4MONTHLY MEETING MINUTES
MENTAL HEALTH COMMISSION (MHC)
November 2nd, 2022 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. B. Serwin, Mental Health Commission (MHC) Chair, called the meeting to order @ 4:35 pm Members Present: Chair, Cmsr. Barbara Serwin, District II Vice-Chair, Cmsr. Laura Griffin, District V Cmsr. Douglas Dunn District III Cmsr. Gerthy Loveday Cohen, District III Cmsr. Leslie May, District V Cmsr. Karen Mitchoff, District IV (alt) Cmsr. Tavane Payne, District IV Cmsr. Pamela Perls, District II Cmsr. Rhiannon Shires, District II Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent: Cmsr. Kerie Dietz-Roberts, District IV Cmsr. Joe Metro, District V Cmsr. Yanelit Madriz Zarate, District I Presenters: Dr. Suzanne Tavano, Director of Behavioral Health Services Roberta Chambers, Indigo Consulting Adam Down, Mental Health Project Manager, Behavioral Health Services Other Attendees: Colleen Awad *Guita Bahramipour* Angela Beck Jennifer Bruggeman Dr. Stephen Field, Medical Director of Behavioral Health Services Kennisha Johnson Teresa Pasquini Jennifer Quallick (Supv. Candace Andersen's ofc) *Cheryl Sudduth*	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None.	
III. COMMISSIONER COMMENTS • (Cmsr. Leslie May) Just wanted to mention that I attended/observed the Board of Supervisors (BOS) meeting (last Tuesday). I was ecstatic on one hand and not so much surprised, but confirming what I had felt about racial equity in the county. I would suggest everyone take some time to watch that video. It is very important. There was a lot of information and very heated but feel vindicated everything I have been sharing on this commission since I have been on the commission regarding the inequality. The worst part is the inequality of those with mental health diagnoses. Everyone unhoused are not drug addicts. There is a	

misconception they are drug addicts and not everyone unhoused is not a drug addict and everyone unhoused doesn't use substances to escape. I would love to see that addressed.

- (Cmsr. Rhiannon Shires) I had asked this be shared with the Commission and notice it was forwarded. There is a town hall tomorrow at 11:00 am. It is a virtual 988 update with Senator Alex Padilla. For anyone available, this would be very informative and hopefully a way to get our voice out there on our perceptions on how this is working. Second item: I had sent an email (unsure if it was received) but it was regarding the Annie E. Casey Foundation State Trends in Child Wellbeing. There is a complete 2022 update and I think it is really important to look at this, the statistics in many areas focusing on child wellbeing. Third item: I am hoping will be on the agenda, we spoke about having liaison roles with some groups, such as Alcohol and Other Drug (AOD), since a lot of times we are piggybacking what we are talking about regarding programs and advocacy. I think it would be good for the 'right hand to know what the left hand is doing' and vice versa. (RESPONSE: Cmsr. Serwin) Thank you, Cmsr. Shires and thank you for reminding me of that last item. You did bring that up at the last meeting and we were to address it. We will have it on the agenda in December or January.
- (Cmsr. Pamela Pearls) I just wanted to mention the California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) and I am thrilled to be able to take some training. In addition, the organization had a list of 'people first language' although I don't think on this commission needs the tutorial, I thought it was a very nice summary of why you don't speak in a disrespectful way and how you might want to speak. I thought that if we are dealing with other communities that may not be as sensitive to those we are representing that I thought we might use it as a packet. Are we allowed to take a stance on policy or legislating not through the Board of Supervisors, but independently or are we so non-political that it is inappropriate? (RESPONSE: Cmsr. Serwin) My understanding is that any stance we take needs to be in alignment with what the BOS legislative committee has defined as the platform for the county.
- (Jen Quallick) As much as I know, you would basically offer your recommendation as it moves forward with what the BOS is recommending as far as legislative supporting for or against what they are recommending as the board. (RESPONSE: Cmsr. Perls) I'm still a little confused, does that mean we can initiate something that may not be on their priority list? (Jen Quallick) You can certainly make a request that legislatively, the committee consider something and that could go forward the legislative committee to be brought forward to the board for consideration.
- (Cmsr. Dunn) Ms. Quallick just confirmed what I thought: We can suggest to the BOS they consider an item to put into their legislative platform and I agree.
- (Jen Quallick) Cmsr. Perls, as Supervisor Andersen is your district representative, you are certainly welcome to reach out to me any time to put forth suggestions or to speak to me with any questions at any time.

