CONTRA COSTA
MENTAL HEALTH COMMISSION

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COMMISSION
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Mental Health Commission (MHC)

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

VIA: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481
Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. **Call to Order/Introductions (10 minutes)**

II. **Public Comments (2 minutes per person max.)**

III. **Commissioner Comments (2 minutes per Commissioner max.)**

IV. **Chair Comments/Announcements (5 minutes)**
   i. **Review of Meeting Protocol:**
      - **No Interruptions**
      - **Limit two (2) minutes**
      - **Stay on topic**
   ii. **Attendance review**

V. **APPROVE October 5th, 2022 Meeting Minutes (5 minutes)**

VI. **"Get to know your Commissioner" – Cmsr. Kerri Dietz-Roberts (5 minutes)**

VII. **UPDATE on the Behavioral Health Continuum Infrastructure Program (BHCIP) activities, Dr. Roberta Chambers, Indigo Consulting, and Adam Down, Mental Health Project Manager, Behavioral Health Services (BHS) (20 minutes)**

VIII. **UPDATE on Site Visits end of year activity and first quarter 2023 projected activity, Cmsr. Laura Griffin (5 minutes)**

IX. **DISCUSS Hope House Final Report, Cmsr. Barbara Serwin (5 minutes)**

(Agenda Continued on Page Two)

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Mental Health Commission (MHC) Agenda (Page Two)

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

X. DISCUSS needs/desires for the new county Children's Crisis Stabilization Unit (20 minutes)

XI. ANNOUNCE Mental Health Commission (MHC) 2023 Officer Slate, MHC Election Committee (5 minutes)

XII. Review progress on MHC 2022 goals (5 minutes)

XIII. Behavioral Health Services Director's report, Dr. Suzanne Tavano (10 minutes)

XIV. Adjourn

ATTACHMENTS:

A. Behavioral Health Continuum Infrastructure Program (BHCIP) Update
B. Final version of Hope House Site Visit Report
C. Behavioral Health Care Partnership Children's Crisis Stabilization Unit Input, September 20, 2022
D. Election Guidelines for 2023
E. 2023 Officer Slate

California Department of Health Care Services
Behavioral Health Continuum Infrastructure Program
Round 5: Crisis and Behavioral Health Continuum
Program Update

The California Department of Health Care Services (DHCS) launched the Behavioral Health Continuum Infrastructure Program (BHCIP) to address historic gaps in the behavioral health and long-term care continuum and meet the growing demand for services and support across the life span of vulnerable individuals in need. **The following information is provided as a supplement to the upcoming release of the Request for Applications (RFA) for BHCIP Round 5: Crisis and Behavioral Health Continuum.**

State priorities for BHCIP:

- Invest in behavioral health and community care options that advance racial equity;
- Seek geographic equity of behavioral health and community care options;
- Address urgent gaps in the care continuum for people with behavioral health conditions, including seniors, adults with disabilities, and children and youth;
- Increase options across the life span that serve as an alternative to incarceration, hospitalization, homelessness, and institutionalization;
- Meet the needs of vulnerable populations with the greatest barriers to access, including people experiencing homelessness and justice involvement;
- Ensure care can be provided in the least restrictive settings to support community integration, choice, and autonomy;
- Leverage county and Medi-Cal investments to support ongoing sustainability; and
- Leverage the historic state investments in housing and homelessness.

Overview

With the need for mental health and substance use disorder services increasing, crisis care gaps in California's behavioral health continuum are more evident and growing. Adults with serious mental illness (SMI) and youth with serious emotional disturbance (SED) often end up in emergency departments, hospitalized, or abandoned in the criminal justice system, and others receive no care. At the same time, the growing opioid crisis, the transition to the 988 Crisis and Suicide Lifeline, and the introduction of new efforts to address the unmet needs of highly vulnerable individuals through the Community Assistance, Recovery, and Empowerment (CARE) Act add to the urgency to increase crisis and behavioral health facility capacity.

According to the statewide needs assessment conducted in 2021, "Assessing the Continuum of Care for Behavioral Health Services in California," acute inpatient beds are occupied for an average of one to two weeks, while one person often occupies a subacute facility bed for several months. The needs assessment stated that short-term residential crisis facilities, with stays of three to seven days, could "provide crisis relief, resolution and intensive supportive resources for adults who need temporary 24/7 support . . . includ[ing] medication management (including the use of previously initiated [medications for addiction treatment (MAT)]), observation and care coordination in a supervised environment."[i] Moreover, the gaps identified within the crisis continuum—many of which are being addressed by other BHCIP funding rounds—are among the highest-priority challenges and opportunities. The needs assessment also highlights a shortage of crisis stabilization unit (CSU) beds:

- Sixteen of 33 counties, only 48 percent, have sufficient CSU capacity;
- Twenty-five counties, both sparsely and densely populated, reported no CSU bed capacity;
- Some areas of the state have no CSU capacity and it often takes hours to transport individuals to the nearest CSU—as a result, these individuals are more likely to be transported to an emergency department or even jail; and
- Thirty-nine counties (67 percent of respondents) have insufficient CSU bed capacity—of those, 17 have some CSU capacity available.

Statewide, it is reported that there are only 2,600 licensed subacute mental health treatment beds; the number of substance use disorder (SUD) treatment facilities decreased by 13 percent between 2018 and 2020.[ii] The RAND Corporation's "Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021," report, which assessed mental health facilities in California, identified an increase in the number of step-down beds as a means to alleviate the system's restricted access. In anticipation of the 1.7 percent growth in the number of psychiatric beds needed in the next four years, the report indicates a gap of approximately 2,796 subacute beds, resulting in the inappropriate placement of individuals in the continuum of care. BHCIP Round 5: Crisis and Behavioral Health Continuum will provide much-needed funding for expanding facility capacity for crisis and behavioral health services to vulnerable Californians, including those receiving Medi-Cal.

