CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
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Mental Health Commission (MHC)

Wednesday, March 2nd, 2022, ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. Call to Order/Introductions (5 min.)

II. Public Comments (2 min. per person, 10 min max.)

III. Commissioner Comments (2 min. per Commissioner, 10 min. max.)

IV. Chair Comments/Announcements (5 minutes)

i. **Second module of Commissioner Orientation (Introduction to Behavioral Health Services) will be presented BEFORE THE APRIL Commission meeting at 3:30 to 4:20** PM
ii. **Final draft of MHC Conduct Guidelines to be reviewed by Executive Committee and will be ready for use for the April Commission meeting**
iii. **Special Commission budget meeting may be called for March 21 or 28 at 4:30 to 5:45 PM**

V. APPROVE February 2nd, 2022 Meeting Minutes (5 min.)

VI. CONSIDER the Motion brought forth from the December 16, 2021 Quality of Care Committee Meeting (10 Min.):

"The Mental Health Commission advises Behavioral Health Services and the Board of Supervisors to fund a comprehensive needs assessment of the county's continuum of care system of placing, tracking, treating, and housing the specialty mental health population."

VII. CONSIDER the Motion brought forth from the February 22, 2022 Justice Systems Committee Meeting (10 Min.):

"Advise the Board of Supervisors to add to its legislative platform the goal that the State appoint and fund a Statewide Conservatorship Director, whose job it would be to provide uniform guidelines to all counties in the state, under which all counties would operate and conform. The position should be funded and mandates that the State require of the Office of the Public Guardian should be funded."

(Agenda continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, March 2nd, 2022 ◊ 4:30 pm - 6:30 pm

VIII. CONSIDER the Motion brought forth from the February 17, 2022 MHSA-Finance Committee Meeting (5 min.):

"The Mental Health Commission (MHC) advises the county Behavioral Health Services (BHS) to actively pursue all state budget approved funding opportunities laid out in the Dept. of State Hospitals (DSH) Incompetent to Stand Trial (IST) Solutions Workgroup Report and Final Report"

IX. CONSIDER the Motion brought forth from the December 16, 2021 MHSA-Finance Committee Meeting (10 min.):

"The Mental Health Commission advises the county Behavioral Health Services to include a minimum of $10million to cover the necessary Housing, Treatment, and Services needed for this most vulnerable and highest need population to include:

a. *Multi-Service level Forensic and Civil Mental Health Rehabilitation Center (MHRC) treatment and services*
b. *Multi-level step down housing, treatment, and services"*

X. DISCUSS Behavioral Health Services 2022-2023 budget (45 min.)

DISCUSS BHS budget advocacy process

DISCUSS BHS budget priorities and their projected budgets

DISCUSS revenue sources

- What are projected revenues from federal and state sources?
- How dependent are revenues on grant awards?
  - What major grants have been awarded?
  - What is the dollar amount of potential, unsecured grant awards?
  - What is the contingency plan for covering projected grant revenues that are not awarded?

DISCUSS process for aligning MHC and BHS priorities and remaining budget steps

XI. PRESENT BHS Director's Report, Dr. Suzanne Tavano (5 min.)

- Status of Children/Adolescent Crisis Residential Treatment Center and process and timing of community input
- Overview of Grand Civil Jury Report No. 2102, Tele-Mental Health: Expansion of Remote Access to Care and status of BHS response

XII. 6:30 Adjourn

ATTACHMENTS:

A. Quality of Care Committee Motion
B. Proposed Quality of Care Motion Needs Assessment
C. Justice Systems Committee Motion
D. Finance Committee Motion related to IST Solutions Workgroup Findings
E. Finance Committee Motion related to the MIST population
F. DSH IST 2022-2023 Funding Analysis
G. Final IST Solutions Proposal
H. Proposed MHS Budget FY22-25 MIST Population
I. CCBHS Grant Summary
J. County Budget Process
K. Civil Grand Jury Report No. 2102 Tele-Mental Health

Mental Health Commission
Proposed Motion(s)

Agenda Item X
Meeting Date: January 20th, 2022

Motion (original): Quality of Care Committee Meeting 12/16/21 (Agenda Item IX)

MOTION:

The Mental Health Commission advises Behavioral Health Services and the Board of Supervisors to fund a comprehensive needs assessment of the county's continuum of care system of placing, tracking, treating, and housing the specialty mental health population.

Quality of Care Committee Proposed Motion:
Needs Assessment for Placements in Contra Costa County

I. Motion Language

> *"The Mental Health Commission advises Behavioral Health Services and the Board of Supervisors to fund a comprehensive needs assessment of the county's continuum of care system of placing, tracking, treating, and housing the specialty mental health population."*

II. Background Research

Over the past year of 2021 the Quality of Care Committee has researched the question of "what types of placements do we need" and "how many placements do we need" for the Seriously Mental Ill (SMI) population in Contra Costa County along the entire continuum of care. We interviewed staff to learn about our county's system of placing clients from Psychiatric Emergency Service in crisis residential facilities, to residential treatment facilities and board and cares, monitoring and reviewed research and proposals on this topic. We are still learning about how clients are monitored and transitioned, but we do have background information in these areas, some of it from staff, much of it from family members.

The timely documents listed in Section IV are seminal to our knowledge and perspective. They detail the need for additional placements for the SMI population in California and a few spotlight counties. The CA Department of Health Care Services report (2022) provides data for counties from all over the state. The "Housing That Heals" paper (2021) describes the need for Contra Costa County and recommends tangible solutions for expanding the county's inventory of placements. The San Francisco bed optimization study (2020) demonstrates how to estimate the need for different categories of placements. The Santa Barbara and Los Angeles county reports (2016 and 2021 respectively) estimate demand and make concrete proposals for expanded or new facilities with price tags attached.

III. Needs Assessment Scope

We have more than enough background information to understand generally what we need. However, we don't have data for defining what we need. We need data in order to determine the county's specific needs and to propose specific projects. We need:

- an inventory of existing placements from acute to crisis to residential to supported living;
- an estimate of demand;
- an estimate of the need for additional placements;
- a mapping where county clients are being treated now;
- the cost of housing/treating client in and out of county.

The Quality of Care Committee recommends a needs assessment to define this data and to then propose solutions based on the data.

IV. Seminal Documents

- “Housing That Heals”, Teresa Pasquini and Lauren Retaggliata, 2020
- “Assessing the Continuum of Care for Behavioral Health Services: Data, Stakeholder Perspectives, and Implications”, State of California Department of Health Care Services, see especially pp. 51-57 on Community Services and Supports and pp. 95-98 on Availability of Inpatient Services, 2022
- "LA County Department of Mental Health Board and Care Initiatives" presentation prepared by Maria Funk, Deputy Director of Housing and Job Development for LA County, 2021
- “Behavioral Health Bed Optimization Study”, San Francisco Department of Public Health, 2020
- “Review of Capital Resources and Behavioral Health Facilities”, Santa Barbara County, 2016

Mental Health Commission
Proposed Motion(s)

Agenda Item VI
Meeting Date: February 22nd, 2022

Motion (original): Justice Systems Committee Meeting 2/22/22 (Agenda Item VI)

MOTION:

Advise the Board of Supervisors to add to its legislative platform the goal that the State appoint and fund a Statewide Conservatorship Director, whose job it would be to provide uniform guidelines to all counties in the state, under which all counties would operate and conform. The position should be funded and mandates that the State require of the Office of the Public Guardian should be funded.

