

Santa Cruz County  
**Mental Health Board Meeting Minutes**

**April 15, 2010**

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Facilitator: Joan McVay, Chairperson  
Recorder: Linda Betts  
Staff Ex-Officio: Rama Khalsa, Director – Health Services Agency  
Meeting Location: 1400 Emeline Avenue, Room 207, Santa Cruz, CA

**Regular Business**

**Meeting Began:** Joan McVay called the meeting to order at 3:05 p.m.

**Roll Call:**

**Members Present:** Ann Andrews, Bill Lewis, Denise Ostlund, Ginny Gomez, Guy Grant, Joan McVay, and Supervisor Neal Coonerty

**Members Absent**

**Excused:** Barbara Bentley, John Laue, and Maria Corriea

**Members Absent**

**Unexcused:** Robert Ackerly

**Guests:**

Carol Williamson and George Carvolho

**Minute Review:**

A quorum was present. Joan McVay motioned to approve the March 2010 meeting minutes with additions and Ann Andrews seconded the motion. The motion passed and the minutes were approved.

**Introductions, Announcements, and Public Comment**

- No announcements or public comments

**Standing Reports**

- Board of Supervisors, Supervisor Coonerty:
  - o The Serial Inebriate Program (SIP) will come up in the June Budget hearings and be put in place by July 1<sup>st</sup>. Individuals identified as serial inebriates who have been put in jail to sober up then released 5 or more times within a 6-month period will be targeted for this program. Some of them will present with dual diagnosis and/or medical problems. The Judge will offer first offenders the choice of 30 days in jail or treatment. If the individual takes the treatment and violates the terms or is drunk in public, they are returned to jail and the term is increased to 90 days (used as a means to encourage treatment). Treatment will be given at Janus residential care, Si Sé Puede, or another Drug & Alcohol program. When the individual is doing well in residence, he/she can be transferred to an outpatient treatment facility. Our partners in this program will be the City of Santa Cruz, County of Santa Cruz, Dominican Hospital, Sutter Hospital, and Central Coast Alliance for Health (partnering will help us buy more service capacity).
- Mental Health Director Report, Rama Khalsa, Director of Health Services Agency:
  - o Psychiatric Health Facility - We are looking at property near Dominican Hospital and environmental issues (we cannot approach the Board with potential sites until 2 levels of environmental review have

been completed). We started out looking at 47 pieces of property and are down to 4/5 of the best options. Another area of interest is focusing on other funding opportunities.

## **Presentation**

- EQRO/Medi-Cal audit review - Karolin Schwartz:
  - Each year the External Quality Review Organization performs a review looking at quality and strengths of County Mental Health Plans (MHP). The focus is how services are delivered and who is/has been served using penetration/retention rates, and performance improvement projects, including focus groups with clients and family members to solicit their input. Each year a particular consumer population is interviewed (for example, those who came in for crisis services or those that have been seen repeatedly in the last 2 years). This information will demonstrate what we are doing to improve delivery of services and what improvements may be needed.
    - Our strengths are:
      - ⤴ Communication between staff and leadership
      - ⤴ We are engaged with stakeholders and other partners regarding budget and planning
      - ⤴ Our Info Systems staff perform and share data analysis with county/contract providers
      - ⤴ We have reduced hospital stays
      - ⤴ Consumers feel safe/supported within the system
      - ⤴ Services are changing to assist consumers with recovery
      - ⤴ Contract providers feel the system is communicating and planning better
    - Areas of improvement are:
      - ⤴ Analyze high cost beneficiaries who use disproportionate share of Medi-Cal revenue
      - ⤴ Increase consumer participation (employee consumers/family members)
      - ⤴ Improve IT systems
      - ⤴ Improve penetration of female Latinos
      - ⤴ Continue improving coordination/collaboration with Primary Care
  - Every 3 years the DMH performs the “Medi-Cal Oversight On-Site Review” verifying mental health providers’ adherence to various state and federal regulations as well as requirements in the contract with the DMH. This covers many areas such as access to services, medical records, and interface with primary care, quality improvement, and MHSA implementation. Santa Cruz Mental Health was found to be in compliance with the following recommendations:
    - ⤴ Provide specific percentage improvement for increasing penetration rate for Latinos
    - ⤴ Insure all providers obtain results for the consumer satisfaction surveys
    - ⤴ Re-start periodic testing of the 800 line to insure appropriate responses
    - ⤴ Improve documentation of services so that it is clear that the goals of treatment are measurable/observable
  - Karolin also reported that the Quality Improvement Steering Committee is looking to recruit consumers and family members as participation has declined. This is required by DMH and will enhance consumer/family input into MHP system of care policies.
    - Carol Williamson - requested description of what is needed and she will have the information added to the next NAMI newsletter.
- Adult Mental Health report – Yana Jacobs:
  - Have been working with Front St. Inc. to move in the direction of recovery with clients in Board and Care facilities to avoid institutionalizing people. The Housing team, in collaboration with Front Street Inc., held all day training for all of Front St. Inc.'s Board and Care staff. We reviewed what the individuals’ goals are as a first step; what do people need to get ready to move towards independent housing (strengths and weaknesses).
  - The Redevelopment Agency will be purchasing homes and/or duplexes to transition from the current rental units that are subsidized with RDA funds in order to have more permanent affordable housing owned by the County and available to people with disabilities on low incomes.
  - I am currently working on a \$750,000 grant to fund a “Peer Run Crisis Respite” center to provide prevention and wellness focused services for people in early stages of crisis, there are currently only 8 in the nation and none in CA. If awarded it will provide \$750,000 each year for 5 years (deadline is 4/30). Only 22 grants will be awarded. Expect notification from SAMHSA in the summer of 2010.

