

Minutes for Yolo County Mental Health Board
Monday, November 26, 2007

Members Present: Chairwoman Marilyn Moyle; Vice-Chairman Robert Schelen; Millie Braunstein; Peter Brixie; Robert Canning; Martha Flammer; Helen Thomson, County Supervisor; Guille Libresco; Carolyn Reiff; Irma Rodriguez; Rev. Hank Scherer; Marilyn Schwartz; Mike Summers

Members Absent:

Members Excused: Anne Breault-Darling; Joanne Welty

Others Present: Richard DeLiberty, ADMH Interim Director; Christina Hill-Coillot, Deputy Director; Mark Bryan, Deputy Director; Joan Beesley, ADMH Program Manager (MHSA); Jon Caldwell, Psychiatrist; Tawny Yambrovich, ADMH Secretary; Don Meyer, Probation; Pat Leary, Assistant County Administrator; Cathy Sutton, Adult Forensics Supervisor; Barbara Brown, Yolo STRIDES; Diane Sommers, Director, Suicide Prevention; June Forbes, NAMI-Yolo; Walter Shwe, client; Louise Walker, psychotherapist; Dave Hosseini, YCCC; Joann Turner, NAMI-Yolo

Location: Walker Room, Bauer Building, 137 North Cottonwood Street, Woodland, CA 95695

- I. Meeting called to order by Chairwoman Marilyn Moyle at 7:05 P.M.
 - a. Introductions
- II. Approval of Agenda; Minutes.

Approval of Meeting Agenda: *Motion was made by Hank Scherer and seconded by Martha Flammer to approve agenda; carried.*

Approval of Meeting Minutes: *Motion was made by Millie Braunstein and seconded by Robert Canning to approve minutes of October 22, 2007 meeting as amended; carried.*

- III. Announcements:
 - a. Marilyn Moyle announced that NAMI-Yolo will be having a holiday party on Wednesday, December 5, from 6:30 – 9:00 P.M., at Destiny Hall, 124 Lincoln Avenue, Woodland. Please bring gift cards for mental health agencies to add to their holiday cheer: e.g. Longs, Safeway, Nugget, Target, Walmart, Walgreens, Home Depot, Starbucks, etc.
- IV. Committee Reports
 - a. Executive
 - b. Budget
 - c. Forensic–Martha Flammer: Established tours for committee members at Woodland Memorial Hospital on December 11 at 9:00 A.M. to view the crisis unit and referral process, and at the Jail Mental Health unit on December 12 at 3:30 P.M. There is new construction being done at the jail, and the LMHB and ADMH have an opportunity to provide input on the construction for providing mental health services at the jail. Ray Groom would like to provide an update at the December 17 LMHB meeting. Committee discussed the restructuring of the Adult Forensic Program. Looking

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forward to Mike Summers providing a broader presentation at the next meeting, with a motion to go before the Board of Supervisors.

- d. Program–Millie Braunstein: Spent a lot of time going over the budget, which will be covered more in the director’s report. The department is mainly over budget in the acute care area; inpatient stays are averaging about 9 days. Medical Director’s position is still vacant. Also looking at trying to shorten in patient stays; strategies for those in crisis/work with clients before crisis is fullblown. Residential care is on budget, and IMD census is slowly coming down. Spent a lot of time discussing the recovery model and harm reduction model of care. Two other areas of concern in the budget are revenue shortfalls/ direct service productivity, and the cost reports going back for 3 years. Revenue from providers is also lower than expected.
 - e. Legislative Advocacy–Martha Flammer: CA Legislative Analyst’s Office (LAO) estimates a \$10 billion shortfall, some of which will come this fiscal year, which may have an impact on services that our clients access (health, housing, social and other).
- V. CIT Training Update–Mike Summers: Moved to December 17 meeting.
- VI. Report: Board of Supervisors–Helen Thomson
- a. 3 articles for members: one from the Contra Costa Times on the mentally ill in jail; one from the New York Times on the high cost of healthcare; fiscal outlook from the LAO’s projections. The coming fiscal crisis in California stems from too many expenses with not enough revenue; we shouldn’t look to the state for assistance. Irma R: Is there any way to extend payment arrangement with the state? Otherwise, counties are going to be giving mental health care back to the state.