Mental Health Commission
Proposed Motion(s)

Agenda Item VIII
Meeting Date: February 17th, 2022

Motion (original): MHSA-Finance Committee Meeting 2/17/22 (Agenda Item VIII)

MOTION:

The Mental Health Commission (MHC) **advises** the county Behavioral Health Services (BHS) to actively pursue all state budget approved funding opportunities laid out in the Dept. of State Hospitals (DSH) Incompetent to Stand Trial (IST) Solutions Workgroup Report and Final Report.

Mental Health Commission
Proposed Motion(s)

Agenda Item X
Meeting Date: February 2nd, 2022

Motion (original): MHSA-Finance Committee Meeting 1/20/22 (Agenda Item VIII)

MOTION:

The Mental Health Commission (MHC) **advises** the county Behavioral Health Services (BHS) to include a minimum of $10mil to cover the necessary Housing, Treatment, and Services needed for this most vulnerable and highest need population to include:

a. Multi-Service level Forensic and Civil Mental Health Rehabilitation Center (MHRC) treatment and services
b. Multi-level step down housing, treatment, and services

DSH IST 2022-2023 Funding Proposal Analysis for MHC 03/02/2022 Meeting

Dept. of State Hospitals (DSH) "Final Proposal" (i.e. 2022-2023 IST funding help proposals for the counties): 8 pages. Proposal Funding Summary is on Page 8. Important Points:

$571M/year ongoing help proposal divided between:

- **Early Stabilization & Community Care Coordination**—page 3
  1. Stabilization and Early Access to Treatment
     A. $25.9M in 2021-2022 dedicated to providing essential treatment services for persons on the DSH waitlist. $66M annually ongoing within existing counties Jail-Based Competency Restoration (JBCT) programs.
     B. Resources included to provide Long-Acting Injectable (LAI) medications to persons on the waitlist.
  2. Care and Coordination Waitlist Management--$.1.7M in 2021-2022 and $.4.9M ongoing to establish and maintain tracking of all Incompetent to Stand Trial (IST) persons in the DSH system.
- **Expanding Felony Incompetent to Stand Trial (FIST) Community Programing vis Community Based Restoration (CBR) and Diversion**—Pages 4-6.
- 60-70% of IST commitments yearly eligible each year for CBR & Diversion. This means 3K annually and 455 referrals monthly are eligible for CBR & Diversion.
  1. Housing Augmentation for Current Housing Contracts—Pages 4-5
     A. $42M from 2021-2022 one time set aside and an existing $18M can be sued for clients participating in a Community Diversion program.
     B. $75K/client will be sued to support clients in appropriate levels of housing, including short-term treatment facilities such as Institute of Mental Diseases (IMD) Mental Health Rehabilitation Centers (MHRCs).
  2. (FIST) Residential Housing Infrastructure Investments – 5,000 CBR or Diversion Beds--Page 5
     A. $6.4M from current set aside and $233M in one-time funds dedicated to rehabilitate or build housing to support FIST clients in CBR & Diversion programs.
     B. Assumes per client Avg. Length of Stay (ALOS) of 18-20 months, need for 5K beds in 700 units of 8-10 persons each and approximated $350K/unit in provided start-up funds.
  3. Felony IST (FIST) Community Program Funding for CBR or Diversion Clients--Pages 5-6
     A. $136.5M from 2021-2022 budget & $130M ongoing to provide permanent , community based treatment programs for the FIST population
     B. $125K/FIST client , including complementing the IMD and Sub-acute infrastructure program step-down programing for FIST clients transitioning from jail or clients in the community needing a higher level of care. Assumes an 18 month Length of Stay (LOS)/client.
     C. Baseline # of county IST referrals will be used to pay for non-direct cost of care and services such as additional District Attorney, Public Defender, pre-trial probation services and Public Guardian personnel.
     D. Every participating county will 43ceive $100K/year to support stakeholder efforts to identify solutions that will reduce IST commitments in their county.
     E. $6M/year ongoing Technical Assistance to participating counties.
- **Increased Placements to CONREP and Transitions to County Services**—Page 7
  NOTE: $33K (2021-2022) and then $1.2M ongoing proposed) for persons committed to DSH as either Not Guilty by Reason of Insanity (NGI)or Offender with a Mental Health Disorder (OMD)..
- **Felony IST Growth & County Share of Costs**—Page 7.
- NOTE: DSH proposes to implement a referral cap based on each counties FIST's committed to DSH in 2021-2022. It they exceed their referral cap, they will be responsible for the portion of treatment costs for IST patients referred above the 2021-2022 baseline. Total share of cost of care t/b based on each IST patient's treatment location (DSH inpatient or in-community).

Department of State Hospitals
Incompetent to Stand Trial Solutions Proposal

The 2021 Budget Act included $75 million in fiscal year (FY) 2021-22 and $175 million in FY 2022-23 and ongoing to support the immediate implementation of actionable solutions, based on recommendations identified by the Incompetent to Stand Trial Workgroup, to provide timely access to treatment for individuals with serious mental illnesses who are found incompetent to stand trial (IST) on felony charges. The Administration proposes a total of $571 million ongoing beginning in FY 2022-23 to support implementation of solutions to provide timely treatment and support the ongoing efforts to decriminalize mental illness in California.

This document provides background regarding California's IST crisis, describes the elements in the Administration's proposal and serves as the basis for further discussions with stakeholders and the Legislature regarding the proposed solutions to be implemented.

Background

Like most states in the country, California is home to thousands of vulnerable and sick individuals who, as a result of not being engaged in early, upstream treatment and support interventions, decompensate to a point where engagement and treatment is difficult. The lives of many of these Californians are lives of illness, vulnerability, and homelessness, and they often cycle in and out of incarceration. Criminal defendants who are unable to understand criminal proceedings or assist counsel in their defense are determined by a court to be Incompetent to Stand Trial (IST). If these individuals are charged with a felony, they can be committed to the Department of State Hospitals (DSH) to provide clinical and medical services with the goal of restoring their competency and enabling them to return to court to resume their criminal proceedings.

Although the 2022-23 Governor's Budget and recent prior budget acts make significant investments that will expand community based behavioral health infrastructure and services, there is still an increasing number of individuals with under or untreated mental health conditions who are being found IST and referred to DSH. Despite recent efforts including increased bed capacity, decreases to the average length of stay, and the implementation of county-based treatment programs, the increasing number of county IST referrals has resulted in a large waitlist and long wait times for defendants pending placement to DSH. Furthermore, the impacts of the COVID-19 Pandemic and necessary infection control measures put in place at DSH facilities resulted in slower admissions and reduced capacity for the treatment of felony ISTs at DSH.

In 2015, the American Civil Liberties Union sued DSH (*Stiavetti v. Clendenin*) alleging that the amount of time IST defendants were waiting for admission into a DSH treatment program violated individuals' due process rights. The Alameda Superior Court ultimately ruled that DSH must commence substantive treatment services within 28 days from receipt of commitment for felony IST patients, with a specified timeline for meeting that standard over the next three years.

In 2021, the Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and DSH to convene an IST Solutions Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed IST on felony charges. The legislation also includes triggers that will authorize DSH to stop admission of Lanterman-Petris-Short (LPS) patients and impose LPS census reduction targets if satisfactory progress towards implementing Workgroup solutions is not made within the outlined timeframes.