Behavioral Health Continuum Infrastructure Program

DHCS was authorized through 2021 legislation to establish BHCIP and award $2.1 billion to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. DHCS is releasing these funds through six grant rounds targeting various gaps in the state's behavioral health facility infrastructure. This is the fifth BHCIP funding round, and through it, DHCS will award $480 million for behavioral health infrastructure projects focusing on crisis services and related behavioral health needs. Awarded grant funds for BHCIP Round 5: Crisis and Behavioral Health Continuum must be fully expended by June 2027.

Four BHCIP rounds were released in 2021 and 2022:

- Round 1: Mobile Crisis, $205M ($55M Substance Abuse and Mental Health Services Administration grant funding)
- Round 2: County and Tribal Planning Grants, $16M
- Round 3: Launch Ready, $518.5M

- Round 4: Children and Youth, $480.5M

The remaining BHCIP rounds will be released in late 2022 and 2023:

- Round 5: Crisis and Behavioral Health Continuum, $480M (current round)
- Round 6: Outstanding Needs Remaining After Rounds 3 Through 5, $480M

Technical Assistance

Advocates for Human Potential, Inc. (AHP), a consulting and research firm focused on improving health and human services systems, is serving as the administrative entity for BHCIP. AHP assists state and local organizations to implement and evaluate a wide range of services focusing on mental health treatment and recovery, SUD treatment and prevention, workforce development, homelessness, housing, and criminal justice.

By October 2022 and as part of the RFA process, AHP will provide pre-application consultations and technical assistance (TA) to individual Round 5: Crisis and Behavioral Health Continuum applicants. Specialized TA will be provided to counties, tribal entities, and nonprofit organizations. In addition, AHP will offer ongoing general training and TA for grantees throughout the life of the project. Applicants will submit a request for a pre-application consultation and complete a survey to indicate their understanding of the project requirements. The deadline to request a pre-application consultation will be three weeks before the application deadline.

TA will help applicants understand the minimum project requirements and budgeting practices. Minimum project requirements include a sustainable business plan, a conceptual site plan, architectural and engineering narratives, and an initial budget based on the site plan. Applicants will also be required to discuss how their proposed project meets local gaps identified in "Assessing the Continuum of Care for Behavioral Health Services in California" and addresses State priorities. An AHP implementation specialist will work with applicants to support them in these areas by connecting them with subject matter experts in real estate, facility financing, and programmatic best practices.

Upon release of the RFA for Round 5: Crisis and Behavioral Health Continuum and in conjunction with DHCS, AHP will conduct informational webinars on topics such as strategies to serve individuals within the crisis and/or behavioral health continuums, braiding resources to ensure viability, and green/sustainable building practices. Additional information on webinars related to the RFA will be available at https://www.buildingcalhhs.com/. This will include topics to help address concerns related to crisis continuum capital development projects.

Eligible Entities

Counties, cities, tribal entities (including 638s and urban clinics), nonprofit organizations, and for-profit organizations whose projects reflect the State's priorities are eligible to apply for this funding, noting the following stipulations and specifications:

- Projects must make a commitment to serve Medi-Cal beneficiaries.
- For-profit organizations, including private real estate developers, with related prior development experience who are collaborating with nonprofit organizations, tribal entities, or counties may apply, but will be required to demonstrate a legal agreement (e.g., Memorandum

of Understanding [MOU]) with the county, tribe, city, for-profit organization, or nonprofit organization to confirm the organization's role in the project, including that they are working on behalf of the service provider.

Eligibility Considerations

All applicants must demonstrate how their infrastructure project will expand community-based facility capacity exclusively for crisis and/or other behavioral health services in the continuum of care. Regional models or collaborative partnerships aimed at construction, renovation, and/or expansion of community-based services are encouraged to apply. Funding priority will be given to facilities that expand access to behavioral health services across the crisis continuum (see table for eligible facility types below).

All prospective applicants will be required to engage in a pre-application consultation that will provide an opportunity to discuss proposed projects, match requirements and potential sources of local match, statutory and regulatory requirements, how the project addresses local need/gaps and the State's priorities, and other related considerations. AHP will provide these pre-application consultations in coordination with Community Development Financial Institutions (CDFIs) and real estate development experts.

For BHCIP Round 5: Crisis and Behavioral Health Continuum funding, three phases of project development will be considered during the evaluation of each application (see description of phases below). Applicants must be in one of the three phases, and applicants in later phases will be scored higher. All projects must meet the minimum threshold of project readiness to be awarded grant funds. Applicant projects are considered to be in a given phase of development only after they have met all the requirements in the previous phase. Required documentation will be reviewed with each applicant during the pre-application consultation process and must be submitted as part of the application.

To be eligible for BHCIP Round 5: Crisis and Behavioral Health Continuum funding, a project must demonstrate "project readiness." The **minimum threshold requirements** for "project readiness" are as follows:

- Site control, defined as ownership, an executed Purchase and Sale Agreement (PSA), an executed Letter of Intent (LOI), or an executed Exclusive Negotiation Agreement (ENA);
- Sustainable business plan with 5-year projections of future objectives and strategies for achieving them;
- Conceptual site plan with a forecast of the developmental potential of the property;
- Stakeholder support as demonstrated by letters of support from internal boards of directors and professional/community partners;
- Demonstration of county and Medi-Cal investments to support ongoing sustainability;
- Match amount identified; and
- Initial budget, one for each phase, and a total budget for acquisition and construction.

Projects will be funded by phase as the applicant demonstrates successful completion of each phase (outlined below). Allowable costs include pre-construction activities identified in the development phases. Applicants must submit documentation demonstrating the completion of each phase in order to move ahead to the next phase.

- Phase 1: Planning and pre-development
  - Development team established; includes attorney, architect, and/or design-build team;
  - Site control, defined as ownership, an executed PSA, an executed LOI, or an executed ENA;
  - Basis of design; includes architectural and engineering narratives;
  - Property-specific site investigation report and due diligence; and
  - Budget with cost estimates based on site plan/drawings.