Helen T: All counties are struggling with the audits; they are looking to the state legislature to provide some oversight of the state Department of Mental Health’s audit procedures.

- VII. Report: LMHB Chairperson–Marilyn Moyle
- a. Training by Elaine Lin from Perry Communications Group: helped develop a general goal, under which the specific goal of establishing a mental health court would fit. The general goal is: “To collaborate in systems change to sustain programs that will manage costs and provide a higher quality of life for those affected by mental illness.” All of the LMHB’s goals, strategies and specific tasks should fit under that general goal.
 - Elaine helped identify strategies, and helped us look beyond obvious collaborators, which are ADMH, Corrections, Judicial, elected officials, to new housing providers, community-based providers, business and developers, other non-profits, the university, tomato and rice growers, the casinos and tribal community, and consider media as an ally in getting the word out about what we are trying to do.
 - Under the category of systems change: expand availability of services; speedier access to effective care; restructuring response to crisis intervention; developing alternatives to hospitalization.
 - The department and LMHB are already working towards some of these goals. Have to emphasize that improving programs will help us balance budget; use accurate cost/benefit estimates; understand various funding sources; remove barriers to funding; leverage funds; identify new partners that might help us; and pursue new

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grants. Find people in the county or in the community who can help us do that. We need to educate people and advertise that this will impact *everyone's* quality of life in the county; the more people that we keep out of the jails, and integrate into the community in a positive way, the better off everyone's going to be.

We outlined some tactics and activities: engaging the public for advocacy, convincing people to take action, exploring CIT—which Mike Summers is doing—and exploring the reality of a mental health court. We have set up a meeting with Don Meyer, Chief of Probation, to go forward.

VIII. Report: ADMH Interim Director—Richard DeLiberty

- a. IMD census is as low as it has been this calendar year; we are slowly making progress.
- b. Mike Tucker has elected to move to a middle management position; we will be recruiting for a new Deputy for Finance and Administration.
- c. We are reopening the search for Medical Director; neither of the two candidates we had worked out.
- d. We are looking at contracting with a locum tenens to help us out for a month or two to get us caught up on medical assessments.

Marilyn S.: How long does it typically take for a client to get a first appt.?

Richard D.: Currently approx. 6 weeks to get seen for an initial visit.

Marilyn S: How do they manage meds while they are waiting?

Dr. Caldwell: We ask them to obtain them from their previous provider while they are waiting; if that doesn't work, we try to get them in for a brief visit to establish a relationship to bridge them to their assessment appointment.

- e. We are finalizing a contract with the California Institute for Mental Health (CIMH) to work on Prevention and Early Intervention with us through the Mental Health Services Act (MHSA).
- f. External Quality Review Organization (EQRO) audit was optimistic; waiting on final report. During the review they look at how we use data, how we use performance improvement projects and other quality assurance activities. They held focus groups with staff, clients, and consumers.

Martha F: Is CMHDA taking the lead on the county issues with audits, to simplify the process, or provide guidance for directors?

Richard: It's a frequent topic of conversation at the directors' meeting. However, our data has improved, and the external organization has smoothed out the process somewhat.

- g. There are two Board of Supervisors meetings this month; after the second one all of our contracts should be approved.
- h. I have included an additional census report that was requested: children in residential care. Locked census has decreased since July 1; acute census has decreased slightly as well. Residential treatment has not really decreased; we are using Pinetree Gardens and Farmhouse to a greater extent; we are still stepping people down from IMDs to residential treatment.

