support in creating wellness centers. Our team are also trying to connect with the schools, social workers on staff, the people on the grounds doing the work to address the tier 1 aspect of the wellness in school programs. The focus is reducing stigma and raise awareness of mental health. We are also certified to provide mental health training for schools. We are out there, gathering information and willing to expand and raise mental health awareness, provide information for our community so they are able to access well needed medical and mental attention for their children. It is very important that services are available at school. (Nick Berger) My goal, as someone who has worked in the districts and been a teacher, I have really been able to get to know this county well. I am really excited about the big picture and long-term effects of this work. We are really trying to create a county that is collaborative with agencies that have historically had a hard time communicating. When you have behavioral health and schoolteachers and staff and you have the medical industry all in communication, aligned and communicating with each other with a place to connect and a point person to help them connect; we will see a lot more support for families and students and a much clearer understanding of how to get that	**PowerPoint presentation screenshared during this Agenda Item and are attached after the minutes and can be found at:** http://cchealth.org/mentalhealth/ mhc/agendas-minutes.php

kind of support. We hope to provide earlier intervention than what we see historically.

(Cmsr. Serwin) From a structural standpoint, how does BHS, both funding and the services, that are currently in place, relate to the WISP funding and activities and then how the school district funding and services factor in. I am trying to wrap my head around how the funding is merging or not. I see you spoke to doing an inventory and aligning resources and having an overarching 'management structure', it is that big picture conceptional model. Maybe what I'm asking doesn't really matter, as long as it all comes together in two years or three. (RESPONSE: Ade Gobir) Just to clarify, Cmsr. Serwin, you were asking what is the big picture? For Office of Education, for my program, the vision for our program is for all schools and students to be able to have access to mental health. We know the schools are already doing the work, we know the community-based organizations are already in schools. What we want to do is to also help them meet their needs and goals. We know that there is this needs among students to have a place to go when they are in distress. Some of the schools do have already established and developed a wellness. Some have not been able to do so and what WISP does, is to meet with the schools interested in developing a wellness center and share resources.
(RESPONSE: Gerold Loenicker) You asked if the different funding streams are aligned or support each other, how that looks. That is something we are just now trying to figure out. The funding announcements are guiding documents and are not even published yet. There are funding announcements and first trickles of the funding are released and coming from different sources. This grant, for example is part of the overall picture. So that is going through behavioral health and through CCCOE and we are 'sort of' acting under the guidelines of that grant. CCHP plan is starting to figure out what kind of money can we actually count on and just try to figure out what it is actually four. Schools get funding, as well, from the Education side. We are just at the point where we are looking at this and trying to figure out how these can align? How can we put together where we leverage each other's resources and maximize the impact? It is not easy and we are just trying to get the lay of the land.

(Cmsr. Serwin) sounds complicated. The community based services that are providing direct mental health services in the schools, is that funded both through BHS and through the CCCOE, are they the primary sources of funds? (RESPONSE: Gerold Loenicker) No. So, the mental health services I mentioned, specialty mental health services are funded through BHS. I actually need to look that up. Much is funded through BHS, but there are also districts pitching in quite a bit. Districts can make funding available, so they are provided to BHS as a local match to draw down federal funds. It is happening so districts are investing funds to provide specialty mental health services in the schools. It's a mix.
(Nick Berger) I would just like to add that one of goals Ade has been working on is when grant opportunities come up, to really showcase those and get in the hand the right people for this fix and to help people better access their funding.

(Cmsr. Metro) I want to thank you and the team for making this presentation. There is a lot of promise in it. I hope that the efforts are rewarded that there is a preventative aspect to this program that would reduce, at least I think that's the initial intent, of you reporting those metrics up front with those different socio-economic backgrounds. (RESPONSE: Gerold Loenicker) Yes, that is correct. The infographic with the socio economic metrics provides backgrounds where mental health needs arise in poverty or areas with a lot of economic or social disparities. It is often in those areas where there is a very low connectivity between

community and schools where mental health problems, such as depression has a high prevalence. Where we want to be, at least part of the force, to build a connection and attachment between school community and the wider community and support the students in those areas.

(Cmsr. Metro) I appreciate that. There are a couple points we won't be able to get out of this particular meeting, but I would certainly like to follow up later on. The WISP you presented, understanding the disparity in those communities, shouldn't the schools themselves build into it much like gym class, shouldn't we have mental health classes? Curriculums based off mental health awareness. Why would BHS take it upon ourselves to put ourselves into a curriculum based environment to influence that environment? The metrics you presented in the programs you described, I would like to understand a bit more about the risk factors you identified, primary focus. I want to see how this organization is going to be addressing those primary risk factors, first. Second, I would also like to see what your goal are. What is the goal of this program? Looking at the metrics and what you are trying to achieve, how do we measure the success of your program? (RESPONSE: Gerold Leonicker) That is also something we are trying to work out right now. A work in progress. How do we evaluate ourselves? We are actually working with our funders and organization that helps us track that information.