- Phase 2: Design development
  - Site control established with deed, PSA, option contract, LOI, or leasehold;
  - Site plan established with a schematic plan with architectural and engineering specifications;
  - Stakeholder support established as demonstrated by a letter from city/county/board of directors/tribal entity;
  - Able to gain building permits within six months of funding;
  - Able to close on land, after gaining building permits, within six months of funding; and
  - Able to start construction within six months of funding.

- Phase 3: Shovel ready
  - Ownership of real estate site;
  - Preliminary plan review completed, with comments received;
  - Construction drawings complete or near completion;
  - General contractor (builder) selected and ready for hire;
  - Ninety-five percent of construction drawings ready for submission for building permit;
  - Building permit issued; and
  - Able to start construction within 60 days or less.

- *Final Phase: Construction*
  Projects that rehabilitate or renovate an existing facility are allowable as long as they result in an expansion of behavioral health services for the target population. Furniture and equipment are not allowable costs.

Full funding of a proposed development project will be contingent on completion of all three phases of development planning. The planning and pre-development phase must be completed in 90 days. Construction documents need to be submitted for building permit review within six months of grant funding award.

Eligible Facility Types

The following facility types may be considered for project funding **only** if they are expanding crisis and/or behavioral health services.

Round 5: Crisis Continuum Eligible Facility Types
Acute Psychiatric Hospital
Adolescent Residential SUD Treatment Facility with a DHCS/American Society of Addiction Medicine (ASAM) Level of Care 3.5 Designation and Withdrawal Management (WM) Designation
Adult Residential SUD Treatment Facility with Incidental Medical Services (IMS) and DHCS/ASAM Level of Care 3.5 Designation only or with DHCS Level of Care 3.2 WM Designation only
Behavioral Health Urgent Care (BHUC)/Mental Health Urgent Care (MHUC)
Children's Crisis Residential Program (CCRP)
Community Residential Treatment System (CRTS)/Social Rehabilitation Program (SRP) with the category of Short-Term Crisis Residential only
Crisis Stabilization Unit (CSU)
Mental Health Rehabilitation Center (MHRC) only with Lanterman-Petris-Short (LPS) Designation
Peer Crisis Respite
Psychiatric Health Facility (PHF)
Psychiatric Residential Treatment Facility (PRTF)*
Sobering Center (funded under the Drug Medi-Cal Organized Delivery System [DMC-ODS] and/or Community Supports)

* Any award funding for PRTFs would be contingent on the grantee complying with future regulations and/or policies.

Round 5: Behavioral Health Continuum Eligible Facility Types
Acute Inpatient Hospital—medical detoxification/withdrawal management (medically managed inpatient detoxification/withdrawal management facility)
Acute Psychiatric Inpatient Facility
Adolescent Residential SUD Treatment Facility
Adult Residential SUD Treatment Facility
Chemical Dependency Recovery Hospital
Community Treatment Facility (CTF)
Community Wellness Center
General Acute Care Hospital (GACH) and Acute Care Hospital (ACH)
Hospital-based Outpatient Treatment (outpatient detoxification/withdrawal management)
Intensive Outpatient Treatment
Mental Health Rehabilitation Center (MHRC)
Narcotic Treatment Program (NTP)
NTP Medication Unit
Office-based Outpatient Treatment
Peer Respite
Short-term Residential Therapeutic Program (STRTP)
Skilled Nursing Facility with Special Treatment Program (SNF/STP)
Social Rehabilitation Facility (SRF) with Transitional or Long-Term Social Rehabilitation Program (SRP)

For purposes of this funding, a Behavioral Health Urgent Care (BHUC) facility, also known as Mental Health Urgent Care (MHUC), is a walk-in center with voluntary stabilization-oriented services specific to individuals experiencing behavioral health or mental health crisis for less than 24 hours. This community-based option is typically designed to provide an alternative to emergency department visits for urgent medical needs. BHUC/MHUCs must focus on serving individuals in need of crisis services, commit to serving Medi-Cal beneficiaries, and offer some or all of the following:

- Multi-disciplinary health assessment;
- Psychiatric evaluation, diagnosis, and treatment;
- Crisis stabilization and intervention, mental health counseling, and medication evaluation;
- Direct referrals for treatment;
- Linkage to community-based solutions; and/or
- Peer support.

Facility types that are not eligible for funding:

- Correctional settings; and
- Schools.

Applicants will be expected to define the types of facilities they will operate and explain how they will expand service capacity exclusively for community-based and crisis and/or behavioral health facilities. Regional models and collaborative partnerships are strongly encouraged to apply. Consideration will be given to entities that propose facilities with new or expanded service capacity in underserved counties and regions based on the needs assessment.

All applicants must describe the local needs based on "Assessing the Continuum of Care for Behavioral Health Services in California" report and any local needs assessment used to justify the proposed expansion. All applicants will be required to demonstrate how the proposed project will advance racial equity. Projects will be required to certify that they will not exclude certain populations, such as those who are justice-involved or children and youth in foster care. BHCIP Round 5: Crisis and Behavioral Health Continuum grantees with behavioral health facilities that offer Medi-Cal behavioral health services will be expected to have a contract in place with their county to ensure the provision of Medi-Cal services once the funded facility's expansion or construction is complete.

Funding Parameters and Use Restrictions

Applicants will be expected to develop a competitive and reasonably priced development budget that will be scored alongside applications for projects of similar setting types and sizes. In addition, scoring will take into consideration a focus on the State's priorities, including efforts to advance racial equity and to expand services in regions and counties that currently do not have an adequate number of treatment options for crisis and/or behavioral health facilities. Funding priority will be given to facilities that expand access to behavioral health services across the crisis continuum. For proposed facilities that are not providing crisis services, applications will need to demonstrate how they are providing step-down services and/or transition of care out of acute crisis care or stabilization services.

AHP and its subcontractors will conduct a financial viability assessment, considering continued fluctuations in construction and other costs. Through various TA activities, such as the RFA pre-application consultation, interviews, and financial document review, the State will assess long-term operational sustainability once the capital project is complete and in use for its intended purpose.

Applicants will be required to commit to a provision of services and building use restriction for the entire 30-year period.

