MENTAL HEALTH COMMISSION
FINANCE COMMITTEE MEETING MINUTES
June 16th, 2022 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Douglas Dunn, District III called the meeting to order at 1:35 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Barbara Serwin, District II Members Absent: Cmsr. Leslie May, District V Cmsr. Rhiannon Shires, District II Other Attendees: Cmsr. Gerthy Loveday Cohen, District IV Angela Beck Jennifer Bruggeman Kerie Dietz-Roberts, District IV Kelly Garcia, SPIRIT Intern Gerold Loenicker, CCBHS Child and Adolescent Programs Chief Jen Quallick (Supv. Candace Andersen's ' ofc)	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Cohen) The presentation was very good, especially since I work in one of the school district and I know the services available. It was enlightening.	
IV. COMMITTEE CHAIR COMMENTS: • (Cmsr. Dunn) I have been made aware of several situations (spanning different districts) ever since Mr. Vic Montoya retired from overseeing (administratively) 4C/4D Psych Emergency Services (PES), PES has basically 'gone to hell in a handbasket'. They are just surficially evaluating patients and if they present the least likely well in the moment, they are letting them go, putting them back out in the community and I know this directly violates the intent of AB-1194 signed by Governor Brown before he left office in 2015 and became effective January 1, 2016. It specifically states that a modified 5150 law (Section 0.5) requires law enforcement or evaluating clinical personnel, when they evaluate the individual, they have to consider the documented mental health history. With my involvement with NAMI, I emphasize the importance of typed, concise but well written family documentation for their loved one with mental health challenges. Apparently PES personnel are just disregarding this in total and this is something this Commission is going to have to pay attention to moving forward.	

V. APPROVE minutes from April 21st, 2022, meeting: • Cmsr. Douglas Dunn moved to approve the minutes as written. • Seconded by Cmsr. Barbara Serwin **Vote:** 2-0-0 **Ayes:** D. Dunn, B. Serwin Abstain: none	**Agendas/minutes can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. REVIEW Behavioral Health Services (BHS) contracts below and ask questions to Program Managers (if available): **A. Seneca Outpatient Contract** **B. Seneca Therapeutic Behavioral Services (TBS) Contract** **C. Early Childhood Mental Health Program (Gerold Loenicker, LMFT, CCBHS Child and Adolescent Services Program Chief)** **D. Youth Homes Contract (Gerold Loenicker, LMFT, CCBHS Child and Adolescent Services Program Chief)** I want to start off by saying that I am really proud of our contract provides and what they are doing for our system of care. They are all a really important part of our system of care. Roughly 60% of services are contracted out, not more and are really important to our system of care. The mobile response team (MRT) is a program that performs mobile crisis intervention in the community. If a young person experiences a mental health crisis, we try to avoid referral to psychiatric emergency services (PES) by providing home-based/field-based crisis intervention. That is what MRT does and runs a hotline 24/7. Family and adolescents know to call the hotline and have an over the phone triage and mitigate the situation of the phone, if possible. If not, a team will go out to the home and helps the family mitigate the crisis. If that is not possible due to the situation being too acute, then they will help facilitate a referral to PES, often with the help of police to facilitate an ambulance to PES. They are, at any given time, three teams, usually of two clinicians and a family partner going out. We have in person response, 7am-11pm during the weekdays, with coverage overnight there is a capability to provide in person coverage. Also, provide a resource called 'family urgent response system (FURS), which is a state mandate for current and former foster youth to provide exactly those services outlined previously: urgent care intervention to help stabilize placement. MRT is a resource for that state mandate, as well. <u>Seneca Outpatient Contract:</u> Under this umbrella contract, there are a number of services. The largest right now is the therapeutic outpatient program (TOP) that provides intensive therapy (field or home-based) dependent on the client's needs. It is a very successful program. There are a number of school-based programs under this contract because Seneca has a long history of providing school-based services. There are a number of programs in West Contra Costa Unified. The **Catalyst** program is a school-based day treatment program. There are a number of elementary schools with fairly intensive supports to young children who are struggling. **Uprising**, the newest addition in Brentwood, is a school-based day treatment program. Another school-based day treatment program in Martinez at Alhambra High School. (*I use the term 'school-based day treatment'	