The IST Workgroup convened between August 2021 and November 2021 with several representatives and stakeholders from multiple state agencies, the Judicial Council, local government, and justice system partners, as well as representatives from patients' rights and family member organizations. Per the statute, the Workgroup identified short-, medium-, and long-term solutions to advance alternatives to placement in DSH restoration of competency programs. The Workgroup report released on November 30, 2021 summarizes identified strategies and solutions and can be reviewed at: https://www.chhs.ca.gov/wp-content/uploads/2021/12/IST_Solutions_Report_Final_v2.pdf.

DSH IST Solutions Proposal Summary

DSH proposes to implement the following solutions informed by the recommendations developed by the IST Solutions Workgroup. Utilizing a combination of existing funding for IST programs, the $75 million in FY 2021-22 and $175 million ongoing that was set aside to support IST solutions implementation, the Governor's Budget proposes a total of $571 million in ongoing funding beginning in 2022-23. The components of the proposal below will provide early stabilization, care coordination, expand community-based treatment and diversion options for felony ISTs that will help end the cycle of criminalization and increase community transitions for state hospital patients. Collectively, these proposals will also assist the state in meeting treatment timelines ordered by the Superior Court in *Stiavetti v. Clendenin*. These proposals also have corresponding proposed trailer bill language, which will be made publicly available in the near future.

Early Stabilization and Community Care Coordination

The goal of Early Stabilization and Community Care Coordination is to provide timely access to treatment and to promote stabilization of IST defendants to increase community-based treatment placements.

1. Stabilization and Early Access Treatment

   $24.9 million from the $75 million current year set-aside and $66.8 million ongoing will be dedicated to providing essential treatment services to individuals on DSH's IST waitlist. This robust program will provide access to treatment at the earliest point possible upon IST commitment when individuals are arrested and booked into jail. Treatment will be facilitated in partnership with county jail mental health providers for individuals found to be IST on felony charges and will include administration of medications, increased clinical engagement, and competency education. Existing Jail-Based Competency Treatment (JBCT) program infrastructure and resources will be leveraged to offer early access to treatment services for additional felony IST defendants waiting in jails.

   In addition, resources are included to support the cost of psychotropic medications including long-acting injectable (LAI) medications. The goal is to facilitate the stabilization and medication compliance of IST patients, both of which will promote increased eligibility and placement in a diversion or other community-based treatment programs.

2. Care Coordination and Waitlist Management

   As DSH continues to add community-based programs to the menu of patient placement options to mitigate the IST crisis, DSH's Patient Management Unit's (PMU) role as the hub of patient information and coordination continues to grow more complex. $1.7 million from the current year set-aside and $4.9 million in budget year is included to further enhance the tracking and management of all felony IST patients committed to the department. Teams will screen all felony IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment-to-admission case management to coordinate appropriate placements and maximize bed usage for ISTs. Resources are included to enhance existing technology systems and to develop a statewide transportation contract to transport patients between facilities within the DSH continuum of care to better facilitate inpatient admissions and transfers. Also included are resources to assist with gathering and maintaining high data quality and meeting data reporting requirements under *Stiavetti*.

Expanding Felony IST Community Programing via Community Based Restoration and Diversion

The goal of expanding Community Based Restoration (CBR) and Diversion programs is to provide care in the most appropriate community-based setting as an alternative to a placement in a DSH bed. The DSH-Diversion program is designed to serve eligible felony IST defendants in intensive community-based services and, if defendants are successful in the program, to have the current charges dropped. DSH's CBR program is also community-based treatment, but with the focus of restoring competency so a defendant's criminal proceedings can resume. Once an individual is restored to competency and their charges are resolved or an individual completes diversion and the charges are dropped, the goal is to transition them to long-term community treatment and support to ultimately reduce the cycle of criminalization. DSH estimates that 60-70% of IST commitments will be eligible for services each year in a community-based program, for a total of approximately 3,000 felony ISTs based on the current (first quarter of 2021-22) monthly average referral rate of 455 ISTs.

The expansion of existing CBR and Diversion programs are made alongside an investment in infrastructure funding to support a dedicated inventory of community placements, most notably housing, to serve felony ISTs in these programs. The following program enhancements were developed in response to the recommendations of the IST Solutions Workgroup.

1. Housing Augmentation for Current Diversion Contracts

   $42 million of the $75 million IST Solutions current year set-aside is dedicated to a one-time interim housing investment for felony IST clients participating in the DSH Diversion program. An additional $18 million in funds from the existing Diversion program will also be leveraged. $75,000 per client will support the cost of appropriate housing to facilitate increased placements into county Diversion programs. This funding will be limited to new clients who have been found felony IST and may not be used to support likely-to-be IST defendants. Counties can utilize this funding to provide housing to diversion clients in the most appropriate level-of-care including, but not limited to short-term treatment facilities such as Institute for Mental Disease (IMD) and Mental Health Rehabilitation Centers, residential housing with clinically enhanced services, board and care homes, or other appropriate residential facilities.

   These resources are designed as a short-term solution to increase the number of felony ISTs served in county diversion programs. Limited placements and housing inventory in the community, as well as the stigma associated with this population, creates barriers for counties that current

Diversion funding levels cannot overcome. This additional funding will support county efforts to secure appropriate placements and housing for Diversion clients until DSH is able to partner with counties to establish long-term residential housing infrastructure (see next section).

2. Felony IST Residential Housing Infrastructure Investments – 5,000 CBR or Diversion Beds

   $6.4 million from the current year set-aside and $233 million one-time funds are dedicated to infrastructure to develop residential housing settings to support felony IST individuals who are participating in either community - based restoration or diversion programs. DSH estimates that approximately 3,000 of the individuals found IST annually are eligible for participation in community-based treatment programs. Average lengths of stay of 18-20 months results in a housing deficit of approximately 5,000 beds. The proposed funding level assumes these beds will be spread across approximately 700 housing units of 8-10 beds each and approximately $350,000 in start-up funds will be provided for each unit to cover the down payment, necessary retrofitting, and furnishings for staff and patients. The ongoing cost of operating the homes will be provided through a per-patient rate (described below), paid to counties or to service providers, who are responsible for securing client housing and providing wrap-around treatment services.

   This residential housing program will complement the IMD, and Sub-Acute infrastructure program funded in the 2021 Budget Act. IMD and sub-acute beds are a key component for treating felony ISTs in the community. DSH is currently developing new IMD and Sub-Acute capacity across the state, and these beds will be available as a step-down stabilization option for ISTs transitioning from jail to the community and can also be utilized when IST clients in the community need a higher-level of care. Together, these programs will create a complete continuum of community placement and housing options for ISTs across the state.

3. Felony IST Community Program Funding for CBR or Diversion Clients

   In combination with current budget authority to support existing CBR and Diversion programs, DSH will invest $136.5 million from the $175 million set-aside in the budget year for IST solutions and an additional $130 million ongoing to the creation or expansion of permanent community-based treatment programs for felony IST patients. These resources will support a robust per-patient rate, non-treatment costs of managing community-based programs, transitional housing support for IST defendants released

directly from custody, and substantial technical assistance resources for participating counties.

Counties will receive $125,000 per felony IST client treated in either a CBR or Diversion program. This rate is intended to support an intensive community treatment model with increased frequency of clinical contacts and access to psychiatry services, as well as all wrap-around services, and housing costs for an average 18-month length of stay. In addition, this rate is intended to support the use of both forensic peer specialists and partnerships with county probation departments to increase treatment engagement and success in community programs.