IX. Yolo STRIDES ACT Team

- a. Barbara Brown: Passionate about what they do, and the philosophy behind their services. When she started out in mental health, they used the clinic model: those who were diagnosed with severe and persistent serious mental illness were placed in

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board-and-cares, hospitals, and IMDs; seen by mental health once a month for 15 minutes to make sure they were stable. In 1993, the social rehabilitation model was introduced: clients shouldn't have to settle for stabilization; they should have other things going on in their lives. Based on the recovery model and harm reduction. Prior to the recovery model, people who had a diagnosis of mental illness AND addiction fell through the cracks. Mental health said, "Take care of your addiction before we can do anything about your mental health," and the substance abuse community said, "You have to address your mental health issues before we can focus on your addiction." Harm reduction allows us to work with those who have both substance abuse and mental health issues. We accept people as is, and work with them where they are right now. We recognize the cyclical nature of substance abuse, and try to use appropriate interventions for the stage the client is in. If s/he is not ready to acknowledge there is a problem, we start with education.

Recovery means that just because you have a mental illness diagnosis doesn't mean you can't have a meaningful live. You have the right to choice, to dignity, to risk, to failure. The idea is to let people take risks, and have support around them if they fail. Clients get to know everybody on a team, so they aren't receiving interventions from a stranger when they are in crisis.

We don't set goals; we ask them "What are your hopes and dreams?" We ask them what they think, and what they want. If they are making poor choices, we discuss and explore that with them.

b. Q and A

Marilyn M: How do you keep loved ones safe?

Barbara B: We don't treat individuals as isolated persons; if possible, we build relationships w/family members and loved ones as well. Families can call us; hopefully they learn to trust that we are also interested in the safety of that individual. We are not going to let people take risks that are dangerous for them; there are the really good choices; there are the questionable choices that we can work with people around because it doesn't involve safety; and there are non-negotiable choices, because they are not safe.

Irma R: How many of your clients are on conservatorship? How do you work with the Public Guardian's office?

Barbara B.: We're working on establishing that relationship; there are some differences in philosophies regarding safety. Most of our clients are under conservatorship because most of the folks are coming out of IMD's

June F.: How are you going to keep a manic client from streetwalking in this age of AIDS?

Barbara B.: Building a close, non-judgmental relationship to help clients work on their harmful behaviors; these relationships make it possible for us to work on dangerous behaviors with them, because they know it's safe to talk to us about it.

Helen T: Could you walk us through a 24-hour day in bringing Mary Jane home?

Barbara B.: Every morning the team meets at 8:00 A.M., and we discuss every client, whether there have been any crises the night before, and then we go down the list review where each client is at, and what his/her needs are. It may be a doctor's appt coming up, it might be needing to go grocery shopping, it might be that we notice there has been no contact for 2-3 days, so then we plan to check in.

Helen T.: Right out of an IMD, how many hours per day do you spend with someone?

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How does someone come out of a locked environment into that kind of atmosphere?
Barbara B.: Most folks are living with roommates; some in board and care facilities, some in room and board situations. Some are with their families, and one in her own apartment. Some clients who hear voices do better in situations where there is less stimulation.

Millie B.: If someone is coming out of an IMD, how are initial contacts made? How do you get to know this person, and determine how often they need to be seen?

Barbara B.: We make that decision on a daily basis. People are referred to us; we do outreach travel to where they are, visit them at the IMD, take them on day passes to see how they do in the community. We establish and develop that relationship before lowering the level of care.

Irma R.: Are you following the ACT model with fidelity in terms of components that you need to make sure it's a well-rounded program, from activities of daily living (ADLs) to integration, etc.? Can you talk about your team composition?

Barbara B.: We have 2 psychiatrists, who work 8 hours each. We have an RN who handles not only psychiatric medications, but also ensures that clients have everything they need in regards to their physical health; makes sure that we coordinate with primary care physicians. We have a number of LCSWs; a license-eligible team leader. We have 4 personal service coordinators, all very dedicated and experienced. We have a consumer position that has recently come open again.

Carolyn R.: What do you do with clients who aren't cooperative?

Barbara B.: We work with them where they're at. We talk about the dissonance between what they say they want, and the way they behave. We try to create some behavioral incentives to alleviate problems.