Depending on the size of the house, can expect to serve 6 – 8 people, with treatment anywhere from 2 – 8 days on average. Ideally, it will be staffed primarily with peers. However, in the beginning can expect to have a mixed staff.

- Carol Williamson – Congratulations and good luck. How do you see this relating to the Psychiatric Health Facility (PHF)? Answer: The PHF is an acute care facility; Peer Respite is a sub-acute facility with the focus on “early intervention” (the goal is catching the symptoms early). Individuals will be able to go in voluntarily. Will try to identify people who are frequent users of the hospital, have peers work with them on a form of "advance directives," crisis prevention plans that will be given to Respite as part of the prevention work that goes with the grant proposal, to reduce recidivism and focus on wellness and recovery.
- Bill Lewis – Who will develop the criteria for admission, and will it have to come from a doctor? Answer: No, the criteria for admission are described in general terms now and we will write up the policy and procedures using models from other successful PRC around the country for guidance.
- Guy Grant – Hiring peers; what will they be called and what is the salary? Answer: The salary will be a living wage for "trainees," those with no prior job history, and higher based on individual experience (currently \$11 per hr). Working on the job description but for now, we are calling them Peer Counselor.
- Ginny Gomez – Who will pay for health unit? (Rama responded to this question) Depends on the payer source; Medi-cal is \$1000 per day.

### **Data Training**

- To use the data provided by the CMHPC to answer questions and make recommendations for improvement. Specifically, to consider two performance indicators (Access and Retention rates) and to analyze them by gender, age, and race/ethnicity

#### 1) “Race/Ethnicity” (Denise Ostlund, Ginny Gomez, and Alicia Nájera, staff)

##### a. Retention

###### ✧ Barriers

- Less exposed to idea of getting services
- Afraid of getting hooked into system
- Stigma
- No insurance, money
- Need to work
- May not like the treatment

###### ✧ Recommendations

- Integration of services with primary health
- Education regarding types of services and range of treatment
- More options/choices of treatment
  - Peer groups
  - Other types of treatment
  - Get to really know the person

##### b. Access

###### ✧ Barriers

- Language
- Lack of information on services
- Lack of information on mental illness
- Transportation
- Work
- Hours of services
- Lack of childcare
- Lack of insurance, money
- Uncomfortable environment
- Fear of