loosely because that is what it is. These are special day classes and kids spend most of the school day in intensive mental health support.) Under this contract, they also run a wrapround program and TBS program. The program Seneca runs is a collaboration between BHS, Child Welfare and Seneca. They provide wraparound services to children through adolescents (14 and up). Seneca has a very good history working with children with very acute mental health needs. The intention is to prevent referrals to residential programs and help those coming out of residential programs stabilize in family-based settings. <u>Seneca Therapeutic Behavioral Services (TBS) Contract:</u> The Systemic, Therapeutic, Assessment, Resources and Treatment (START) program is a full service provider (FSP) to provide services to children and families where the children are at risk of being hospitalized, for those coming out of the hospital and/or critical enough they are at risk of hospitalization. The START is a team of therapists, a services coordinate, a behavioral specialist and family partner who provides services to stabilize the situation. <u>Early Childhood Mental Health Program:</u> Early Childhood Mental Health Program is 'birth to six' or '0-5' provider. We have several '0-5' providers because the children are very young, special population and to serve requires special training and expertise. In Contra Costa, in our county operated programs, we really focus more on the older youth and adolescent (ages 6-18 and beyond), so the very young are contracted out. We have three providers that do that and are broken down by region. Early Childhood Mental Health Program is one of those providers, serving West County region. We Care serves the Central County region. The Lindt Center which is under the umbrella of an organization "Vistability" is in East County. One of the core programs is the comprehensive therapeutic pre-school. It has approximately 12 preschoolers at this program. They are children that exhibit behaviors that would make them not a good fit for any normal pre-school. Early Childhood Mental Health is not only using pre-school curriculum but also providing therapeutic support, individual and family consultation for parents how to best care for their children. This is located in Richmond. In addition, they run the child and family therapy services, which is the biggest part of the program, where they get referrals for 2-4 young children and their parents, from a variety of referral sources: i.e., our access line, child and family services. Sometimes Child and Family Services get involved when there are concerns about child safety at the home or neglect, etc. When the social workers get involved, their first thought is to provide preventive care, family maintenance services. As part of that, they refer those kids and their families to family therapy. So, Child and Family Services is an important referral source. Since they are known it the community, with preschool and they have been providing these services and working in the community for a very long time, so the community knows about them. They know they are a medical provider and they get direct calls from the community, as well. Other pre-schools are referring to them for services. That is the biggest component where a number of therapists provide play therapy, dialectic therapy, family therapy to children and their families.	

The next component of their service work plan is their wrap around program. The wrap around is for kids and families that need additional support where the weekly therapy session may not be enough to help stabilize the family. The activity happens when there are more complex needs, i.e., housing insecurity, food insecurity, child welfare involvement or any of the other social determinants of health, when those factors play a big role making the case 'more complicated', then wrap around is an important resource. Wrap around is a team-based planning process. Typically this is in conjunction with other mental health services. There is a wraparound facilitator who convenes the family, as well as professional and other supports to the family to help the family create an achievable plan. Let's the family identify what are the issues we need to solve and in what sequence. It helps the family come up with concrete actions that can be taken by the family members or by support people that are part of the wrap around team. This is entirely family driven. An important competent of the wrap around philosophy that this is consumer voice and choice. Respect for the individual family circumstances and cultural circumstances.

Another important component, recent addition to Early Childhood Mental Health is the HeadStart program. A couple years ago, the HeadStart component was added onto the program after a request for application process and official grant process. They applied and got the award. HeadStart is a federal program for low income families and their children to provide early HeadStart to their education. Many children accessing HeadStart services (federally funded pre-schools) struggle with complicated issues. HeadStart is administered by the community services bureau (CSB), which is an office under Employment & Human Services Department (EHSD), which also houses child and family services. CSB administer the network of HeadStart programs in contra costa. They used to run their own, in collaboration with us, mental health program for the HeadStart schools, until they no longer could. When that happened, two or three years ago, we put out this competitive bid and early childhood mental health received the award. What they do, with their clinicians, pushing the HeadStart preschools to provide therapy and consultation to help the teacher understand the behavioral / emotional needs of their students and provide consultation and therapeutic support to the students and their families.

In this FY (end of May) they served about 281 students: in outpatient program 246; in HeadStart 36; wraparound 33.

Youth Homes Contract:

They provide a range of services. Traditionally it use to be one of our largest group home providers in Contra Costa County (CCC). They had four group homes (all) in central county – Pleasant Hill or Concord. With the continuum of care reform, those group homes had to be converted into short-term residential treatment programs (STRTPs). They are distinguished from the normal group homes, in that they not only have to provide supportive board and care services (house, feed, basic care coordination, school, etc.) but they also have to provide therapeutic services in those settings. Under the old group home rules, there used to be different levels (1 to 14). Level 14 was the highest with the most behaviorally challenged youth. We used to have mental health contracts