Match

Match guidelines will be set according to applicant type.

- Tribal entities = 5 percent match.
- Counties, cities, and nonprofit providers = 10 percent match.
- For-profit providers and/or private organizations = 25 percent match.

Match in the form of cash and in-kind contributions—such as land or existing structures—to the real costs of the project will be allowed. The State must approve the match source. Cash may come from:

- American Rescue Plan Act (ARPA) funds granted to counties and cities;
- Local funding;
- Mental Health Services Act (MHSA) funds in the 3-year plan (considered "other local");
- Foundation/philanthropic support;
- Opioid settlement funds for SUD facilities;
- Loans or investments;
- Incentive payments from managed care plans; or
- Another source.

Services, Behavioral Health Subaccount funding, and State general funds will **not** be allowed as match.

Funding Regions

Regional funding caps will be established and the amounts available per region will be determined based on the Behavioral Health Subaccount.

In addition, 20 percent of funds available for BHCIP will be set aside for use in regions at the State's discretion to ensure funding is effectively aligned with need. (For instance, this reserve money may be used to fund high-scoring projects in oversubscribed regions.) Another five percent of funds will be set aside for tribal entities.

Following an initial round of funding allocations (timeframes to be determined by DHCS), DHCS will conduct periodic reviews of the number of completed applications from each region. Any unspent funds may be considered for viable applications falling outside of the initial allocation priority schedules, geographical divisions, or other initial fund allocation restrictions.

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[i] Manatt Health. (2022). *Assessing the continuum of care for behavioral health services in California: Data, stakeholder perspectives, and implications*. State of California Department of Health Care Services. https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf, p. 89.

[ii] Budget Change Proposal 4260-175-BCP-2021-A1; 4260-195-ECP-2021-A1 (2021, April 1). State of California Department of Finance. https://esd.dof.ca.gov/Documents/bcp/2122/FY2122_ORG4260_BCP4562.pdf

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Draft Report Date: September 28, 2022

(Please see updates to 8/30/22 draft from Hope House are in yellow)

Site Audit Date: April 7, 2022 (via Zoom Meetings)

Site Name: Hope House, Crisis Residential Treatment Facility

Address: 300 Ilene Street Martinez, California 94553

Audit Team: Commissioners Joe Metro and Geri Stern

Audit Team Lead: Laura Griffin (Mentor)

I. Site Description

Telecare's Hope House opened on April 22, 2014 and is currently the only Crisis Residential Treatment Facility operating in Contra Costa County. The mission of Hope House is to deliver excellent and effective behavioral health services that engage individuals with complex needs in recovering their health, hopes, and dreams - add recovery statement

This is a 16-bed facility, ages 18-59. The program is a 14 day program. However, it has the ability to request a 7 day extension at the end of the 14th day, and a second 7 day extension at the end of the 21st day. This is on a case-by-case basis. The maximum length of stay is 30 days.

Staff: Hope House is a multidisciplinary team that includes psychiatrists, licensed vocational nurses, clinicians/social workers, residential counselors, peer professionals, a clinical director, an administrator, and administrative support staff. The psychiatrists are currently providing telehealth services. In addition to the afore-mentioned staff, Hope House utilizes interns.

Hope House is working with NAMI and looking into partnering with them for training and assisting clients connect to resources in the community. (Note that the Hope House Program Administrator, BJay Jones, has accepted a position on the NAMI board.)

Voluntary Program Admission Criteria:

- Residents of Contra Costa County, ages 18-59 (individuals aged 59 and older are served at Hope House on a case by case basis)
- People diagnosed with serious mental illness who are experiencing a mental health crisis and who may have a co-occurring substance use disorder
- Walk-in clients and self-referrals are not accepted at the crisis residential program. Referrals come to Hope House through the county Behavioral Health Services and the regional hospital (CCRMC) Psychiatric Emergency Services
- Referrals are interviewed to determine whether they are a "good fit" for the program

- Clients must be independent to benefit from the program
- Clients must be ambulatory

Programs offered by Hope House include:

- Crisis intervention, including emotional support and de-escalation of crisis situations
- Temporary respite from a living situation that was contributing to the crisis
- Development of a service/recovery plan
- Brief individual and group rehabilitation treatment, including individual psychiatric visits three times weekly, and such groups as meditation, yoga, therapy, exercise, coping skills
- Family counseling as needed
- Assistance with self-administration of medications
- Discharge planning and implementation of integrated aftercare services in the community
- Linkage and referral to services including assistance with obtaining disability entitlements, community housing, community treatment resources, and referral to appropriate medical services

Facility Visit Rules Relating to COVID:

At the time of this site visit on April 7th, families were not permitted to visit clients due to COVID policy. Hope House currently allows visiting and follows CDC guidelines as well as public health directives in relation to visitors during the pandemic. This is a fluid process.

II. Method

1. Commissioners interviewed a total of five clients, two staff members, and the Program Administrator:
   - Program Administrator
   - Direct Care Counselor
   - Clinical Supervisor (Team Leader and LMFT)
2. There were two (2) questionnaires provided by the Audit Team Lead used to conduct the interviews:
   - Program Director Questions – 8 questions
   - Staff Questions – 8 questions
   - Client Questions - 26 questions

III. Client Length of Stay

The length of stay varied among the four clients: Two clients were there less than two days. One client has been at this facility six times prior.

IV. Broad Themes

Some themes emerged from staff and client responses. Specific observations by staff and clients are spelled out below in sections V and VI.