IV. CHAIR COMMENTS/ANNOUNCEMENTS:

i. Review of Meeting Protocol: ➢ No Interruptions ➢ Limit two (2) minutes ➢ Stay on topic ii. Retreat: It is on the fence and we will know by the end of the week, there has been unexpected (health) challenges in my family, as well as there has been some issues the vice chair is having personally so we are bit behind. We want to ensure that by the end of the week we can have a solid plan in place. If we are ale to just hold one and we will update on this shortly. If we don't have a retreat in December, we have thought about holding it in January. If there is no retreat in December, we will have a full meeting. If we do hold the retreat, we while have an abbreviated meeting to vote. iii. Attendance Review and a reminder that if you need to miss a meeting for an unexpected circumstance/emergency, that will count as an excused absence from a meeting but you would need to contact myself and the vice chair (Cmsr. Griffin) and cc Ms. Beck. There are three non-excused absences permitted and if you miss a fourth meeting in a running year, then it is assumed you have resigned from the commission. I just want to make it clear that attendance for committee meetings is likewise mandatory and are dependent on a quorum for proceeding, just like the full commission meetings are. So, if Justice Committee works hard to pull in a presenters who are obviously very busy themselves and we don't have a quorum, she doesn't know who will show up, it is embarrassing, unfair to our presenting and it is unfair to anyone who planned on attending the meeting. It runs the same way, if you have three unexcused absences, the fourth it is assumed you have resigned from the committee and will need to find another committee because committee participation is required for everyone.	
V. APPROVE September 7th, 2022 Meeting Minutes • October 2nd, 2022 Minutes reviewed. **Motion:** L. May moved to approve the minutes. Seconded by D. Dunn. **Vote: 10-0-0** **Ayes:** B. Serwin (Chair), L. Griffin (Vice-Chair), D. Dunn, G. Loveday Cohen, L. May, K Mitchoff, T. Payne, P. Perls, R. Shires, G. Stern, G. Swirsding Abstain: None	**Agenda and minutes can be found:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. "Get to know your Commissioner" – Commissioner Kerie Dietz-Roberts	***Agenda Item tabled for next meeting (absent)***
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) Roberta Chambers screenshared the PowerPoint presentation <meeting participants after the meeting> This presentation is an update, background information will not be reviewed. **Timeline:**	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda

CC BHS received a mobile crisis infrastructure grant and a planning grant. The planning grant is actually what funded Indigo Consulting to be hired to perform the needs assessment and support project development for the subsequent applications. Round 3 – The County supported some shovel ready projects in another neighboring covered that CC children would have access to and supported an application to do some additional beds at John Muir for children in Round 4. Round 5 opened last week. This is the round we have been actively working towards, as it is the open application for the crisis acute and subacute facilities. This is for the 'front door' programs, as well as the high intensity programs. We were all waiting for a December 31st deadline but the state has been very gracious and made the deadline January 17th. We are actively working towards the January 17th deadline for three of the four projects we have been working on for the past four to six months. Round 6 has been clearly moved into 2023. In Round 5, there are two sets of facilities eligible. One is the facility that has been defined as the crisis continuum but it includes acute and subacute facilities. In the RFA, they have allowed other facilities that aren't on this list to be eligible that are full list of BHCIP eligible facilities. Our 'behind the scenes' read is that any project that submitted needs t have at least one of these crisis, acute or subacute facilities, and if you are co-locating something else, that is okay, but the applications are unlikely to be competitive if there is nothing on the list, and these are all the high end services. The needs assessment was conducted, which many of you participated in a number of different ways, including community meetings and various committee meetings within this body. The short list that came out of this on the BHCIP side was 45-bed mental health rehabilitation center (MHRC), an additional crisis residential treatment (CRT) program and two adult residential treatment (ART) programs, all focusing on West and East county if at all possible; and then a multi-level substance use residential treatment program to add some capacity for co-occurring disorders on the AODS (Alcohol and Other Drug Services) side. That is really where we got to on the BHCIP, what were the facilities that had been prioritized, the bed capacity that estimated to be needed. That is what we have been working towards. You will hear where we are, with just checking those boxes off with projects that are getting closer to being able to submit. There is a weekly meeting, essentially a project management meeting where those from public works (capital projects), real-estate, BHS all get together and go over all the projects, what needs to be resolved, what are the questions, and has been the group that has reviewed properties and gotten to the place of 'this one is going on the list that we will do a 'full court press' to get this ready versus this other maybe not so much. We have definitely we've had properties come and go from that list and have also had some that have just been on the whole time. In these meetings, we have four viable properties that are getting that 'full court press' towards the application and then there is also some continued exploration. When you see where the properties are, we know there is still a need for additional project development in East county. BHS has been working with the city of Antioch to identify any surplus properties they might have available to ensure there is good geographic capacity built throughout this process.	and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

We have worker orders approved for all the properties, the architects have all been onboarded and doing the schematic design work that gives us enough of a design to submit the grant. Once the grant is submitted the full design process kicks in. There are a number of inspections and due diligence processes are either underway, and actually one, if not two, have been completed for at least one project.

The specific projects, I will review with you what I can. Some are county owned properties, some are vacant, some are not. There are two that are acquisition projects. So, just in the spirit of protecting the best interests of the county and allowing certain negotiations to occur with the level of confidentiality that is allowed, I will give you as much information as is possible without sacrificing the negotiations.