DSH acknowledges that County costs for establishing and maintaining this programming goes beyond the direct costs of care for the clients. Ongoing new funding is also included to assist counties with the additional costs incurred by the county implementers and stakeholders involved in planning and running these programs. Funds will be allocated based on the county's baseline number of actual IST referrals, and can be used by counties to pay for expenses such as a community care coordinator to facilitate client placement, a forensic evaluator, additional positions for the District Attorney and Public Defender offices, pre-trial probation services, additional Public Guardian services, and data collection activities. In addition to this allocation, every participating county will receive $100,000 per year to support local behavioral health and justice stakeholder collaborative efforts to identify solutions that target the overall reduction of felony IST commitments in their county.

DSH also proposes to work with counties to explore opportunities for transitional placement services to support client housing needs if an IST is restored in jail and released back to the community. The goal is to facilitate a smooth community transition and allow time for the county's coordination of benefits and qualified services.

Finally, $6 million ongoing is included for robust technical assistance for counties, an external program evaluation of the community programs established, and resources for DSH to provide administrative and clinical support to the community programs. These components are intended to fully support counties in effectively managing the treatment of felony ISTs in their communities through workforce development initiatives, clinical and psychopharmacological support and training, and data-driven decision-making.

Increased Placements to CONREP and Transitions to County Services

$433,000 ($1.2 million ongoing) is included to pilot a new independent placement determination panel to increase the number of individuals served in the community via Conditional Release Program (CONREP). This new panel will revise the Community Program Director (CPD) role as part of CONREP and improve the assessment process for patients who are committed to DSH as Not Guilty by Reason of Insanity (NGI) or as an Offender with Mental Health Disorder (OMD). The overall increased utilization of CONREP will free beds in the state hospitals. While CONREP CPDs will continue to be responsible for placement determinations of ISTs prior to DSH commitment, future consideration will be made to revise this responsibility and pilot an independent evaluation model for IST placement determinations.

Felony IST Growth and County Share of Costs

These investments support the goal of providing care in the least restrictive, community-based settings while maintaining public safety. The growing number of county IST referrals is largely driven by insufficient appropriate community treatment services which leads to under or untreated individuals with serious mental illnesses being increasingly involved in the justice system. To ensure that the expansion of DSH funded community-based care does not create unintended incentives that drive additional IST referrals, the state will implement a growth cap that will include a county cost sharing methodology if the growth cap is exceeded.

DSH proposes to set each county's referral cap at the total number of felony ISTs committed to DSH in the current fiscal year (FY 2021-22). If counties exceed their baseline referral rate, they will be responsible for a portion of treatment costs for IST patients that are referred above their baseline. The total share of cost of care will be based on the treatment location for each IST patient (DSH in-patient or community-based programs) and will apply to all counties, regardless of whether they contract with the department for community-based programming.

Proposal Funding Summary

	(Dollars in Thousands)	
Program Costs	**CY**	**BY Ongoing**
Early Stabilization and Community Care Coordination		
Stabilization and Early Access Treatment	$ 24,900	$ 66,800
Care Coordination and Waitlist Management	$ 1,700	$ 4,900
Subtotal, Stabilization and Community Care Coordination	**$ 26,600**	**$ 71,700**
Funding - IST Solutions $75M & $175M	*$ 26,600*	*$ 38,500*
Additional Funding Needed	$ -	$ 33,200
Expanding Felony IST Community Programming via Diversion and Community Based Restoration		
Housing Augmentation for Current Diversion Contracts	$ 60,000	$ -
Felony IST Residential Housing Infrastructure Investments - 5,000 CBR or Diversion Beds	$ 6,400	$ 233,000
Felony IST Community Program Funding for CBR or Diversion Clients	$ -	$ 266,500
Subtotal, Expand Community Capacity	**$ 66,400**	**$ 499,500**
Existing Diversion and CBR Authority	*$ 18,000*	*$ 46,000*
Funding - IST Solutions $75M & $175M	*$ 48,400*	*$ 136,500*
Additional Funding Needed	$ -	$ 317,000
Increased Placements to CONREP and Transitions to County Services		
Increased CONREP Placements	$ -	$ 433
Subtotal, Increased CONREP Placements and Transition Services	**$ -**	**$ 433**
Funding - IST Solutions $75M & $175M	$ -	$ -
Additional Funding Needed	$ -	$ 433
Total, DSH IST Solutions Proposal	**$ 93,000**	**$ 571,000**
Existing Diversion and CBR Authority	$ 18,000	$ 46,000
Funding - IST Solutions $75M & $175M	$ 75,000	$ 175,000
Total Additional Funding	$ -	$ 350,000