Strengths:

- Overall client response to questions indicates that in general they are sufficiently cared for, feel safe, and consider their stay to be in a supportive and helpful environment that includes individual and group rehabilitation treatment options.
- Overall site administration was consistently positive in their views regarding how the team functions effectively within the organized structure of operational policies and practices.
- Staff appreciated the staff training, naming several types: CPR, CPI, Conflict resolution, Motivational Interviews, 2-week orientation training involving: Shadowing, instructions, online training courses -- competency is measured via exams, Risk Assessment, Treatment Planning, De-escalation Techniques, Motivational Interviews, and Elopement Risk.
- Clients mentioned appreciation for available resources, including the library, music, TV, access to phones, computers and video chatting (available 24/7); such classes as life skills, money management, and laundry; and such activities as cooking and doing chores in exchange for Hope House dollars.
- Clients mentioned appreciation for the various groups, including therapy, exercise, meditation, yoga, and coping.
- There was nearly unanimous positive responses to questions related to doctor and staff support for treatment. Clients are offered treatment alternatives, side-effects are described, questions are answered, and staff listen to concerns.
- Clients state that they understand the various documents that they review and sign, e.g. HIPPA, consent, and patient rights.
- Clients understand their patient's rights and half understand what a Patient Advocate is.
- Clients mentioned exercise numerous times, valuing it and desiring more.

Challenges, Needs and Opportunities:

- While Hope House is a voluntary program, staff do their best to engage clients in the program. That being said, some residents choose to leave the program early for various reasons. Staff pointed out that prior to FY 21/22, 50% of clients walked away after admission. However, this percentage has dropped to 20% in FY 21/22. This is a major improvement, yet still a critical issue to understand and address.
- Staff reiterated the need for more step-down placements and housing multiple times. The lack of appropriate and desirable options was called out, with staff stating that there are many clients who prefer to go to the streets rather than accept what is available at the time of their discharge. One staff stated that the number one issue for

clients is housing insecurity. Another wished that everyone gets a free one-bedroom apartment and are safe.

- Staff specified the need for more money for a variety of purposes, including housing, hiring more staff, e.g. LVN's and clinicians, increasing staff compensation, additional beds, and laptops for each client.
- Staff spoke to the need to have Behavioral Health Services communicate better with the facility on a regular basis and wished that there was a direct line.
- Staff appreciate the interventions from the county mental health crisis team and are trained on how to manage crisis situations. When at all possible, Hope House prefers to call the Mobile Crisis team, but because of Mobile Crisis staffing issues, situations usually end up being deescalated by Hope House staff. Staff would like more Mental Health Crisis teams available to intervene in crisis situations. They do not like to have to call the police to intervene. They see the Mobile Crisis Teams as being more effective in their interventions than the police.
- While case managers and social workers are available to work with clients and families after discharge, staff indicated that there is often no follow up, and one client said that they did not receive follow up.
- Only one client understood what an Advanced Directive is (note this may be a matter of terminology). This important tool could perhaps be better communicated, revisited multiple times throughout the client's stay, or otherwise emphasized more.
- Clients benefit from peer support at Hope House, e.g. for conflict resolution and groups. However, they didn't understand what "peer support" means. (Again, this may be a matter of terminology.) This may or may not be important, but given efforts to improve the recognition and standing of peer support in recovery, it may be helpful to familiarize clients with the term. Clients may also make more intentionally seek out peer support if they understand what this resource is and benefits that it offers.

V. Responses to Program Staff Questions

1. What age group do you work with and what do type of services do you provide?

   Staff 1:

   - 18 to 60-year range. Crisis Residential Treatment facility – bed, meals, personal care. Clinicians after client discharge have plans with Case Manager. Groups – Therapy, exercise, coping; Nurse/Psych Technicians help with medical services. Client see Psych personnel initially, discuss meds. Majority of clients come from hospital interview/referrals to determine if "good fit".

2. Do you feel the program is meeting the needs of the individuals you serve?

   Staff 1:

   - Good fit, client wants to come into program. Medical, ambulatory. Program is only for 2 weeks for client. Should be independent to benefit from program. Assist with transition from hospital to next steps: 1) Home, or 2) County program rehabs (e.g., Crestwood). Number one issue for clients is insecurity around housing. In terms of

family involvement – must be a safe support member. Facility is currently not allowing families to visit. Is this a Telecare policy – not certain where it comes from.

Staff 2:

- Feels that the program is meeting the needs of the clients. If they arrive with Substance abuse issues, they have every 30-minute checks for DT's or Opioid withdrawal. If clients begin to show symptoms, they are sent back to CCRMC
- There are 3 Interdisciplinary teams (Nursing, Residential Counselors, and Social Workers)
- They offer meditation, yoga, and many groups. The residents can sign up for chores.

3. What are areas of improvement for the services you deliver?

Staff 1:

- Mission of Hope House – to stabilize, reintegrate back into community.
- More resources needed for Clinical support (e.g., Therapists). Currently staff 4 Clinicians (2 Full Time) 9 am to 5 pm. Clinicians do shift exchange meetings, write official reports, participate in training.

Staff 2:

- They need more licensed clinicians and specifically an RN to help with overnight medication issues.
- They need more money for housing.
- They would like higher levels of staffing.
- They would like more Mental Health Crisis Teams to be able to intervene in crisis situations. They do not like to have to call the police to intervene. They see the MHCT's being more effective in their interventions than the police.
- Wishes they could do more for the clients and staff.
- Half the clients walk away after admission.

Program Manager:

- He stated that some clients are discharged to the streets as disposition is up to the clients. Some have no follow up. Hope House follows the lead of the client to discharge to their preferred place of shelter. Follow up suggestions and resources are provided for each client upon discharge

4. How well does the treatment and support team work together? Is there mutual respect, cooperation, and cooperation?

Staff 1:

- No visitors were allowed in the facility as of April 7th, the date of this site visit. However, Hope House now allows visiting and follows CDC guidelines as well as public health directive in relation to visitors during the pandemic.
- House offers phones, computers, video chats 24/7. Clinician to client ration is 1:1. Groups are supported by the Residential Councilors.

Staff 2:

- The team leader felt his supervisors had “his back".

Program Manager:

- He felt that the facility creates a safe environment where clients as seen as “people”.
- Measurements they use for treatment outcome are based on length of stay, connection to resources, and placements.
- He indicated that about 50% of the clients participate in exercise classes, but 100% get some exercise (walking).
- He felt peer group support was important in conflict resolution.
- He was pleased with the amount of staff training i.e., CPR, CPI, Conflict resolution, motivational training.
- They enjoy volunteers from NAMI Contra Costa and use Interns as extra Social Workers.
- He feels he has an “Open Door Policy” with staff. He’s very “flexible” to new ideas, however, he stated he was the one who usually brought the new ideas.