1. Brookside: This building is adjacent to the Brookside Shelter. We will apply to have this be CCC's first MHRC. 45-beds. We are planning to have this submitted in Round 5. Real estate has already provided all the documents we need for the application and public works is working on their set of documents, which take a bit longer. This building is set like a plus sign. One wing will be administrative, there will be two wings that are for clients and in the back of the building, there is a huge outdoor space and it is very nice. All things considered, this could be an actually really nice place with outdoor space as well.
2. Confidential Project (not purchased): If the grants are funded, the county would be able to purchase them. West County and has a lot of space. This would be a renovation of an existing building to create a social rehab (either a CRT or an ART). Due to where it is, it makes sense to had an outpatient clinic that has some urgent care capacity, as well as a community wellness center in some new construction adjacent to the where the social rehab and urgent care would be. 16 beds, short-term or transitional residential, and the outpatient and wellness space.
3. Confidential Project (not purchased): Central County/as far East as you can be without actually crossing into East County. It is a large space and it is new construction with the idea of two social rehabs; one CRT and one ART on the same property. Assuming the acquisition can get worked out, to prepare for the application and some issues with the architects, design and budgeting that will go in in Round 5 as well. It looks promising. Each of these facilities will provide 16 beds (32 beds total).
4. County owned building (confidential) East County. Currently occupied and would be a multi-level AODS residential treatment program with solid co-occurring capacity. There are some things to work out in terms of the property and easements and setbacks, as well specific program design elements, so this one doesn't have a front door aspect to it; no urgent care, crisis, etc. We think this will be most competitive in Round 6 and it will give us enough time to work through all the things that we need to work through.

Questions and Comments

- (Cmsr. Dunn, in CHAT) What projects are being considered for Antioch. (RESPONSE: Roberta Chambers) It really depends on the site at this point. We both have to agree on the property(ies). _____<cutting out> It really depends on what the property is and what it might lend itself too.

- (Cmsr. May) I just want to thank you so much for being so transparent and explaining and having the slides to explain everything. You said you will be sending them out after the meeting? (RESPONSE: Roberta Chambers) Yes. I will send the presentation to the executive assistant to send out to the commission.
- (Cmsr. Dunn) Thank you so much for the great presentation. Are there any comments Adam Down wishes to make? (RESPONSE: Adam Down) Roberta summarized really well. From my perspective, there is a lot of work that goes into this that doesn't show up in a PowerPoint like this. The county will not let us get engaged in something with environmental hazards, like contamination. So just due diligence that all these departments are putting into this, all the steps to get there, it is quite a lot in the background and is coming together. We can't wait to share even more as it starting to come together and we are almost ready to submit applications well ahead of time for some of these projects.
- (Kennisha Johnson) Thank you, just to echo what has already been said. There has been a lot of consistent work for many. It is really exciting to see it all come together and we just need a lot of good vibes for our applications to get awarded.
- (Adam Down) At some point, we will be coming to the commission hoping for letters of support and we want to make you aware we will be asking as we approach the submittals.
- (Cmsr. Perls) I just wonder if you could explain some of these projects that are well along with design and just waiting for final touches. That is a lot of investment in the programs and properties. If you do not get the grant, are those going to be funded by the county and built even without the grant. (RESPONSE: Adam Down) We would have decided at that point. The county has done a great thing investing in this and it is under the planning grant, a few thousand dollars in architecture time adds up very fast. If it is a $30m renovation for an MHRC, that would a Supervisor level decision. That seems like a big ask. The smaller projects, we may find different approaches for and definitely don't think the work would go to waste. We would have to look at this on a case by case basis.
- (Cmsr. May) I also wanted to say that I appreciate the mention that you are all working with the City of Antioch. It have been their to push them, informing them and telling them to step up to the plate. I am so happy to see you working with the city of Antioch. In terms of Cmsr. Perls comment(s), I am always thinking there is 'no door closed' to me and think that should be how everyone feels. There is federal and state money, there are funds to finish up these projects. It takes a lot of extra rolling up the sleeves and working but I always look at every endeavor, especially when it is something positive to give back to the community and help those that can't help themselves. The county can get funding from somewhere. Keeping positive thoughts.
- (Cmsr. Stern) In terms of getting the grant(s) accepted, what has been the experience in the rest of the state with those that have been accepted? Is it a percentage proposed that are accepted? Do they all get accepted? Do you have any data on that?
- (RESPONSE: Roberta Chambers) The way it is structured is that it is a $2.2bil informal procurement from Department of Health Care Services (DHCS) and they have a consulting firm, Advocates for Human Protentional, that is administering the grant. Because it is an informal