- Getting deported
  - Getting stuck in the system
  - The treatment
  - Getting separated from kids
- ✧ Recommendations
- Public education of services and of mental health
  - Offering child care
  - Spanish speakers at different points of contact
  - Peer counselors that speak Spanish
  - Comfortable environment
  - Meeting people where they are at (customer service, no wrong, accommodating)
- 2) "Age" (Bill Lewis, Guy Grant, and Stan Einhorn - staff)
- a. Access
- What age groups have higher access?
    - 12-17, 6-11, and 45-54
  - What factors account for differences in access by age?
    - The partnerships that the County Mental Health system has with referring agencies or those who are purchasing service from the system.
    - The number of community contacts interacting with the given age group such as school, care facilities, or community based agencies that may assist clients in accessing services.
    - Different set of expectations from the general community regarding the needs of specific aged clients. Such as the community as a whole may be more interested in mental health issues that relate to child abuse, as compared to general homelessness.
  - What barriers exist?
    - Lack of awareness of the need for services specific to any particular age group.
    - Lack of awareness of existing services that target the needs of specific age groups.
    - Degree of willingness to access service.
    - Limits on what services are funded.
    - Older adults may not want to ask for help or assistance due to fear of loss of independence.
  - What is the County doing to increase access by age group?
    - 0-6: Increased First 5 and PEI services.
    - 7-11: Maintain current services and focus on early intervention and prevention.
    - 12-17: Maintain current levels and encourage early intervention and treatment.
    - 18-24: Continue outreach and engagement to TAY and client advocacy.
    - 25-44 and 45-54: Maintain or improve ease of choice of services and access to services.
    - 55-64: Increased Outreach for services.
    - 65 +: PEI is funding an occupational therapist to assist in evaluating the needs of older adults.
  - What recommendations do we have for increasing access for the identified age groups?
    - Work to increase partnerships with other existing community resources.
    - Increase education and awareness of services for age groups most impacted by access issues.
    - Assist most impacted groups (0-5 and 65+) in successfully engaging existing services as funding allows.
- b. Retention - The Data Workbook for Santa Cruz County did not provide any data on the retention rates by age. The workgroup was unable to answer the following questions without data:
- What groups have higher retention in mental health services?

- What factors account for the difference in retention by age?
- What barriers exist to increasing the retention for the identified underserved age groups?
- What is being done to increase retention by age group?
- What recommendation do you have to increase retention for the identified underserved age groups?

3) "Gender" (Joan McVay and Karolin Schwartz - staff)

Note: The data presented to the committees was from the previous census so we brought to our committee meeting data from Jan. 27, '09 – April 2009 (EQRO). We answered our questions from the data workbook questions and formulated our goals for improvement based upon the '09 data from our area as well as data from the workbook.

PENETRATION / ACCESS

Number of people served in comparison to the number of people who are estimated to need services.

Context related to Data

*Question responses and context for recommendations*

1. *Males or Females higher access?*

Males have a higher penetration rate – Statewide it is the case also.

County – '09 data: Penetration rate for females overall = 6%; males 9.27% Statewide – females 5.6%; males 6.9%. Based on '09 data, the state penetration rate slightly more.

2. *Factors that account for difference?*

From '01-'02 to '08-'09, not a lot of change in data. Starting from age 0 – 5 years of age, more males than females across age spectrum until age 60+. At 60+, almost 100 more females than males. Between ages 16 & 17, 146 females to 252 males.

Using the '08-'09 data:

\* Males brought to MH attention more often than females due to more males get involved with probation and the juvenile justice system.

\* Males more likely to act out overtly & get noticed in schools and in community, whereas, young girls have different behaviors related to MH issues, i.e. eating disorders, mood disorders, etc. Girls' behaviors are not as often as aggressive toward others and are easier to hide by families and themselves. The pathways of reporting and access / penetration are less likely to be used when law breaking and aggression are not part of the observed symptoms.

\* Penetration rate among Latino youth may be higher because they are often more involved with public funded services where data is accumulated in order to qualify for funds. (16 & 17 ages – twice the number of Latinos as whites)

\* Over 60+ women – penetration rate may be higher than for males because widowhood numbers increase & women seek support and when alone, symptoms may be more observable by others or more self-observed.

\* School intervention & juvenile justice tend to identify more males needing services – hence, greater penetration/access.

3. *Barriers existing to increasing access for the underserved gender group?*

We have already addressed some of the barriers as we have implemented not only the MHSA, but also worked on collaborations due to budget cuts, but some of the barriers that have existed over the years since the reports data collection are:

\* Our stakeholders – probation, etc. and the school ID and referral programs have driven whom we serve.... We need to serve them.

\* The numbers of education and juvenile justice interventions with males have not changed.

\* Referrals through our stakeholders for eating disorders and other non-aggressive/law breaking symptoms, which might be more common to females, have not changed and the pathways are not as defined or as clear as for males.

\* There are few access/penetration pathways for early intervention of mental health early warning signs &/or symptoms except through the schools and juvenile justice that are mandated and used without more education and PR for parents, community, private practitioners, etc.

\* Financial means for parents of females / individual widows and females with needs for MH services are not readily available outside the old/current pathways that have referred more males because of the more identified aggressive behaviors.

#### 4. *What Santa Cruz County is doing to increase access by gender?*

Because of the work on the MHSA, especially the PEI implementations and because of the collaborations and networking already created as budget holds and cuts have occurred and are planned, Santa Cruz County has already been working on increased access by gender.

\* We have created the Prevention/Early Intervention outreach team / services.

\* We have a new program "Side by Side" for children under 3.