X. AIM ACT Team

- a. Forensic ACT Team – Cathy Sutton, new clinical supervisor for FACT team. Adult forensic programs serves people involved in the judicial system who have mental health issues. Project AIM (Alternatives to Incarceration for the Mentally Ill); MIOCR (Mentally Ill Offenders Crime Reduction); ConRep (Conditional Release – court ordered) and Proposition 36 (court-ordered substance abuse clients); will also take Medi-Cal and other referrals.

We have a great team, 3 LCSWs, Dr. Jon Caldwell, George Pence, who is an expert in the area of recovery, probation officers, etc. We don't yet have a behavioral health court, but we do have team-based services.

- b. Q and A

Irma R.: Please tell us about the funding.

Cathy S.: AIM and MIOCR are both grant funded; ConRep and Proposition 36 are court-ordered, so they're under different funding streams, and Medi-Cal and ADMH people we're trying to get those who are eligible for services enrolled so that when the grants run out we will still be able to provide services.

Mark B: Drug Medi-Cal is contracted out, meaning no longer contract directly with the state. CommuniCare is our primary provider for drug Medi-Cal for intensive outpatient and perinatal services. We also use Progress House for inpatient services.

Cathy S.: Prop 36 is identifying those with substance abuse issues who will benefit from mental health services, and referring them to the appropriate care.

June F: How many are in these programs?

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Mark B.: AIM has 31 individuals; MIOCR is just starting to take referrals; ConRep has a consistent caseload of 8, with 18-25 who are in the state hospital that are followed up on, because they will be eligible for services at some point in the future; Prop 36 has about 1,000 who are served through various stages of probation. We are trying to broaden services to help serve those who might not fit nicely into one of the niche services.

Cathy S.: We are providing cross training in the unit, shadowing other clinicians, learning to do ASIs (screenings for substance abuse). For AIM and MIOCR, we go out into the community, and provide whatever services are needed.

Marilyn M.: Are clients in Adult Forensics in the same sorts of housing as the ACT team?

Cathy S.: They are in all different kinds of living situations: room and boards, motels, with family. Affordable housing is hard to find.

Martha F.: Is there affordable housing?

Cathy S.: Some transition from Walters House; some new subsidized housing is being built, and we are trying to get people on waiting lists.

Irma R.: You're sharing staff, but programs have categorical funding streams?

Cathy S.: We are sharing work by FTEs, but not necessarily by one single staff member.

Helen T.: When the jail medical contract was renegotiated, the Board added a discharge planner to the jail...are you working closely with this person?

Mark B.: We have continued the process of the jail case management meetings to see that those who have mental health and substance abuse issues can access appropriate services when they are released. Assessments are done at the jail.

Hank S.: Doesn't the jail know who is coming due for release (i.e. priorities)? Don't they communicate that with ADMH?

Mark B.: Typically it's the level of offense, but oftentimes they are released unexpectedly due to a court order. The jail is good about contacting ADMH, and the relationships are there with the custody lieutenants and the psychiatric nurse and psychologist to take care of people who are unexpectedly released.

Bob S.: What happens with psychotic clients, or one who has a psychotic episode?

Cathy S.: First, we will make sure that person is safe and has the support that they need, and make sure that they are not put in a situation where harm will befall them or somebody else. What we try to do is help people transition safely. Our goal is for people to be able to live in the community safely, and make their own choices; live in the setting they want. If they are going to be in danger, we will address that first. We will help with housing, supported employment, etc. We provide client-centered services; whatever the particular person needs.

XI. Full Service Partnerships

- a. Joan Beesley – We have four programs, all have some aspect of a “blended program;” we have the full service partnership (FSP) component combined with general system development services, as well as outreach and engagement services. When these three program aspects are all together in one program it's called a blended program. The Yolo STRIDES ACT team is funded under the MHSA Adult Wellness Program, and serves *only* FSP clients. The Wellness Center and the rest of the adult programs to serve a blended program. Intensive services have been slow to start, partially due to staffing issues. We are very fortunate that the mental health specialists we hired last

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year are all still with us. Another challenge of the program is that it is entirely voluntary, so we have no leverage to say “You have to come to this program and participate,” but we still want to do whatever it takes to allow clients to live how they want to in the community.