procurement, they don't publish any scoring, or what gets priority points or much else of the process and it is one that there is no ability appeal or ask for feedback after the fact. It makes it tough. We do know there is a set amount of money in Round 5. That set amount has regional limits, so the Bay Area has a certain amount that is available for Round 5 and will fund highest scoring projects within the Bay Area region until they hit the funding limit. If there is any money left over from other regions, they will go back to projects that were determined they would like to fund. I have submitted a number of Round 3 and 4 applications in other counties, many of which were funded. What we do know from our friends at AHP is there are priorities they are looking for, so the level of site control matters. Owned buildings, options to purchase, those do better than a long-term lease. Also, with Round 5, we suspect the higher end services (crisis) will receive priority. Other than that, we do think these projects, for different reasons, will be quite competitive within the region and any left over money within the state, if it gets to that.	
VIII. UPDATE on Site Visits end of year activity and first quarter 2023 projected activity, Cmsr. Laura Griffin We wrapped up the year with not as many site visits that we had planned for. We completed Hope House report and Cmsr. Serwin will speak on that report on the next agenda item. The plan at the beginning of the new year is to meet and assess what worked, what didn't work and what improvements we can make moving forward. We will aggressively start out in the beginning of the year with more site visits, including in person site visits, which will make a huge difference and our hopes are to start visiting children and adolescent sites. Those are the goals. We have yet to have a team meeting but will do so shortly. **Questions and Comments** • (Cmsr. May) I would just like to re-iterate that every commissioner must participate. We all must do our part to be successful. This means showing, participating in training. Every commissioner is part of this commission and must perform and do at least one site visit. • (Cmsr. Griffin) Thank you. That is what we were lacking in the last year so it hindered us a little. • (Cmsr. Serwin) I would just like to add that some commissioners get frustrated with what we accomplish as a commission, that we do a lot of educating, discussion of issues, but it is really these committees (like the site visit committee) that do a lot of the hands on work and where the rubber meets the road. It takes a lot of work due to things like this and just encourage everyone to participate in their committee's hands on work.	
IX. DISCUSS Hope House Final Report, Cmsr. Barbara Serwin (Cmsr. Serwin) Not much to report other than I wanted to mention this site visit and report is fully wrapped up. We initially wrote the report, had input from the program administrator and incorporated, reviewed with the Quality of Care Committee and those changes have been incorporated. It is finished and we will figure out how to post/present our site visit reports on the commission website.	

X. DISCUSS needs/desires for the new county Children's Crisis Stabilization Unit, Cmsr. Barbara Serwin

I hope you all came with ideas for this agenda item, as you can see in our packet I included an attachment, "The Behavioral Health Care Partnership (BHCP), a group of people coming from the hospital, the community, BHS, many with lived experience. This group meets on a bi-weekly basis and did some brainstorming on the same question. What are your needs and wants for the Children's Crisis Stabilization Unit (CCSU) and I attached that to the agenda.

What are some of the essential services that should be provided at the CCSU? Imagine your own child at the new facility and what kind of experience would you like your own child to have? As a caregiver of a minor child, what experience would you like to have with CCSU? What would this look like for BIPOC (black, Indigenous and people of color) child?

I want to, at this time, open up for discussion. We did have a few suggestions come in by email and would like to share as well.

Questions and Comments

- (Cmsr. Dunn) It is very important for this CCSU to be able to have adolescents that are in mental health crisis and either juvenile hall and/or Orin Allen Youth Rehabilitation Center (OAYRC) to be admitted to this unit when they are in crisis. The background to my comment is that I found out children from Juvenile Hall and OAYRC are not currently allowed (since 2010) to be admitted to psych emergency services (PES) 4-bed children's unit. We have got to ensure this situation does not continue to occur in this new CCSU. One, it is not owned by Contra Costa Regional Medical Center (CCRMC), but built by Mental Health Services Act (MHSA) funds and, as I understand, Miller Wellness Center (MWC) is operated by CCBHS and will operate CCSU. There should be no problem admitting persons from these facilities in these kinds of crisis to this unit when needed.
- (Cmsr. Loveday Cohen) I have a 15 yr. old that has autism. He is not quite verbal and was thinking that this unit should have a sensory room. They don't know the patients they will be receiving. Also, as far as specialists, I would like to see play therapists (sand tray, etc.), as I have done this in the past in Peru and Mexico. Some children feel more at ease / relaxed talking while engaging in this activity. Also, Art and music therapy, as well as specialists in attachment therapy (Attachment Disorder Therapy). It is very important. This gives the kids that have Reactive Attachment Disorder and develop other mental health issues in the future (i.e., Borderline Personally Disorder). When these kids start school, these behaviors present because they cannot trust adults. That is one of the symptoms of the Reactive Attachment Disorder. I would like to see more specialists working with children and adolescents in this facility.
- (Cmsr. May) We know the cultural issues and putting that into this program. Autism and treatment of separation anxiety. That is a big issue, along with attachment disorders. Many of the youth have been in foster homes and moved from one family member to the other, it creates multiple trauma and builds upon each instance. We need to have therapists that will be able to focus on that 'de-sensory' and I am also

into that somatic work, touching (even if the child isn't on the spectrum), just the touching/feeling, the play therapy. I use sand tray all the time in my office. Mixing clinical with this, which we so often don't do. Not just treating the mental health issues but the whole person. There could be some medical disorders happening with these children and we need to look at every part of that child, treat the whole person. Finally, Cognitive Behavioral Therapy (CBT), client centered therapies, etc. there are a great many things that could be looked to and included. The playroom, sensory room, rock climbing, (smaller) trampolines, etc. There are so may things that can be incorporated.