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget

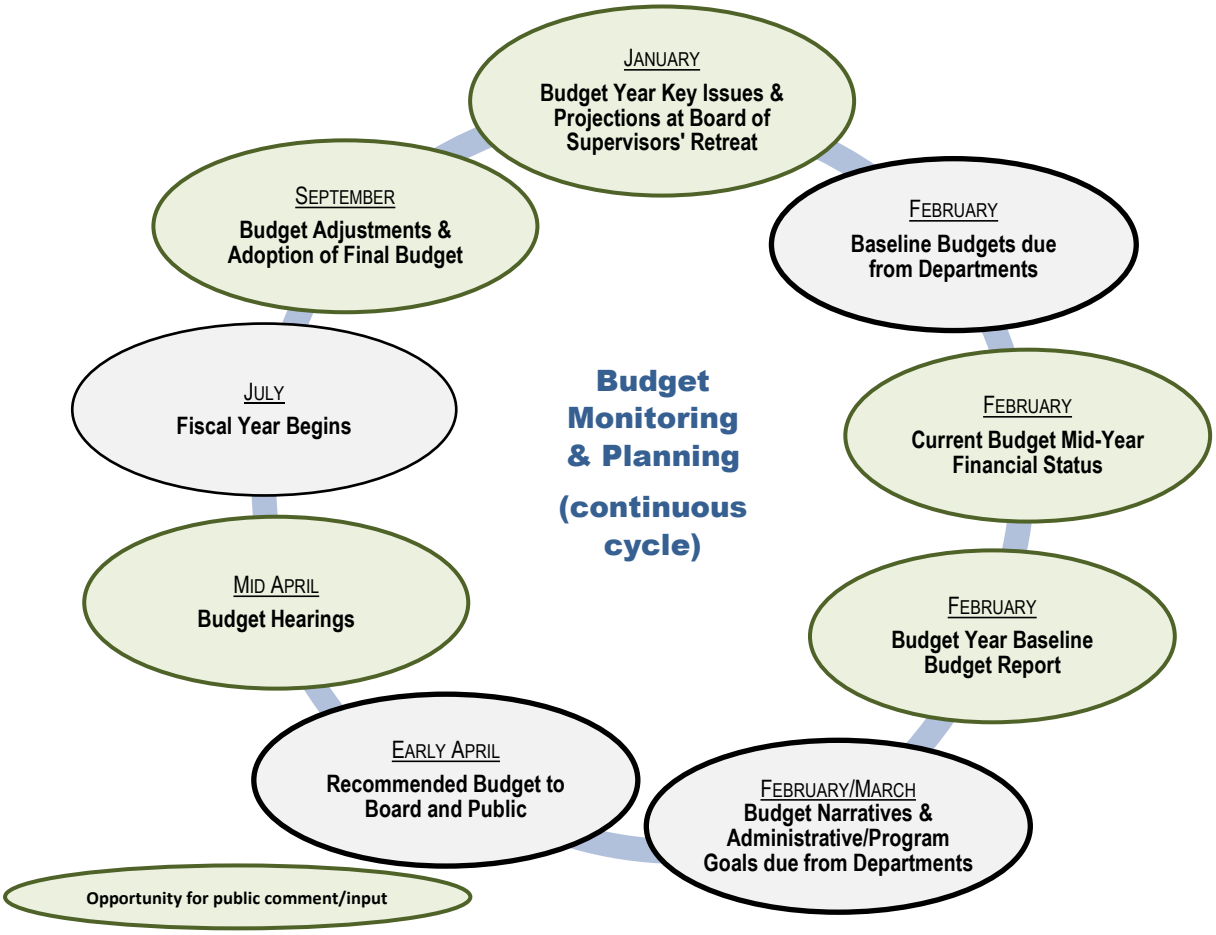
PERSONNEL	No. of Positions	Monthly Salary or Hourly Rate	% of Project Time	Months	Hours	TOTAL
Monthly Salary Positions						
Hourly Positions						
Case Manager (Licensed or BBS Reg PSC)	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Case Manager (Licensed or BBS Reg PSC)	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Registered Nurse	1.0	$ 70.00	100%	12.00	173	$ 145,600.00
Family and Peer Advocate	1.0	$ 24.00	100%	12.00	173	$ 49,920.00
Peer Support Specialist	1.0	$ 24.00	100%	12.00	173	$ 49,920.00
Housing Specialist	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Housing Specialist	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Dual Recovery Specialist	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Increases for ACT Staff	1.0	$ 77.50	100%	12.00	173	$ 161,191.68
LVN (ACT Side)	1.0	$ 35.00	100%	12.00	173	$ 72,800.00
					TOTAL STAFF SALARIES	**$ 972,391.68**
Total Staff Benefits (% of Total Staff Salaries)			**Current Percentage =**		**25.00%**	243,097.92
					TOTAL PERSONNEL COSTS	**$ 1,215,489.60**
SUBCONTRACTORS/CONSULTANT COSTS		**Direct Hours**		**Proposed Rate**		
Consultants - Psychiatrist		1040		$ 260		$ 270,400.00
					TOTAL SUBCONTRACTORS/CONSULTANT COSTS	**$ 270,400.00**
OPERATING COSTS						
Building Rent & Leases						$ 33,612.00
Building Repairs/Maintenance						$ 4,321.00
Equipment Rent & Leases						$ 42,843.00
Equipment Repair/Maintenance						$ 50,030.00
Telecommunications						$ 26,388.00
Utilities						$ -
Medical Supplies						$ 3,000.00
Minor Equipment						$ 66,699.00
Equipment Purchases > $5,000						$ -
Office Supplies						$ 12,134.00
Other Supplies						$ 8,266.00
Printing						$ 740.00
Drug Testing Supplies						$ 3,840.00
Travel						$ 32,632.00
Accounting/Auditing/Legal Fees						$ 200.00
Dues and Subscriptions						$ -
Insurance						$ 31,472.00
Staff Development/Training/Education						$ 15,600.00
Tax/License/Fees						$ 13,114.00
Other Business Services						$ 3,360.00
Interpreter Services						$ 500.00
					TOTAL OPERATING COSTS	**$ 348,751.00**
FLEX FUNDS						
Wraparound Funds						$ 6,000.00
Gift Cards						$ -
Pharmaceutical Costs						$ 1,200.00
Client Transportation						$ 1,980.00
Client Housing						$ 765,945.46
Payee Services						$ -
Client Curriculum						$ 1,200.00
					TOTAL FLEX FUNDS	**$ 776,325.46**
					SUBTOTAL ANNUAL DIRECT EXPENSES	**$ 2,610,966.06**
TOTAL INDIRECT COSTS					**14.90%**	$ 389,033.94
					TOTAL GROSS COST FOR 12-months	**$ 3,000,000.00**

CCBHS Grant Summary

Funding Source	Acronymn	Status	Description	Amount	Pefromance Period
Federal Allocation	Federal Earmark Request	Awarded/ Waiting contract	Funds for renovation for Oak Grove	$1,000,000	unknown
Federal Allocation	Federal Earmark Request	Awarded / Awaiting Contract	Expansion of exisitin MCRT teams	$1,061,552.00	unknown
MHBG CRRSAA	Mental Health Block Grant Coronavirus Response and Relief Supplemental Appropriations Act	Awaiting Approval/ No Contract required	Equipment and software for HUB dispatch services, First Episode Set-Aside	$1,095,579	9/15/2021-6/30/2023
MHBG ARPA	Mental Health Block Grant American Rescus Plan Act	Awaiting Approval/ No Contract required	Level 1 and Housing Crisis response staffing and training	$2,597,143	9/15/2021 - 6/30/2025
BHCIP CCMU (Round 1)	Behavioral Health Care Infrastructure Project - Community Crisis Mobile Unit	Awarded/Awaiting Contract	Call system implementation, equipment, software and licensing, vehicles, project management, training and peer support (time limited)	$2,992,679	9/15/2021 - 6/30/2025
Measure X	Contra Costa Local Funding	Awarded		$5,000,000 one time, $20,000,000 annual	Ongoing
BHJIS	Behaviora Health Justice Innovation Services	Requested	Spanish language specialty mobile crisis teams pilot	$699,647	TBD
BHCIP Planning Grant (Round 2)	Behavioral Health Care Infrastructure Project - Community Crisis Mobile Unit	Awarded/Awaiting Contract	Planning for Infrastructrue	$150,000	1/31/2022 - 12/31/2022
BHCIP Launch Ready (Round 3)	Behavioral Health Care Infrastructure Project	RFA Released 1/31/22	Launch ready infrastructure projects for Medi-Cal benificiaries	TBD	TBD
CCE	Community Care Expansion	RFA Released 1/31/22	Infrastructure/Adult Resisdiential and senior care for SSI/SSD recipients and those experiencing homelessness	TBD	TBD
BHCIP - Child/Youth (Round 4)	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHCIP Round 5	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHCIP Round 6	Behavioral Health Care Infrastructure Project	RFA Not Issued at this time	TBD	TBD	TBD
BHQIP Planning Grant	Behavioral Health Quality Improvement Program	Awarded	Participation in state EHR scoping and review	$200,000	
QI Implementation	Behavioral Health Quality Improvement Program	Awarded	CalAim Implementation. Incentive based. Deliverables required.	$1,983,440.00	
CHFFA Wellness Grant	California Health Facility Finance Authority	Contract Signed	Children's Crisis Stabilization Unit	$2,322,571.00	4/21/2021 - 12/31/2024
AOD CRRSAA	Alcohol and Other Drugs Coronavirus Response and Relief Supplemental Apporpriations Act	Awarded	AOD HER Implementaion (compliments ARPA)	$3,488,600.16	9/15/2021-6/30/2023
AOD ARPA	Alcohol and Other Drugs American Recover Plan Act	Awarded	County EHR and 1Mill to support technology and staff for prevention CBOS	$2,508,138.66	9/15/2021 - 6/30/2025
Opioid Settlemenmt		Awarded	Funds 1FTE Addiction Psychiatrist, Treatment in the Jail 2FTE counselors, 1FTE Manager, Expands Residential Adolescent Treatment, Increases rates for AOD CBOS 3% COLA	$2,000,000	Annual
RSAT		Awarded	Treatment in West County Detention Facility	$1,500,000	7/1/2022 - 6/30/2025
P-64		Awarded	Cannabis, Youth and Social Media	$1,000	

BUDGET PROCESS

The County budget process is a continuous cycle of developing, monitoring and planning, with specific steps each year to achieve adoption of the Final Budget.