5. What staff development training have you or are you receiving to ensure you can provide the best quality of service possible?

   Staff 1:

   - All staff receive a 2-week orientation training involving: Shadowing, instructions, online training courses via Alliance. Competency is measured via exams.

   Staff 2:

   - There are a variety of Trainings each year for the staff (Risk Assessment, Treatment Planning, De-escalation techniques, Motivational Interviews, and Elopement risk.)

6. What systems are in place to address incident reporting and other means of ensuring quality of service review?

   Staff 1:

   - No staff issues to report. Clients – if extreme issue and no Therapist on call, police and the Mobile Crisis Response Team are called (5150). Incident last weekend was most recent. Client with similar issues during their last visit – Staff was prepared in advance and knew what to do.

   Staff 2:

   - They offer meditation, yoga, and many groups. The residents can sign up for chores.

7. Do you feel fulfilled in your role, if not, why not?

   Staff 1:

   - Yes, likes to talk with clients – listens.

8. If you had a magic wand and could change anything in this program, what would that be?

   Staff 1:

   - That everyone gets a free 1-bedroom apartment and are safe.

Staff 2:

- Staff would like more beds to help more people, stating they are the only CRT in CC County as Nyrika House has closed.
- Would like to pay the staff more in wages.

Staff 3:

- Raises for the staff
- To have Behavioral Health Services communicate better with the facility on a regular basis.
- Would like a direct line to someone in Behavioral health Services
- Would like more lap tops for the clients
- More Community groups to assist clients find more places to live upon discharge

VI. CLIENT QUESTIONS

1. How long have you been in this program?
   - **Client 1:** First time, 2nd day.
   - **Client 2:** First time, 2nd day.
   - **Client 3:** Sixth time, 8th day.
   - **Client 4**
2. Do you feel that you are getting better and that your quality of life is improving?
   - **Client 1:** Yes, was able to shower, completed her paperwork, toured the facility and met other residents. Had the option for this interview to miss the group meeting. Feels this is a safe place, welcoming and without judgement.
   - **Client 2:** Yes, emotionally supported, program offers tools for expressing (e.g. music, TV, and books)
   - **Client 3:** Yes, the Clinicians are good. He is allowed to cook meals, which is a hobby that he loves to do.
   - **Client 4**
3. Are there ways in which this program is different for you than other programs you have participated in? How is different?
   - **Client 1:** N/A
   - **Client 2:** N/A
   - **Client 3:** N/A
   - **Client 4**
4. Tell me a few things about this program that you like the best.
   - **Client 1:** Inviting, sense of community, feels safe.
   - **Client 2:** The attention to details communicated by staff, feels they have the Client's needs at best.
   - **Client 3:** Good staff, vocal (i.e. they talk and converse with the Client)
   - **Client 4**

5. In respect to making this program better, are there any recommendations that you would make to improve this program?
   - **Client 1:** Notifications and announcements of group sessions and times, staff should communicate when events are coming.
   - **Client 2:** None
   - **Client 3:** A bigger backyard, would like to go outside more frequently to work in the yard. Would like more physical activities available.
   - **Client 4:**
6. Does the staff ask you for your input on services that you might need?
   - **Client 1:** Yes, helped with meds, met with Councilor who gave overview.
   - **Client 2:** Yes, most staff does this.
   - **Client 3:**No, not all the time. No staff help with Section 8 housing questions. Would need to move in with Sister, when asking staff repeatedly he was told no help available.
   - **Client 4:**
7. Does the staff help you use your strengths, skills, and capabilities in your recovery? (e.g., your leadership abilities, compassion for others, artistic talents, computer skills)
   - **Client 1:** Too soon to determine a staff helps with her strengths and weaknesses
   - **Client 2:** No, too soon. Did meet with Councilor and paperwork is forthcoming.
   - **Client 3:** Yes, groups throughout the day incentivized by earning "Hope House Dollars ($)" to earn and buy items on site.
   - **Client 4:**
8. Do you feel the services you receive are adjusted to your specific needs (e.g., gender, ethnicity, disability, language)?
   - **Client 1:**Yes, co-ed facility
   - **Client 2:** Yes
   - **Client 3:** Yes
   - **Client 4:**
9. Does the program provide or connect you with meaningful social opportunities or therapeutic activities? Are there any other types of activities that are important to you?
   - **Client 1–** Yes
   - **Client 2 –** Yes, group meetings, library, and therapy are all beneficial. Use of Wi-Fi and phone a positive.
   - **Client 3 –** Yes, Clinicians setup time with paperwork and doctor appointments, they pick-up the medication, and staff offers someone to talk with (e.g. Client wanting a sleep study – staff helped and transported Client).
   - **Client 4**
10. Do you attend group therapy? How often do you attend? Did you sign a confidentiality agreement? What do you like or dislike about your group therapy?
    - **Client 1:** Yes, group at 9:30 am, Check-in, second session at 10:30 am. Signed a lot of documents, no phones allowed during session.

- **Client 2:** Yes, group at 9:30 am, but missed 10:30 am
- **Client 3:** Yes
- **Client 4:** Yes

11. Are you comfortable with us asking you questions about your behavioral health medications?
    - **Client 1:** Yes
    - **Client 2:** Yes
    - **Client 3:** Yes
    - **Client 4:** Yes

    Are you taking medications? (If "Yes," go to question "11a". If "No," skip remaining medication-related questions.)
    - **Client 1:** Yes
    - **Client 2:** Yes
    - **Client 3:** Yes
    - **Client 4:** Yes

    11a. Did a doctor or staff person talk to you about what the medications are for?
    - **Client 1:** Yes
    - **Client 2:** Yes
    - **Client 3:** Yes
    - **Client 4:** Yes

    11b. Did a doctor or staff talk to you about the medications' side effects, including interaction with other medications you are taking?
    - **Client 1:** Yes
    - **Client 2:** Yes
    - **Client 3:** No Not until discharge
    - **Client 4:**Yes

    11c. Did a doctor or staff talk to you about alternatives to medication such Cognitive Behavioral Therapy, Acupuncture, Yoga, or Mindfulness?
    - **Client 1:** Yes -
    - **Client 2:** Yes -Rusty explained withdrawals and symptoms
    - **Client 3:** Yes - No discussion
    - **Client 4:** Yes

    11d. Did the doctor or staff answer all your questions about your medications?
    - **Client 1:** Yes - has doctor session tomorrow.
    - **Client 2:** Yes
    - **Client 3:** Yes
    - **Client 4:** Yes

    11e. Do you feel the medications are helping you?
    - **Client 1:** Yes, some dose adjustments needed.