- (Cmsr. Griffin) All these ideas are fantastic and I just want to mention one that I feel strongly that is so important. How the facility is decorated (colors used, is it friendly for those coming in? We don't want it to be a sterile scary place. We want art on the walls a things that make them feel comfortable and not scared. That is very important.
- (Cmsr. Swirsding) Before I became a commissioner, there as a mother in our community that lost their son (gun violence) and started reaching out to other mothers. As a result, she also reached out to other families. Those participating, parents with kids, talking about the trauma of gunfire. It was amazing how many of the older kids (5th grade and up) started talking about their fear. I feel their fear, and kids are allowed to share their experiences living in their neighborhoods. They see these people, and as a result, these kids end up going into gangs because they feel more protected. I am hoping the trauma center there will be a place where families and kids can talk about what is traumatizing them.
- (Cmsr. Perls) I responded via email just before the meeting regarding CALICO Mental Health Services. It is in Alameda and their work is a bit different. They are doing forensic interviews of children and adolescents for the District Attorney's office, so they are either victims or suspected or actual sexual abuse, physical abuse, neglect, trafficking, etc. I have taken a tour of the facility. This is not residential, it is strictly for interviews. I think it would still be very helpful if we sent a small group to report back to see what they have done. They have done a lot of what we have talked about (sensory rooms, play therapy, etc.) The kind of interview rooms they have would easily be translated into common rooms, the colors on the walls, the artwork. I know they are very open to having visitors. I am certain if we contacted them, we could find out how many they can accommodate and when. I want to say they are in Hayward or San Leandro. I think it would be incredibly helpful to see what they have done. It would allow us to reflect a little more realistically regarding what would work for this CCSU.
- (Dr. Tavano – Chat comment) The CCSU is crisis so the maximum amount of time would be up to 24 hours. It is, again, crisis stabilization, so the focus will be assessing, providing crisis intervention, determining what level of care is needed, arranging for that level of care. Then, of course, being with the family during the period of time the youth is there in terms of helping to assess and determine next steps. It is not a treatment facility. The ideas you have all been talking about are wonderful but would not fit in emergency care model. So I just wanted to bring that up.
- (Teresa Pasquini) I just spent the day at a 'Words to Deeds' conference that was focusing on the Anyone, Anytime, Anywhere (A^3) work that we are doing here in CCC, but the state vision for that work, so I heard a lot

of different models of care. I really learned a lot and it was such a great day. I am presenting tomorrow morning on a panel regarding housing. Today was strictly focused on mobile crisis, crisis stabilization units, etc. Heard a great presentation from Seneca Mobile Crisis Team, which our county utilizes. *<I just have to say I am so proud of our county. Our county has so many amazing things in CCC that other counties don't have.>*

The final presentation today was two models: (1) in Roseville; Dr. Scott Zeller presented at the end on the Empath Model. Dr. Zeller is a nationally renowned psychiatrist that has travelled the country. He was in Alameda county. He consulted with CCRMC and I actually met with him several years ago when I was chairing the BHCP.

To go back to Cmsr. Serwin comment regarding the partnership, I would strongly encourage a member of the commission to actively participate in the BHCP and to be a liaison. They have done a lot of work and their suggestions are all great. I think it would be really helpful to work together. It will provide a different view of this process by sitting with providers that are hospital based and working in the hospital and can explain the process.

Empath Model (in Montana?) has both a child and adult Empath Model. Physical space design is a large open mixed use space where patients can be together in the same room; high ceilings; ambient light; soothing décor; and designed to facilitate socialization, discussion, interaction and therapy. Chair model design with fold flat recliners. Space recommendations: 80^2 ft total per patient, which includes 40^2 feet area around each recliner; open nursing station with instant access to staff; no 'bullet-proof glass fishbowl', which we have in our current CSU model (I know our Health Services Director was not a fan). There is no bullet-proof glass to separate the patients and the staff; voluntary calming rooms to avoid locked seclusion rooms or restraints.

There was also a lot of data that supported this model and more. I have slides and can share with the commission once they are posted. I know Dr. Tavano knows more than I do, but I just heard about it this afternoon. I wanted to share and encourage everybody to look into best practices. This really is an opportunity for us to create a therapeutic space for children in crisis. We don't want them to stay in crisis, or boarded in these locations, we want it to be a place where they can go and get the care they need and move on to the next least restrictive level of care as soon as possible.