\* We continue to work with education and awareness for parents, the public / community, and with doctors who see boys and girls with possible early MH behaviors.

Recommendations The recommendations the gender committee has for increasing access / penetration by gender is as follows:

\* Continue efforts to implement PEI plans and continue collaborations that keep moving forward the progress we have already been making.

\* Continue to follow the basic values SCCMH has been using to prioritize and help with necessary decisions related to budget cutbacks and varying future scenarios.

\* Outreach to women and girls to create awareness and knowledge regarding H symptoms and behaviors and where to access information and care.

\* Co-locating MH clinicians with primary care.

\* Educating parents regarding girls and young women's needs related to mental health.

\* Look at exit process, support services etc. regarding exiting males. Educate and train males in how to develop community support systems and personal networks and support and create healthy reconnections with family members.

\* Educate women in self-help regarding the need for and access to services.

\* Educate men as fathers and husbands and in other roles to identify behaviors in young girls and women that may need services.

\* Continue to educate and support the process of destigmatizing mental health needs in males and females of all ages. As individuals and committees and as board members we can be diligent in listening for negativity regarding mental health participants and mental health needs and services. We can continue to support and create ways to show that MH services for all saves money for our communities in the long run.

This effort at positive PR will hopefully create community awareness that allows access to services other than through the justice system or more for boys / men who act out aggressively.

#### RETENTION RATE

The CMHPC defines retention as the days of services received. Once access to services is obtained, appropriate engagement of consumers and their families is also important.

One of the values / focuses of Santa Cruz Co. Mental Health has been quality of life for those who receive services. We have worked on the sections of the MH services act with retention factors in mind since Santa Cruz has one of the highest retention rates in the State. Identifying why this is so is important for future implementation of the MHSA and budget planning during difficult fiscal times. Factors leading to high retention rates are not necessarily negative, but alternatives, collaborations, etc. can lead to alternatives affecting this rate.

#### Context related to data

*Questions related to recommendations*

1. *What gender has higher retention in mental health services?*

Males have a higher retention rate in MH services.

2. Factors that account for difference?

\* Certain diagnostic categories are more prevalent for males than for females – i.e. males are identified earlier so they receive more programs and services via the school systems and juvenile justice.

\* Males are more prevalent in group homes and services delivered show up more in the data.

\* Females MH diagnosis are not the ones that more often involve juvenile justice or group homes where services are received. They are more likely to be dealt with at home or by private physicians where public funded programs and services are not used as much and not in the data.

\* Access to alternative and supportive services within the community may be less for males than females.

\* Because of the access process for males, services may be required longer for males than females via the related legal sentences, etc. by the justice system or required programs in schools.

3. *Barriers that exist to increasing the retention in mental health services for females?*

\* Lack of education to teachers, parents, law enforcement, primary care services, and the community related to early intervention as to what the signals of MH needs are for females.

\* Female behavior / symptoms of MH diagnoses often is perceived less as a threat to the school or to the community and therefore gets less attention for services. Girls are perceived by notions that they are just “shy” or “scatterbrained” or “girly” etc. and their needs are not seen realistically because of the stereotypes from the past. These behaviors are not seen as dangers, warnings as calls for help, or as behaviors which may have serious causes related to MH / trauma.

4. *What is SC County doing to work on retention?*

\* The county / SCCMH has been working on retention issues related to longer retention for males and less for females during the planning and implementation of the MHSA and as we have worked on better collaborations with stake holders, providers in the community, etc.

\* As we have worked on PEI, we have focused on being aware of new and continuing ways to provide the awareness and knowledge necessary to address the variables that go into the problems previously addressed.

\* The county is also working on ways of exiting males to community and other support services other than those directly from MH.

Recommendations:

\* Further analysis of age groups related to ethnicity groups to see factors that also effect gender. Need more factors that may be relevant to be able to recommend and act on to truly address data on gender.

\* In looking at '06-'07 gender data, we need to look at the patterns that relate to age: Over age 46, males and females do not differ as much as younger ages. Over time, this pattern has increased to where it is consistent that for 60 year olds +, females increase in numbers related to retention as well as access...one year females were two times as many. This data needs to be looked at more closely with other committees and MH staff to make better recommendations over time related to gender.

\* There is a big bump of males at 16 & 17 years of age, which may be related to justice programs and school discipline policies.

\* Our retention rate in foster care is very large compared to other areas. Services / retention may be more related to stake holders than MH.

\* We need to tease out the factors and identify more recommendations but we need to gather more information.

**Adjourned at 5:00 p.m.**