The County's fiscal year spans from July 1 to June 30; however, the budget development process begins as early as December with the Board of Supervisors setting a Preliminary Budget Schedule for preparation of the ensuing budget. The County Administrator presents the Board, Department Heads and the public with an analysis of key issues and budget projections in January; followed by budget instructions, which include direction for departments to work with their respective advisory committees and community-based organizations; departmental budget submissions; meetings with Departments in February and March; and presentation of the State Controller's Office required Recommended Budget Schedules for Board consideration in April. Absent the adoption of the County's Recommended Budget by June 30, the State Controller's Office Recommended Budget Schedules are passed into the new fiscal year as the spending authority until a Final Budget is adopted. Unlike the State Controller's Office Recommended and Final Budget schedules, which are solely publications of financial State Schedules required by State Statutes collectively referred to as the *County Budget Act*, the County Recommended Budget includes detailed information and narrative regarding the County, including its current and projected financial situation; the programs/services and administrative/program goals of individual Departments; and the County Administrator's budgetary recommendations for the upcoming budget year.

After public hearings and budget deliberations, the Board adopts the Recommended Budget no later May 31 (pursuant to the Budget Policy). After the State budget is passed (legally due by June 15) and County fiscal year-end closing activities are completed in August, a Final Budget is prepared for Board consideration. (Pursuant to the County Budget Act, the deadline for adopting a Final Budget is October 2 each year. This allows incorporation of any needed adjustments resulting from the State budget.)

Grand Jury

Contra
Costa
County

725 Court Street
P.O. Box 431
Martinez, CA 94553-0091

October 18, 2021

Monica Nino
Contra Costa County
1025 Escobar Street
Martinez, CA 94553

Dear Monica Nino:

Attached is a copy of Grand Jury Report No. 2102, "Tele-Mental Health: Expansion of Remote Access to Care" by the 2020-2021 Contra Costa County Grand Jury.

Sincerely,

Samil Beret, Foreperson
2020-2021 Contra Costa County Civil Grand Jury

Enclosure

A REPORT BY

THE 2020-2021 CONTRA COSTA COUNTY CIVIL GRAND JURY

725 Court Street
Martinez, California 94553

Report 2102

Tele-Mental Health: Expansion of Remote Access to Care

APPROVED BY THE GRAND JURY

Date 10/15/2021

/s/ Samil Beret

SAMIL BERET
GRAND JURY FOREPERSON

ACCEPTED FOR FILING

Date 10/12/21

JILL C. FANNIN
JUDGE OF THE SUPERIOR COURT

Contra Costa Grand Jury Report

Tele-Mental Health: Expansion of Remote Access to Care

To: Contra Costa County Behavioral Health Services
Contra Costa County Board of Supervisors

SUMMARY

Barriers to people receiving mental health intervention include the limited availability of mental health clinicians, geographic distances, transportation difficulties, and insufficient financial resources to afford treatment costs. Research indicates that tele-mental health services are comparable to in-person mental health services regarding patient satisfaction, efficacy, and cost effectiveness with diverse populations. Identifying the need and benefit of telehealth services, the California Telehealth Advancement Act of 2011 promotes the parity of telehealth with in-person health care services.

Although Contra Costa County Behavioral Health Services (BHS) identifies the priority of increasing access to mental health services, this investigation determines that BHS does not incorporate tele-mental health services in its service delivery model. In addition, BHS lacks adequate resources to collect data to improve the quality of outpatient mental health services offered to the community.

The Grand Jury recommends that BHS develop a hybrid plan to integrate tele-mental health services with in-person services in both their outpatient clinics and network provider groups. In addition, the Grand Jury recommends that BHS collect outcome data from their clinics and network provider groups to improve the quality of outpatient mental health services offered to the community. Toward this goal, the Grand Jury recommends that BHS modernize the electronic data collection capabilities of the quality management program, seeking grants and funding through the Mental Health Services Act (MHSA). The Grand Jury also recommends that the Contra Costa County Board of Supervisors provide funds to BHS to upgrade its quality management program.

METHODOLOGY

The Grand Jury used the following investigative methods:

- Researched internet-based scholarly literature pertaining to the use of tele-mental health practices with different clinical populations
- Reviewed Federal and State legislation concerning telehealth

- Reviewed BHS authorizations approving the use of tele-mental health services during the Covid-19 public health emergency
- Reviewed the Contra Costa County MHSA Three Year Program and Expenditure Plan for Fiscal Year 2020-2023
- Reviewed information provided by BHS administration in response to Requests for Information
- Conducted multiple interviews with behavioral health program administrators and clinical personnel
- Reviewed BHS clinical staff and network provider surveys

BACKGROUND

The Need

The demand for mental health services exceeds the supply of trained clinicians. In 2018, there were 115 million Americans living in an area with a shortage of professional service delivery providers. According to the National Survey on Drug Use and Health, almost one-quarter of adults with mental illness reported not receiving treatment. Between 1999 and 2017, the Centers for Disease Control and Prevention reported an increase of 33% in suicide rates with the highest increase in rural counties, which was double the rate of urban areas.[1] In 2016, 16.5% of children in the United States had at least one treatable mental health disorder. Half of the estimated 7.7 million children in the United States with a treatable mental health disorder did not receive treatment from a mental health professional.[2] In California there are only 13 practicing child and adolescent psychiatrists for every 100,000 children under 18.[3]

In addition to the limited availability of mental health clinicians, barriers to people receiving mental health intervention include geographic distances, transportation difficulties, insufficient financial resources to afford treatment costs, and time constraints, such as being unable to take time off from work or having caretaking responsibilities.

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[1]Michael L. Barnett and Haiden A. Huskamp, Telemedicine for mental health in the United States: Making progress, still a long way to go. A commentary, Psychiatric Services, 71 no. 2, (February 2020): 197-198.

[2] Daniel G. Whitney and Mark D. Peterson, US national and state-level prevalence of mental health disorder and disparities of mental health care use in children, JAMA Pediatric, 173 no. 4 (February 11, 2019): 389-391.

[3] American Academy of Child and Adolescent Psychiatry, Workforce Maps by State – Practicing child and adolescent psychiatrists (2021).

Access

Tele-mental health is the use of telecommunication or videoconferencing technology, rather than in-person services, to provide mental health services.[4] Tele-mental health is emerging as an alternative to in-person mental health services for addressing the limited accessibility to mental health services. Studies showed tele-mental health services to be comparable to in-person intervention in patient satisfaction, efficacy, and cost effectiveness.[5] Evidence indicated the strength of the patient-therapist relationship was comparable to in-person treatment.[6] Research showed tele-mental health was an effective treatment approach with diverse groups, including children and adolescents, rural residents, nursing home populations, college students, veterans, immigrants, and incarcerated individuals.[7] Additionally, psychotherapy services delivered by phone were shown to reduce symptoms of anxiety and depression.[8]

A Service Delivery Model

Identifying an expanded approach to providing behavioral health services to meet the needs of underserved populations, the American Psychological Association identified a four-level model of health care delivery [9] to provide access based on the diverse needs of patients:

1. In-person services
2. Traditional telehealth services provided at an originating site such as a clinic or health care facility
3. Telehealth service without originating site restrictions to allow for certain services to be delivered directly into a patient's home
4. Audio-only telehealth for a subset of services and/or particular populations

The California Telehealth Advancement Act of 2011

Recognizing the potential of telehealth to meet the needs of underserved populations the California legislature passed the California Telehealth Advancement Act of 2011 (AB 415). It states, in part,

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[4] National Institute of Mental Health, National Institute of Health Publication No. 21-MH-8155.