- (Cmsr. May) My brother lives in Arizona and he told me about this project. I looked it up and found/posted
  <AZ Project: https://www.adaptivearchitectsinc.com/project/childcrisis/ >
  This is one of the crisis centers (in Arizona). My brother and his wife do philanthropic work and donate/fundraise. I wanted to share that with everyone. It similar to what Teresa was speaking to.
- (Cmsr. Serwin) By the way, Cmsr. Griffin (Vice-Chair) is our liaison to the BHCP group. I also wanted to add, as much as possible, providing the children with opportunities to exercise control, help make decisions with what is happening with them in the moment and next steps. They are young, going through something, but the more they feel they have some control, I think has a real positive impact. Dr. Tavano, is there anything included in the vision about having physical assessment on site?
  (RESPONSE: Dr. Tavano) Every incoming youth would have a screening to

rule out any outstanding medical condition, because then, they would go to the emergency department (ED) if other issues are identified. We won't have pediatricians there. There will be a screening, as it is required in regulations that each person has a medical screening before actually being fully admitted to a CSU. Sometimes that occurs because of a 5150 is placed, the ambulance is called, the EMT determines if there is an outstanding health problem/issue and would take the individual to the closest hospital ED to evaluate their health condition and provide whatever is necessary. If they are cleared medically, they would then come over to the CSU. Most likely, the screening would occur at the front door at intake.

- (Cmsr. May) Is it inclusive of physically disabled children? We know there are children that have both physical disabilities (wheelchair-bound, etc.) and mental health issues. I wanted to ensure it is all inclusive. (RESPONSE: Dr. Tavano) Yes, it would be ADA compliant.

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

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

Questions and Comments

- (Cmsr. Serwin) It is exciting to see such a diverse choice and good to see we have strong leadership moving forward into 2023.

XII. Review progress on Mental Health Commission 2022 goals, Cmsr. Barbara Serwin

(Cmsr. Serwin) The goal of promoting insurance parity for physical and mental health services, it is one of our goals and have stated before how difficult it is to get any traction on it. I still have been unable to get any traction. I am unsure but I am happy to keep working on it. However, we may wish to set aside and approach it more as it is something we are learning about as information becomes available.

(Dr. Tavano) I believe there are some new opportunities. Parity is supposed to be in place a long time ago, never quite happened and then it was reinforced in California not that long ago. The state does seem to be hearing what we have all been saying, when you look at mobile crisis and the upcoming Care Court, I'm starting to see language built into it that is putting forth that commercial plans are responsible for the care of their beneficiaries

and if they don't provide the service themselves, they must pay the county for the services provided to their beneficiaries; considered as an out-of-plan expenditure. This is really the first time I have seen it clearly stated that we are all in this together and everyone has responsibilities in meeting the needs of their beneficiaries, whether it is MediCAL beneficiary or commercially ensured beneficiary. There might be some more room for discussion given the language that I am seeing currently.

(Cmsr. Serwin) The goal of tracking the funding (where the money goes). There was progress made in terms of starting to look at contracts and to get a sense of what is contained in them and what we can learn from them. That said, the BHCIP process really landed squarely in Cmsr. Dunn's lap and was a full-time job to track on the Rounds, projects, the funding involved. I suggest we move that goal forward into 2023.

The third goal is looking at the gaps in BHS for the K-12 public school population. We have made progress. The Quality of Care committee is spearheading that effort. We have definitely made progress, spoke to various people and got some grounding in terms of who is doing what. We are starting to look at contracts to understand who is providing what services and where. We have a committee. It will be a process to map this out. It involves speaking to a lot of different school districts but feel confident we can accomplish this. Please with the progress.

The fourth goal, site visits. Cmsr. Griffin just gave you the run down on this. We would like to debrief, make the improvements in our process that we need to make, choose our sites for the first quarter of next year and then really find a way to focus on the children's facilities. Everyone is quite eager to that part. The other piece, as Cmsr. Griffin mentioned, is getting the onsite reviews in place as well. Cmsr. May is aware of an international standard 'best practices for review of sites' from the view that we are looking at them.