- **Client 2:** Yes
- **Client 3:** Yes
- **Client 4:** Yes

11f. If you had a problem with your medications, did the doctor or staff listen to your concerns? What did they do about your concerns?

- **Client 1:** Yes
- **Client 2:** Yes Nurse recorded and will be discussed with doctor in am.
- **Client 3:** Yes
- **Client 4:** Yes

11g. (For female clients): Did a doctor talk to you about the impact of medication on your hormones, menstrual cycle, menopause, pregnancy, or sexual function?

- **Client 1:** Yes

11h. (For male clients): Did a doctor talk to you about the impact of medication on your hormones or sexual function?

- **Client 2:** No
- **Client 3:** No

11i. Where do you get your prescriptions filled? Is it convenient for you?

- **Client 1:** N/A
- **Client 2:** They are delivered
- **Client 3:** Walgreens
- **Client 4:**

11j. Did you sign any papers agreeing to take the medications at admission?

- **Client 1:** Yes
- **Client 2:** Yes did not recall at first
- **Client 3:** Yes
- **Client 4:** Yes

11k. Did you understand the papers you signed at admission?

- **Client 1:** Yes
- **Client 2:** Yes
- **Client 3:** Yes
- **Client 4:** Yes

12. How is your physical health? Do you have access to physical health treatment and support that you need? Is your physical health accounted for in your treatment plan?
    - **Client 1:** Physical health is good, she gets migraines they provide her with aspirin and ask what she needs.
    - **Client 2:** Remains active, good.
    - **Client 3:** Could be better, not asked for treatment plan (he is on a treatment plan, but not a physical plan).
    - **Client 4:**

13. Does any of your family members, caregivers, friends, or other advocates participate in your program? Are services provided to support them?
    - **Client 1** Yes, relies on her partner more than family at this point.
    - **Client 2** Yes
    - **Client 3** Yes, relies on Fiancé and sister.
    - **Client 4**
14. Do you have a Peer Provider? (*See description) What services or support do you receive from peer providers in this program?
    - **Client 1** Not certain, not familiar with this term.
    - **Client 2** Not certain.
    - **Client 3** Not certain who it is.
    - **Client 4**
15. (Inpatients Only) Do you like your accommodations and your meals here? What about the common areas and therapy spaces or any other aspects of the facility?
    - **Client 1** Yes Meals three times with snacks the food is good fresh fruit.
    - **Client 2** Yes Facility is well taken care of, choirs.
    - **Client 3**
    - **Client 4**
16. How do you get to and from this program? How long does it take you to get here from where you live?
    - **Client 1** No issues with getting to and from the program.
    - **Client 2** No issues
    - **Client 3** No issues
    - **Client 4**
17. Do you feel safe in this program's neighborhood? Do you feel the premises are secure?
    - **Client 1** Yes near the Contra Costa regional hospital with no concerns
    - **Client 2** Yes
    - **Client 3** Yes
    - **Client 4**
18. Is it easy to get appointments with your doctor, therapist, social worker, or whoever else you want to meet with? Can you get appointments within a reasonable time frame?
    - **Client 1** Yes Easy to get appointments with her doctor and therapist and social worker.
    - **Client 2** Yes
    - **Client 3** Yes
    - **Client 4**
19. Do you have children, elderly parents, or anyone else whom you are responsible to care for? What are some ways that this program helps you manage your caregiving needs? (E.g., providing toys and a play space for children?)
    - **Client 1** No
    - **Client 2** No

- **Client 3** No
- **Client 4**

20. Does this program provide you with other services, such as legal help, housing services, financial resources, medical expense resources, educational services, SNAP benefits (food assistance program known as CalFresh in CA), or other services?
    - **Client 1** Yes was offered helped Advanced Directives
    - **Client 2** No not certain
    - **Client 3** No not on housing, but "yes" with other recovery house services.
    - **Client 4**
21. Consider the intake documents you signed upon admission, such as HIPPA notice (privacy), financial responsibility, and patient rights. Did you read them? Did you understand them?
    - **Client 1** Yes During intake she was told exactly what it was that she was signing what it was and to ask questions.
    - **Client 2** Yes HIPPA was explained, Consent during medical care, estimate time of stay.
    - **Client 3** Yes
    - **Client 4**
22. Do you know your rights as a participant in this program? Confidentiality is a right, for example. Do you feel your rights are respected?
    - **Client 1** Yes understands her rights in the program
    - **Client 2** Yes
    - **Client 3** Yes
    - **Client 4**
23. If you have ever had a concern or grievance with your treatment or some other aspect of the program, have you been able to address your concern successfully? What process did you follow? Did you use a grievance form?
    - **Client 1** No not at this time.
    - **Client 2** No
    - **Client 3** Yes client would like to spend more time outdoors
    - **Client 4** No
24. Do you know what a Patient's Rights Advocate is? (**See description) Do you know how to contact one?
    - **Client 1** Yes understands what a patient's right advocate is through emergency services
    - **Client 2** Yes
    - **Client 3** No
    - **Client 4**
25. Do you have a Mental Health Advanced Directive, also known as a Psychiatric Advanced Directive? (***See description)
    - **Client 1** Yes, does not have a mental health advance directive yet but program would offer if she needed one.
    - **Client 2** No not at this time

- **Client 3** No
- **Client 4**

26. If you had a magic wand and could change anything about this program, what would that be?
    - **Client 1** To be more outside be on the patio daily walks with directors of required supervised walks.
    - **Client 2** No changes
    - **Client 3** Would like to see an exercise area to work out in.
    - **Client 4** The client wanted to have a dietician be involved in her food selections. She stated some of the food offered at the facility was too spicy for her.