with those that were levels 12-14. The lower levels of group homes did not have mental health services on site. Now, every group home has had to be converted to an STRTP. This means all the former group homes now have to really be capable of providing services to the kids with the highest level of need for mental health treatment. This made it pretty challenging for many STRTPs up and down the state to adjust to the situation and stay afloat. It is challenging to find staff currently for these STRTPs and it is expensive to run. It requires a whole other level of expertise to do this. Youth Homes made that conversion pretty successfully, running four STRTPs. With the pandemic and changes in leadership, they had to re-evaluate just how many group homes they can successfully run. Currently they have one fully staff and fully occupied and another one that they are in contract with CFS to care for a limited amount of youth, but those with the highest needs. The other two houses are undergoing the evaluation process of how to best provide. There is a severe workforce shortage and it has hit many providers hard, including Youth Homes. We are also happy to have them onboard and are one of our few STRTP providers in the county. We are contracted with them to provide those mental health services within the STRTP. In addition, they provide therapeutic behavioral services (TBS). TBS is an adjunct services to mental health services. If someone has therapy or case management services, and a client exhibits specific challenging behaviors that really get in the way of succeeding in a placement or in the family or at school, then those targeted TBS services are put into place to help the child develop alternative behaviors on coping skills to decrease those kind of behaviors that can get in the way/support of adaptive behaviors. We have several TBS providers in our county, Youth Homes is one of them. The other program is Intensive Care Coordination (ICC) is a little like wraparound, again a team based planning process the state has introduced. ICC often goes along with Intensive Home based services. We have an ICC coordinator in our county, we have received referrals for ICC coordination and we provide those ICC services in house or we refer out to our contract providers. We have several providers that do ICC for us and Youth Homes is one of them. Typically, they provide services to either to residents in their own homes or other foster care youth in the older spectrum. They also provide mental health services, again on the older adolescent side (15yo and older). **Comments and Questions:** • (Cmsr. Dunn) Speaking to Intensive Services – what factors determine whether the therapy services are provided. The contract says it provided it the agency or school or at home. What determines where the services are provided? The level of services provided. (RESPONSE: G. Loenicker) Individual circumstances. For children who are in their own therapeutic preschool or in one of the HeadStart preschools, services are provided in those schools. If that aligns with what the family needs, many of the non-preschool related referrals, they either provide the services in the clinic or in the family home. It is all depending on what the family needs.	

- (Cmsr. Dunn) There is a term in this contract called 'intensive coordinated care, child family teams (ICC-CFT), how many teams are in this contract? (RESPONSE: G. Leonicker) They are fold into wrap around services. They are no longer involved in ICC-CFT. It is a very similar process. Their intensive care coordination is done, a child family team is like a wraparound team and there really is no separation. It is done under wrap around.
- (Cmsr. Dunn) This is a standing question on all four contracts: What are the program measurement outcomes? (RESPONSE: G. Leonicker) for any mental health program, the outcome is helping the families meet their own goals. We don't have more systematic outcome tracking in place yet. Every child in our system, we complete a child and adolescent needs and strengths (CANS) assessment. This helps us determine where the needs are and how the needs are changing over time. That is our best tool we currently have to help track the success of a program.
- (Cmsr. Dunn) In my 2018 SPIRIT class, I interned at Seneca and I was an intern for their MRT and saw firsthand how they connect with their TBS program and some of the other programs. It was a very eye-opening internship for me. With that in mind, the Seneca program, do you happen to know how many clients have been served and from which county regions? Or is this something we would need to get from Seneca. They did say they were willing to come in a couple months to speak. (RESPONSE: Gerold Loenicker) Seneca could easily provide that information. I can tell you from our monthly reports that typically (in a month) they get between 90-100 crisis calls and can go out 30 times on community based interventions. That is not all the crisis hotline response does. They also receive referrals and all kids admitted (or referred) to PES are referred to Seneca MRT for post-PES Support, to connect the family to see if there is additional support necessary. Then they go out and provide short-term stabilization.
- (Cmsr. Serwin) Of the groups of children served, where do you feel the biggest unmet needs are? (RESPONSE: Gerold Loenicker) I think there is a gap with children who are hard to place (child welfare) that have really intensive mental health needs and are typically foster care youth. There is a statewide shortage of Short-Term Residential Therapeutic Programs (STRTPs) that can take care of kids with intensive treatment needs. That is one gap.
- (Cmsr. Serwin) What happens to those kids that can't be placed? Is it more they end up going out of county, typically? (RESPONSE: Gerold Leonicker) They are going out of county or stay at the receiving center until something can be found, not ideal. There is always a scramble to find appropriate placement for children with acute symptoms, especially during the pandemic, that entire 0-5 population, families have been really struggling. What I hear from schools, pre-schools is that kids entering schools/pre-schools are under socialized due to the long period of isolation and not being able to associate with peers, they come in under socialized.
- (Jennifer Bruggeman) I wanted to address along Cmsr. Serwin's comment about gaps, my understanding is that, in terms of youth with eating disorders and issues related to that, that is also an area of

gap in support. (RESPONSE: Gerold Leonicker) That is true, there is an increasing population of kids with eating disorders (persistent ED) and it s a very dangerous track. If you intervene early with family based treatment, you can head it off, but if it is entrenched, it is very difficult to treat. Often then there is a high level of care needed, i.e. residential placement or a partial hospitalization program. It is difficult for us to access that level of care. • (Cmsr. Serwin) what is the size of that population? (RESPONSE: Gerold Leonicker) The numbers are not high, approximately five to six in a year. It can be a very lethal affliction. The numbers are not high but the stakes are very high.	
VII. Adjourned meeting at 2:29 pm	