Questions and Comments

- (Teresa Pasquini) I think we spoke on this already but there never will be parity with the IMD exclusion in place. We are still waiting on the state to apply for the waiver. They keep pushing it back. I have had a few senators insist it is going to happen but I will believe it when I see it. There are different forms of parity that need tracking. I was really encouraged today to find out that mobile crisis services are going to be a MediCAL benefit which I had not heard before until today. It was definitely mentioned today that commercial insurance plans have gotten away without paying for crisis services.
- (Cmsr. Serwin) Was there anyone there that you are aware of that represented the insurance companies? (RESPONSE: Teresa Pasquini) No.
- (Cmsr. Loveday Cohen) I think this will be good. I am a counselor at Liberty Unified School District (LUSD) and every time we want resources, we cannot find them. We have an intern for counseling and I don't know if there are other resources or if there is a pushback from the administration, that the community doesn't want it, they think there are no mental health problems, due to socio-economic status. I will say we have them, a lot of them. Coming from the background that I do and I have a police officer decide on a 5150, or an assessment; sometimes I hear the assessments and I am shocked and think "How can this child's life depend on you?" That is protocol. The Police are to determine a

5150. Once the student returns, what are the resources for that student? There are none. It has been challenging. If you need my help or input, let me know. • (Dr. Tavano) Sorry, I just received a notice. CCBHS will be honored at the 2022 You Make A Difference Awards, the Community Advisory Committee and the Mount Diablo Unified School District's Special Education Department invites you to join us as we honor the recipient. Just to say we are working very hard with the county Office of Education and the different districts. We have partnered with Contra Costa Health Plan (CCHP) because under CalAIM, the managed care plans now have responsibility for supporting students for school-based mental health services, so I think we will start seeing some more growth there. When CCHP really started talking about how they would implement some benefits, we brought them into the coalition so that collectively, we are looking at everything and every funding stream possible to fit it together. So BHS does contract for a lot of the services that are school based, but other entities are as well. Some school districts are the fiscal intermediary, where the district actually provides the services, but the funding is through us. It is how do we build equity throughout the system for those districts that don't benefit from state/federal funding.	
XIII. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano BHS is working on a lot of big initiatives at the same time. The biggest projects we are working on concurrently is still A^3, BHCIP Round 5 (and Round 6) and there is a lot of work going on there identifying properties, working with PW (public works) and the CAO (county administrator's office) and Kennisha is reviewing quite a bit on that. CalAIM (California Advancing and Innovating Medicaid), which is really is about transforming our system and we are walking into it. The state started with paperwork, assessments and whether there is a treatment plan or a problem. All of the service of improving access and not having clinician's spend a lot of time in administrative type functions. CalAIM's goal is that when a patient walks through the door, asks/understands what they need, start providing services and even before a full assessment is completed (as we have had to do until July), services that are needed are provided by way of a problem list, rather than a really detailed partnership plan that was required until July. I feel like our efforts need to go towards building out more rapid access so people don't have to wait. That will take a lot of lifting in many ways, but as I <dropped off?> If we call because we need help, or a condition addressed and call an access line, how long will it be to see someone? I think we have all experienced this, even when there is what we consider somewhat important physical health conditions might need to wait a month, two months, three months, etc. So really, when people are asking for help is the time to provide the help, it's not weeks to months later. We are all committed to moving toward having more rapid access to services but that means building out our system in a number of ways. Funding is part of it, but quite honestly, staffing is our biggest dilemma right now. It is very unusual where we have funds, but are struggling to find the staff to provide the services and that is at the CBO's (contracted level) and the county level. At this point, CBOs are more impacted in this way that the county delivery	

system, but we have been working with all of our CBOs as you all know to help keep them afloat since the pandemic started.

There are so many parts under CalAIM that a lot of times I reference it but I don't THINK there is any way to easily communicate all the work that is needed and is going on moving to CPT codes, there is a big lift for all the staff. I know for many of you that doesn't really resonate in any way, but it is a big deal because it's part of payment reform. Moving our whole system from a cost-based system up until next July, we get reimbursed for the cost of providing services, but starting next July, we will get paid for what we actually provide as services and that is a very fundamental difference. It means the system being more efficient in many ways. We still want to support staff and keep morale up, and then there is this balancing point.

I would also add related to CalAIM and payment reform, the more local money we have to be put into an intergovernmental transfer, we broaden down the federal dollars. So for every dollar in, we get back that dollar back plus another dollar for service. So it is a real balancing act.

Realignment is our biggest funding source coming into the county which is state funds to match federal dollars (MediCAL), it is the federal funds participation (FFP). So realignment is the biggest, but the MHSA is a very close second. We want to continue to support prevention and early intervention, innovation, workforce education and training. All very important but at the same time, think about how we maximize those funds for services for patients with significant mental health challenges, whether they are youth or adults. I felt it was important to get input from county staff who are out in the clinics and in the community providing services as to what they think our system needs to shore up our system. We will be going into public forums starting this week and moving forward.

It is really important that everyone is thoughtful in how we accomplish this together. There is a lot of planning going on and fitting pieces together to make the whole system work and supportive.

We are well on our way with permits and the architect and taking input on design features with regards to the CCSU. Then we have the whole program piece that you will all be engaging in. Care Court is another big piece to follow but Contra Costa is not in the first cohort and I know you have all heard me say that, so it gives us a year of learning from what the first cohort of counties go through and can be better prepared in the second year. The state did issue planning funds to each county but we still do not know what that grant funding will be for the actual Care Court programs.