[5] Sam Hubley, Sarah B. Lynch, Christopher Schneck, Marshall Thomas, and Jay Shore, Review of key telepsychiatry outcomes, World Journal of Psychiatry, no. 2 (2016): 269-282.

[6] American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues, Clinical Update: Telepsychiatry with children and adolescents, American Academy of Child and Adolescent Psychiatry 56, no. 10 (2017): 875-893.

[7] Stacie Deslich, Bruce Stec, Shane Tomblin, and Alberto Coustasse, Telepsychiatry in the 21st Century: Transforming healthcare with technology, Perspectives in health information management (Summer 2013).

[8] Mental Health Liaison Group, Submission to the Subcommittee on Health of the House Committee on Energy & Commerce Hearing, The future of Telehealth: How Covid-19 is changing the delivery of virtual care, Recommendations for tele-behavioral health priorities (March 2, 2021).

[9] American Psychological Association, Submission to the Subcommittee on Health of the House Committee on Energy & Commerce Hearing, The future of Telehealth: How Covid-19 is changing the delivery of virtual care (March 2, 2021).

[The] lack of primary care providers, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas [and] parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care. . . . It is the intent of the legislature to create a parity of telehealth with other health care delivery modes. . . .Telehealth is a mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers. . . .The use of information and telecommunication technologies to deliver health services have the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas. Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

The Covid-19 Public Health Emergency

The Covid-19 pandemic prompted the temporary expansion of public and private telehealth services. The U.S. Department of Health and Human Services declared a public health emergency on January 31, 2020, followed by the President's declaration of a national emergency on March 13, 2020, allowing greater flexibility for Medicare providers' use of telehealth services. Consequently, the California Department of Managed Health Care (DMHC) issued temporary emergency orders[10] requiring Medi-Cal and other health plans regulated by the DMHC to reimburse providers at a parity rate for telehealth services typically delivered to patients in-person. Audio-only communication was an allowed service. Additionally, geographic-site constraints in providing telehealth services were suspended, enabling patients to receive services at-home.

Following this state directive, Contra Costa County authorized telehealth services on March 25, 2020.[11] BHS provided the following directive to be in effect during the Covid-19 public health emergency:

Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth. DHCS [The Department of Health Care Services] does not restrict the location of services via telehealth. Patients may receive services via telehealth in their home, and providers may deliver

[10] California Health and Human Services Agency, Department of Health Care Services, Medi-Cal payment for telehealth and virtual/telephonic communications relative to the 2019-Novel Coronavirus (Covid-19) (3/18/20).
[11] Contra Costa County BHS Memorandum (4/1/20).

services via telehealth from anywhere in the community, outside a clinic or other provider site.

The Future of Tele-Mental Health

Policies enabling temporary telehealth services during the public health emergency period will expire when the state of emergency ends, which has yet to be determined. There have been national and California legislative bills drafted to extend the expansion of telehealth services permanently. Congress recently passed the Consolidated Appropriations Act of 2021[12] to be enacted after the public health emergency regulations are no longer in effect, allowing Medicare providers to permanently receive reimbursement for tele-mental health services that are integrated with in-person sessions. As a result of this legislation, tele-mental health services will be accessible in one's home and extended to residents who do not live in rural locations. Audio-only services are not included in this legislation.

Contra Costa County Broadband Access

The 2018 U.S. Census Bureau estimated the population of Contra Costa County to be 1,150,215 with approximately 9% living in poverty and 30% of the noninstitutionalized residents receiving public health coverage.[13] Nonetheless, in 2021, the Federal Communications Commission (FCC) reported that 99.2 percent of Contra Costa County residents have fixed broadband access.[14] Therefore, most Contra Costa County residents will be able to access tele-mental health services by either computer or smartphone.

Investigation Purpose

Underserved people in the community with mental illness concerns who may have difficulty receiving in-person services, including rural residents and those with mobility and financial limitations, could benefit from tele-mental health services. The focus of this investigation is to ascertain Contra Costa County BHS' plan to maintain and expand tele-mental health services for the community following the termination of the Covid-19 state of emergency.

DISCUSSION

Contra Costa County BHS is staffed by dedicated and compassionate professionals who are invested in the wellbeing of county residents. Clinical staff at BHS clinics provides services to people with severe mental illness. BHS contracts with outside network providers to offer services to people with mild and moderate mental health

[12] Consolidated Appropriations Act (2021): 1775-1776.
[13] Contra Costa Mental Health Services Act Three Year Program and Expenditure Plan Fiscal year 2020-2023.
[14] Federal Communication Commission, Fourteenth Broadband Deployment Report (January 19, 2021): 81.

needs. Despite extensive programs to meet the needs of underserved populations with severe mental illness, the mental health needs of the community exceed the available resources.

The Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan[15] identifies "access" to service programs as a priority concern. "The cost of transportation and the County's geographical challenges make access to services a continuing priority." This was particularly pertinent for "homebound frail and elderly residents." The Contra Costa County MHSA Three Year Program identified several factors hindering residents receiving mental health services

- Transportation to clinics, especially for rural residents
- The need to provide services outside customary clinic hours
- The importance of clinicians who can offer cultural sensitivity and competent language skills for underserved ethnic groups

In addition, the MHSA plan notes a shortage of psychiatrists, which contributes to long waiting periods for an appointment and undermines the wellbeing of patients who do not have their medication regimens monitored in a timely manner.[16]

Notwithstanding this defined need to increase access to mental health services, the Contra Costa County MHSA Three Year Program did not include any initiatives to develop tele-mental health services.

In 2017, **the Mental Health Commission**[17] advocated offering telepsychiatry to increase the availability of psychiatrists and to reduce wait times for appointments.[18]

BHS Limited Implementation of Tele-Mental Health

BHS addressed the need for more psychiatrists by hiring telepsychiatrists, improving access to psychiatric care. However, BHS did not initiate programs to provide tele-mental health services in accordance with the California Telehealth Advancement Act of 2011.

As noted in Table 1, prior to the Covid-19 public health emergency, tele-mental and audio-only health services collectively represented approximately 7% and 8% of total outpatient services provided in 2018 and 2019, respectively. After the public health

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[15] In 2004, the Mental Health Services Act became California Law providing additional funding to the existing public mental health system.

[16] Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Fiscal Year 2020 – 2023: 25-27.

[17] Contra Costa Mental Health Commission Amended Bylaws (September 16, 2014). The Mental Health Commission was established in 1993 to serve in an advisory capacity to the Contra Costa County Board of Supervisors on matters related to mental health.

[18] Mental Health Commission Annual Report 2018.

emergency in March 2020 allowing telehealth services to be reimbursed at parity with in-person services, telehealth services were 18% of services provided, fewer than the office sessions (30%) and services delivered by phone (52%).