(Cmsr. Metro) How do we put money into a program where we don't know what the achievement or what the objectives will primarily be for the return on that investment? (RESPONSE: Gerold Loenicker) Well, in the end, it would be an improved mental health situation at the schools. That is the goal. A reduction in the level of depression, anxiety, and other mental health problems. That there is treatment readily available. Both from the public and the private side and people know where to turn when mental health issues occur. People feel empowered to do something about it.

(Cmsr. Metro) Given this program that is being initiated in CCC, what programs are we benchmarking against? What standard? What other programs run similar to what we are implementing here in CCC? How do we measure against that benchmark? (RESPONSE: Gerold Loenicker) There is not another county that exactly is doing what we are. There are sister counties, Nick would you speak to this? (Nick Berger) Out of all the counties that received this grant, there is a variety of ways folks are going about it. One piece that is important, one of the main goals in the grant we received was to have a Tier 1 system of support in all schools. Ade spoke a bit to wellness centers, but having a curriculum and materials, a way of teaching all students that mental health is health and that it is okay to talk about mental health and it is normal to have mental health problems. We are all good at saying my leg hurts but most can't say I'm feeling emotionally unstable. That's a major goal.

(Cmsr. Metro) I just want you to know where I'm coming from on this. We can throw a bunch of money at different programs and different initiatives, but the bottom line is: What is it we want to achieve? What are we benchmarking against? How are we going to measure the success of these programs? Not to just put money into a program because we have a grant. I don't believe putting money in something is necessarily the only solution, so if we do put money into it, I want to make sure we get the return that we expect.

(Ade Gobir) I just want to say I hear you Cmsr. Metro and I also want to add that when we seek treatment timely, Tier 1, if we are actually able to successfully implement Tier 1, it would reduce our kids mental health would be addressed

earlier on. Before it gets bigger, where it's impacting their daily lives. That is actually a big goal for us and how do we do that is also talking about it, getting it into our schools. Curriculum is wonderful. But we are not there. Mental health has been an issue since 1902, and to reduce stigma of mental health. We are in 2022 and we are still talking about the same three goals that were established in 1902. So, I hear you, not throwing money away. I think we all need to hold each other accountable. You want to know how I'm going to know when we reach success? When suicidal ideation is decreased. When we don't hear about our youth committing suicide. That is a success rate. Every child saved is what millions of dollars that _____ _____ mental health. I came from child welfare and this is my first year back in education and I am deeply touched on how much need is in our schools and I was even telling Gerold last week that I don't think we are moving fast enough. The needs is so great. Our kids are so stressed. I want to be able to walk into any school in CCC and see the language. I want to walk into any school and have youth be able to talk about their mental health. The way we give eye test screening, hearing tests, etc. We should be able to screen for mental health also. When mental health is removed, our kids are able to sit down and learn and do what they need to do. That is my vision for CCC and where my passion lies and I am hopeful to get results. (Edgar Martinez) Wow. Just amazing, some of the data you presented. I remember giving a presentation in school regarding west and east county and it seems we are still stuck in the same boat. That was six years ago. Back in 2016, I started as a health educator specialist in Oakland. I commuted from Antioch to Oakland, it was brutal. I always wondered to myself, why doesn't CCC have these wellness centers at school? Why don't they think outside the box? I agree, I feel like we are not moving fast enough. There is funding to consider, implementation, objectives to consider. But why does CCC not have the resources? Wellness Centers are important to the community and to the school. I see where Cmsr. Metro is coming from. I'm a little skeptical of how this will work and how are the metrics going to be worked at and hope we can continue to have this dialog and conversation. I am totally excited for this county and also wonder what are the cities doing? What are the school districts doing? That's why I asked the Hume Center, is the Antioch City Council being helpful because they come to the community with 'well we are going to do something about the homelessness. We are going to do something about this" yet there are people at city council meetings that are expressing their concerns to the mayor. I wonder if there are ways we can push the cities and say, 'hey are you with us or not?' Not just leave it to the districts because the city council needs to be held accountable. (Cmsr. Serwin) Well, I have more questions but due to the time, I am going to solicit everyone's questions, I can type them up and forward them on to you and what I am thinking is just another round where we just work on questions. I think we should have enough questions to do that easily. We can do this in writing but I think this interactive conversation is very helpful. We would like to have you back.	
X. DISCUSS background information supporting the Quality of Care Committee Mission Statement (current): *"To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and support delivered with dignity and respect."*	Due to time, this Agenda Item will be taken up at the next committee meeting in March

I have asked all the committee chairs to develop (if they didn't have one) or revisit their respective committee Mission Statements. Then to evaluate the topics we would like to present on, whether they fit inside the scope of that mission. Due to time constraints, we will just pick this up at our next meeting. I really wanted at this meeting just to introduce the idea and get people thinking about whether or not we want to move forward with this one or consider other languages. I have also attached an interesting article titled "50 top mission statements" and it defines what a mission statement is, what the components are, what the qualities are of good mission statements. It gives the mission statements of 50 not for profits and grades them on readability, understandability and it is very useful.	
XI. Adjourned at 5:49 pm.	