Questions and Comments

- (Cmsr. Swirsding) I have been informed there is a lack of therapists and psychiatrists, not just county but private insurance such as Kaiser. Is this what is also happening our county? Is there not enough staff to help those in need? (RESPONSE: Dr. Tavano) It is not just behavioral health, it is the county, the state, the nation and it is all behavioral health providers. The pandemic really did a lot of damage. There are more people needing services, more people going into private practice because they can do telehealth and potentially have a different level of income. I think we are all competing with each other, so what goes on in CCC, the CBOs are unable to compete with Kaiser or Alameda our SF counties. That is the progression of things. Mental health practitioners are in very high demand and we are putting a lot of effort into recruiting

and really recognizing we are at a point where we need to put the time and effort into bringing in people and providing continuing training and support and help grow our own system.

- (Dr. Field) The struggle is exactly this. It is not unique to us here at the county. One approach I have really leaned into and seems to be promising is partnering with UCSF. California has taken an initiative to train nurse practitioners and certified psychiatric mental health nurse practitioners (PMH NP) and thus far, we are actively engaged in training those students in our clinics helping to retain them after and actively adding PMH in key positions to supplement our current work force. Psychiatry has changed over the last decade. It is highly competitive, people are moving into the field, it is just going to take time. It is a four year program for adults in general psychiatry, six years for child. The system just has to catch up. Getting creative within this is a way to make sure people are cared for as the system has time to rebuild. It happens with all disciplines and ebbs/flows within different disciplines (anesthesiology, etc.). (RESPONSE: Dr. Tavano) To that end, it is all the little things we looked at. We were having a hard time even recruiting the PMH because the county classification read family nurse practitioner. People who receive advance training in psychiatry and mental health did not want to be in a family nurse practitioner classification because they had received additional training, education, etc. It was a little tweak but it took a few years to have the family piece taken off the nurse practitioner. Since that was done, we have found people are interested because they feel they have a distinct identity and we want to respect that.
- (Teresa Pasquini) I participated in the Board of Supervisors (BOS) meeting yesterday and the OAYRC discussion item and gave public comment based on my knowledge of the situation from attending the Justice System committee meeting where I heard Steve Blum present and have been tracking. I was surprised to find out that there was a report from the Juvenile Justice Commission that was very much part of the conversation and the decision making process yesterday that I had not seen. I was really troubled by the level division in the community and pushing back on the closure and it seems there was lack of knowledge and understanding about the process. I bring it up because you mentioned about attending meetings and providing information and I just think this is another example of the need to partner to share information. I was disappointed in the board item that the report referenced was not part of the packet. I might have made a different comment had I seen the report, which is a really good report that I have now shared with the commission. I am asking you because it was mentioned in the report that probation had a lot of discussion with BHS and the county education department. But where are all these conversations happening? I am pushing for shared information and more transparency and information to the full community. (RESPONSE: Dr. Tavano) Thank you. I was in meetings and did not attend the BOS meeting yesterday and I don't even know the outcome is.
- (Teresa Pasquini) They voted to close it. They closed it 3-2 so we had a divided board and a divided community. That, to me, is really is unfortunate and sad and I think there was a lot of misinformation. There is a lot of the community that doesn't even know the history of our county, in terms of the stakeholder processing and discussion. They

don't know we once had a Chris Adams or that we advocating strongly for a crisis residential for youth at Oak Grove, years ago. It is just so sad to me there is so much miscommunication or lack of shared information. I would just like to share and raise the awareness and ask you if you could intervene and help bring more of a partnership. • (Dr. Tavano) The discussion I have personally been involved with probation was that if you are going to close down the property, CCBHS and some community partners are very interested in that property for development. That was the extent of the conversations. • (Cmsr. Serwin) I have a question regarding wait times. You did mention wait times, correct? (RESPONSE: Dr. Tavano) I did, and I was speaking broadly because, if we just look at recent events with Kaiser had a nine-week long labor action and that certainly impacted people, as well as in general. We are held to pretty tight measurements with timely access to care and we are monitored very regularly. When I was speaking to wait times, when people come in, seeing them within the right time frames but also ensuring all other services they need are provided as soon as possible and we are meeting our timeliness standards but feel we could improve. • (Cmsr. Serwin) I am just recalling from the EQRO (External Quality Review Organization) Report that there was a recommendation regarding wait times. Could you clarify what part of the process that was referencing? (RESPONSE: Dr. Tavano) Patient receives an assessment, some services, and again, there might be additional services needed in addition to one's they are already receiving and there might be wait times to get those additional services. • (Cmsr. Serwin) so it is not the psychiatric/mental health services? (RESPONSE: Dr. Tavano) Yes, that was addressed in a number of ways including telehealth bringing on more staff and we are still working on that by bringing on more nurse practitioners in addition to psychiatrists.	
XIV. Adjourned at 6:38 pm	