Table 1: BHS Outpatient Modes of Service Delivery[19]

Year	Office	%	Audio-Only	%	Tele-mental health	%	Grand Total
2018	58,293	93%	3,263	5%	1,076	2%	62,632
2019	63,319	92%	3,162	4.5%	2,424	3.5%	68,905
2020	24,286	30%	42,495	52%	14,650	18%	81,431

When the public health emergency orders were implemented, BHS created a list of General Telehealth Logistical Guidelines[20] for providers, who were given Zoom accounts. There was no evidence that providers or clients were given further training to use a tele-mental health approach appropriately and maintaining confidentiality, which would be likely to increase familiarity and comfort with using this approach. Rather than use tele-mental health with video capabilities, the majority of providers used audio-only, which does not allow visual contact with clients. Reportedly, clients preferred audio-only services for the convenience or discomfort with video. Although the Federal Communication Commission (FCC) in 2021 reported 99.2% of Contra Costa residents had fixed broadband access,[21] BHS staff was concerned that a significant number of their clients did not have internet access.

Notwithstanding limited implementation, BHS clinical staff considered tele-mental health and audio-only services to be effective with clients who displayed symptoms of anxiety and depression. The clinical staff viewed clients who were more stable, verbal, insightful, and capable of managing technology benefited more from tele-mental health services. At the outset of the Covid-19 pandemic, BHS reported fewer missed appointments using telehealth and audio-only services in contrast to in-person services. However, as the pandemic persisted, some clients stopped seeking services.

Noteworthy, BHS clinical staff viewed tele-mental health to be inappropriate for the homeless and chronic schizophrenic patients with limited capacity to manage the tasks of daily life. A predominant method of service delivery, audio-only, was determined to be inadequate for patients prescribed controlled substances because of the absence of visual cues to assess the patient. Tele-mental health was also considered inappropriate for patients receiving medication injections.

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[19] Data provided by BHS.

[20] Contra Costa County BHS Memorandum (4/1/20).

[21] Federal Communication Commission, Fourteenth Broadband Deployment Report (January 19, 2021): 81.

Concerned for the adverse effects of clients' social isolation, BHS expressed the intention to resume in-person sessions as the public health emergency waned. As previously noted, Medicare expanded eligibility for tele-mental health services when the Covid-19 public health emergency ends.[22] BHS has not communicated plans to augment tele-mental health services in its mental health program.

Quality Management

BHS collects financial data on services provided and ensures documentation meets state standards. The BHS quality management program gathers information about the effectiveness of services provided by its clinical staff. The quality management information collected about tele-mental health services is limited to survey data about BHS clinicians' and network providers' perspectives.[23] The quality management program does not have access to electronic, email and texting forms of data collection.

Although BHS clinicians and network providers preferred in-person sessions, they conveyed confidence meeting client needs using tele-mental health services. Tele-mental health enabled clinicians to maintain connections with clients and facilitated family involvement, while reducing missed appointments. Another advantage acknowledged was the elimination of transportation difficulties to receive in-person treatment.

Network providers contract with the State of California, not Contra Costa County. BHS does not collect clinical information from network providers, who do not use the County electronic medical record system. Additionally, only one-third of clients use the Contra Costa County medical MyChart electronic records system, limiting the opportunity to collect information.

FINDINGS

F1. Prior to the Covid-19 pandemic, tele-mental health and audio-only services available through BHS were a small portion of the outpatient services provided (7% in 2018; 8% in 2019).

F2. During the Covid-19 pandemic, BHS did not offer training to prepare clinicians or clients for effective and confidential use of tele-mental health services.

F3. During the Covid-19 pandemic, BHS tele-mental health services continue to be underutilized. While audio-only increased to 52% of all outpatient services, tele-mental health was 18% of outpatient services delivered.

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[22] Consolidated Appropriations Act (2021): 1775-1776.

[23] CCBHS Remote Work Survey (September 2, 2020).
CCBHS Contract Providers Remote Work Survey (September 10, 2020).

F4. At the outset of the Covid-19 pandemic, tele-mental health and audio-only services decreased the number of missed appointments.

F5. Tele-mental health services are appropriate for clients who are more stable, verbal and insightful.

F6. Tele-mental health services are appropriate to use with clients displaying symptoms of anxiety and depression.

F7. The greater use of audio-only services has the limitation of not offering visual cues, which provide clinicians with important clinical information.

F8. Tele-mental health services are not appropriate for

a. Homeless populations
b. Patients presenting with chronic schizophrenia with a limited capacity to manage the tasks of daily life
c. Patients prescribed controlled substances or injectable medication.

F9. BHS has not incorporated tele-mental health into a comprehensive service delivery model to offer a broad range of opportunities for underserved populations to receive outpatient mental health services.

F10. Access to outpatient mental health services in Contra Costa County suffers from difficulties with transportation to clinics, long wait times for appointments, and insufficient availability of after-hours appointments.

F11. BHS has a limited number of clinicians who can provide culturally and linguistically sensitive services to diverse minority groups.

F12. Increasing access to mental health services is a priority for Contra Costa County BHS.

F13. The FCC reported 99.2% of Contra Costa County residents have access to internet broadband for greater use of tele-mental health services.

F14. BHS has not followed the directives of the California Telehealth Advancement Act of 2011 to develop telehealth services to better meet the needs of underserved populations in the community.

F15. The Congressional Consolidated Appropriations Act of 2021 expands Medicare services to allow tele-mental health services to be integrated with in-person sessions, and to be received by beneficiaries in their home without geographic limitations.

F16. BHS lacks an adequate electronic data system to evaluate the efficacy of outpatient mental health services provided.

F17. BHS does not collect clinical data from network providers, which limits accountability for the outpatient mental health services provided to county residents.

RECOMMENDATIONS

By June 30, 2022, it is recommended that Contra Costa Behavioral Health Services:

R1. Develop a hybrid plan to integrate tele-mental health services with in-person services in their clinics.

R2. Coordinate with network provider groups to integrate tele-mental health services with in-person services.

R3. Develop a training program for BHS clinicians, network providers, and support staff to facilitate the use of tele-mental health.

R4. Develop a training program for clients to facilitate and provide support for the use of tele-mental health.

R5. Collect outcome data from BHS providers and programs to provide feedback to improve mental health services delivered to the community.

R6. Collect outcome data from network providers to provide feedback to improve mental health services delivered to the community.

R7. Increase the use of the MyChart health care information system to make clinical information accessible to clients and providers.

R8. Modernize the electronic data collection capabilities of the quality management program to provide meaningful information about mental health services.

R9. Develop appropriate clinical metrics to evaluate outcomes that improve the effectiveness of mental health services provided.

R10. Seek grants and MHSA funding to upgrade the technological resources of the quality management program.

By June 30, 2022, it is recommended that Contra Costa Board of Supervisors:

R11. Allocate funds for BHS to upgrade its quality management program.

REQUIRED RESPONSES

	Findings	Recommendations
Contra Costa Behavioral Health Services	F1 through F17	R1 through R10
Contra Costa Board of Supervisors	F16	R11

These responses must be provided in the format and by the date set forth in the cover letter that accompanies this report. An electronic copy of these responses in the form of a Word document should be sent by e-mail to ctadmin@contracosta.courts.ca.gov and a hard (paper) copy should be sent to:

Civil Grand Jury – Foreperson
725 Court Street P.O. Box 431
Martinez, CA 94553-0091