Housing is a serious issue for us; we have a contract with Turning Point Community Programs to provide housing to our FSP clients, as well as our AB2034 clients. Only FSP clients receive intensive housing supports, including rent subsidies. Every client who qualifies for SSI in Yolo County has difficulty paying the rent. In FSP we usually try to home 2 clients/unit, unless circumstances make a solo placement necessary. Staff works very hard, and makes frequent contact with clients. They have daily meetings to update on most recent contacts. We have a range of services; not a full ACT model. We are hiring a new group of consumer/family member interns. Senior peer counselors are going very well; we have a group of articulate, friendly, good human beings, who are spending 5-10 hours a week doing senior peer counseling.

b. Q and A

Millie B.: For FSP clients: what is the difference between MHSA programs serving them, and ACT serving them?

Joan B.: Blended programs serve a variety of clients; center activities are generally open to all clients. Intensive housing and supportive services are only available to FSP clients. Those who are coming out of IMDs usually have established benefits; MHSA often sees clients who have not been able to access benefits either because of their poverty, or lack of insurance, etc. We help them access services and benefits in a relaxed atmosphere, since MHSA programs are voluntary.

Can you tell us the location of the centers?

Joan B.: Adult Wellness Center is located at 825 East Street, Suites 301 and 302; the Transition Age Youth (TAY) center is located at 825 East Street, Suites 122-124. They are open M-F from 10 A.M. – 5 P.M. It’s bus accessible; we can provide rides when requested, although we try to encourage self-sufficiency, providing bus passes, etc. We try to work with the strengths of the staff.

Marilyn M.: Is the reason there is no one enrolled in the Capay Valley Children’s Pilot Program that there is no need, or that you don’t have the staff?

Joan B.: Staffing has been a problem, but we are fully staffed now, but the Esparto School District has been very insulated for the last couple of years, and have just started to open up and access the MHSA services. We are beginning to do well, and see children in the schools. We have a number of system development clients, but no full system partnerships yet. We now have a full-time bilingual, bicultural clinician in place, and we hope that will make a difference.

Helen T.: The SB2034 homeless programs and adult wellness program will be fully merged by the end of the year. Is that because of the financing and that the one-year funding is gone?

Joan B.: Yes. We have some rollover funds, and the state is providing some one time funding for unserved clients, without designating them as 2034 funds. By that time, we hope to have absorbed the clients into the wellness program.

Jo Ann T.: What about vans? Plans said 7 were to be purchased? Clients need transportation assistance.

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Joan B.: Plans were for 2 vans, state allowed purchase of one van and several cars, and said we could apply for funding for the remaining cars when programs were fully implemented.

Louise W.: Resource centers in Woodland, West Sacramento and Davis were cut, replaced by a single wellness center in Woodland.

Joan B.: The wellness center was not intended to take the place of the regional resource centers.

Richard D.: The regional resource centers were cut because they were not meeting the goals for which they were originally intended, and they were cost prohibitive.

Marilyn S.: If a person was placed in housing, and then started receiving benefits...are they going to lose their spot now that they are benefitted?

Joan B.: No, we would not drop someone for being benefitted.

Irma R.: Are Medi-Cal beneficiaries billed?

Joan B.: They see the benefits specialist before they come to MHSA.

Hank S.: Are we interfacing with the VA and other benefits?

Joan B.: Our benefits specialist would assist in facilitating access to their VA benefits, and work to merge their SSI and veteran's benefits. We help people access what they are eligible for.

XII. Public Comment

- a. Irma R.: Would like to see a budget with allocations and expenditures year-to-date in a simpler format; Richard states is not possible at this time.
 - b. June F.: Requests an addition to the Director's report that shows the average initial wait to be seen; Richard indicates that we can't currently pull this information, but will provide it when it's available.
- XIII. Adjournment – 9:10 P.M.