    Note that one client offered several specific concerns:
    - Client emphasized that staff tend to treat her like a child and are a little "over-protective"
    - Client requested more assistance with Time Management skills and to be connected to more outside resources to assist her with her home life and financial needs.
    - Internet and cell phone connectivity is spotty at the facility.
    - Client felt her bed was not comfortable because she is a larger woman, and the mattress does not accommodate to her needs.
    - The programs for her family are "confusing" and some of her families are not allowed to participate.
    - The Client does not like telehealth visits with her therapist as she cannot focus with the chaos/noise in her home. She would prefer to see the therapist in the relative quiet of an office setting.
    - The client was diagnosed with cancer on her last Pap smear and has not had a follow up visit to offer her guidance on what she should be doing next.
    - Client is having difficulty with her psych meds, She is experiencing many side effects.

VII. Premise Inspection

Due to COVID-19 restrictions per CDSS Department of Social Services, Community Care Licensing Division, we were unable to conduct a physical site visit. Hope House has specific guidelines which address vaccination and booster requirements, mask wearing, and other updated visitation requirements. Hopefully, once COVID restrictions are removed, we will be able to physically tour the site and publish an Addendum to this report.

Behavioral Health Care Partnership Children's Crisis Services Unit Input

What are you hoping for in the new Children's Crisis Services Unit

- Warm welcoming environment for first time visits, clean waiting room
- Remaining mindful that sometimes it may be the family environment that could contribute to onset of diagnosis.
- Maintaining readiness in case of need for counseling/intervention with family (to include family partner).
- A special skill set and understanding to care for children, and children with mental health
- Hire people who have experience working with youth and parent/caregivers skilled in family dynamics
- Look at their background and experience and provide correct customer services training for staff including clerks who check people in or answer doors.
- Education for parent/caregiver about next steps

What are some of the essential services that should be provided at the CSU?

- Family resources, descalation of situation, employees trained in crisis training, Trauma informed cultural appropriate, age-appropriate responsive care for different stages of crisis

Imagine your own child at the new facility and what kind of experience would you like your child to have at the CSU?

- Culturally responsive support in native language
- Interpreter so that the children don't have to translate for their families

As a caregiver of a minor child what experience would you like to have with CSU?

- Easy access and open communication for families with the child and providers.
- Address language barriers.
- Make social worker available to communicate with families and go over process to ensure that the family knows that the child is safe and secure.

What would it look like for a BIPOC child?

- Prioritize linguistic capacity and diversity in staff hiring.

Mental Health Commission
DRAFT Guidelines for Nominating Committee, 2023 Elections

Elections Held For:

- Chair
- Vice-Chair
- Executive Committee (minimum of three members, maximum of five, Chair and Vice Chair are automatic members so need to elect one to three additional members)

Timeline:

- September: Formation of Nominating Committee
- September – October: Develop slate
- November: Announce slate
- December: Hold election

Who Votes:

- Only Commissioners vote – not members of the public

Term:

- One year terms
- Chair and Vice Chair may hold their position for three consecutive years only; they may run again for the same position after not holding it for one year

Process:

- Select one person to represent/lead the Committee, e.g. give updates at Commission and Executive Committee meetings, lead the voting process at the Commission meeting
- Develop Slate
    - Objective is to develop a list of candidates for each elected role: Chair, Vice Chair and Executive Board Members
    - Identify potential candidates (excluding Supervisor)
        - Email all Commissioners to request that Commissioners interested in a position contact the Nominating Committee; include a description of roles in the email
        - Ask Commissioners for potential candidates too
        - Identify Commissioners who appear to be strong candidates for a leadership role (e.g. experience with the Commission, engaged with Commission issues and work, collegial, speak up at meetings)
    - Divide up list of potential candidates among Nominating Committee members
    - Reach out to each potential candidates and walk through: why they are interested in running, job responsibilities and time commitment (note that this is NOT an interview but more a vetting process and chance for Commissioners to ask questions and to really reflect on whether the role they want to run for is really a good fit)

    - Aim for at least two candidates for Chair and Vice Chair and four to five candidates for Executive Committee
    - Document candidates
- Announce Slate
    - Ideally, if the slate is ready by one week before the November Commission meeting, provide the slate to the Executive Assistant for inclusion in the meeting packet
    - At the November Commission meeting announce the slate – there will be an item on the meeting agenda for this
- Hold Election
    - For the December meeting election, be prepared with voting materials, method/process for conducting the voting, instructions for Commissioners
    - Since the meeting will most likely be conducted in Zoom, voting materials will need to be a Zoom poll or private Zoom Chat (each Commissioner messages their choices to one member of the Nominating Committee) or other electronic technique that ensures privacy of the voter and ensures that only Commissioners vote (rather than pencil and paper)
    - Tally the votes by entering a break-out room and reviewing the results of the poll or tallying up the votes sent by Chat
    - Winners are selected by simple majority
    - In the case of a tie, ballots may be recast until the tie is broken; if this approach fails to result in a majority winner(s) the vote may be deferred until the next Commission meeting
    - In the event there is only one candidate for the Chair and Vice Chair positions, there is still a vote for these positions; if there is less than three candidates for the Executive Committee slots, there is still a vote for these slots
    - At the end of the vote tallying, announce the winners

2023 Mental Health Commission Election

Nomination List

Chair Nominees

Laura Griffin

Leslie May

Vice-Chair Nominees

Douglas Dunn

Laura Griffin

Leslie May

Executive Committee Member Nominees

Douglas Dunn

Laura Griffin

Leslie May

Pamela Perls

Barbara Serwin

Gina Swirsding