Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

QUALITY OF CARE Committee Meeting

July 20, 2017 ♦ 3:15 pm-5pm

2425 Bisso Lane, in Concord

Second floor conference room

AGENDA

I. Call to order/Introductions

II. Public comments

III. Commissioner's comments

IV. Chair announcements

V. APPROVE minutes from April 20, 2017 meeting

VI. DISCUSS consumer advocacy and grievance resolution programs and identify and possible gaps within the current County resources and summarize for further consideration

VII. DISCUSS the expansion of the West County Jail facility and identify potential considerations in the planning process of the new treatment center.

VIII. RECEIVE and DISCUSS the financial analysis to evaluate the feasibility of a children's inpatient treatment facility within the County, with Pat Godley, Chief Operating Officer and Chief Financial Officer

IX. DISCUSS the opportunity in discovering key factors, to be considered, in a feasibility analysis for an inpatient children's treatment facility for Contra Costa County.

X. Adjourn

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item may occur. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute time limit.
If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140

Mental Health Commission
Quality of Care Committee Minutes
May 18, 2017, First draft

Agenda Item / Discussion	Action / Follow-up
I. Call to Order / Introductions The meeting was called to order by Committee Chair Barbara Serwin @ 3:49 p.m. - (Arrived late because thought meetings had been switched to Bisso Lane. Starting in June, all committee meetings will be at 2425 Bisso in Concord. Chair apologized to attendees for late arrival). **Members Present**: Chair- Barbara Serwin, District II **Members Absent**: Gina Swirsding **Others Present**: Margaret Netherby, NAMI representative Vern Wallace- Children/Teen/TAY Program Chief Steve Wilbur, Quality Improvement Coordinator Dr. Ann Isbell-Health Services Planner/Evaluator Christina Boothman- MPH Health Services Planner/Evaluator Liza A. Molina-Huntley, Executive Assistant for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II. Public Comment • None	
III. Commissioner Comments • None	
IV. Chair announcements/comments: • None	
V. APPROVE Minutes from April 20, 2017 meeting • **MOTION VOTE: 2-0-0** • **Connie moved to motion to approve the minutes, without corrections, and Barbara seconded the motion** • **YAYS: 2 NAYS: 0 ABSTAIN: 0** **Present: Barbara, Connie** **Absent: Gina Swirsding**	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**
VI. DISCUSS grievance protocol for patients- Steven Wilbur, QI Coordinator • **Steve-** I am the Quality Improvement Coordinator for the County. The grievance procedure is beneficiary protection, as listed in the Medi-Cal beneficiary guide, your beneficiary protection and their rights. Basically a grievance is an expression of unhappiness by a beneficiary about any of their services. It covers a wide range of topics from billing, change in provider, clinic services, confidentiality, medication services, money management, quality of care, residential, staff behavior and other. So it can be any kind, that their unhappy with. There's a blue form, which is available on line and in every clinic lobby or by request. The beneficiary fills out the form, or they can make a grievance early by calling me directly and they can also work with Barbara Banks, who presented last month, at this committee, who is the grievance advocate. She can help fill out the form and make sure the consumer understands their rights. Once I receive the form, then the 60 day time frame initiates, to respond	•

Agenda Item / Discussion	Action / Follow-up
with a resolution to the person's grievance. I usually work with whoever the grievance is concerning, with their supervisor or manager, to jointly respond with a resolution that would be satisfactory to the beneficiary. That is a summary of the grievance process. If we fail to resolve the grievance within the 60 days and need an extension of time then we would issue a notice of action "D", which would give us an additional 14 days to come up with a resolution. • **Connie-** Does anything ever go to the Director of Department of Mental Health? • **Vern-** To the Department of Mental Health Care Services? • **Steve-** It use to be if you were unsatisfied with the way the grievance was resolved, then you could go to a "State Fair Hearing," now you can only to a hearing with a grievance if we fail to resolve within our timeline of 60 days or the extension. The grievances are a closed in process. • **Barbara- "**What is a State Fair Hearing?" • **Steve-** If you have an appeal or an expedite appeal, after any action that the Mental Health Plan takes, whether they stopped your service or deem you that you don't meet medical necessity, you can appeal that decision at the local level, the county level. If after that appeal, you're not satisfied with the appeal results, then you can request a "State Fair Hearing," but you have to exhaust all your local appeal prior to going to the State level. • **Barbara-** How many grievances do you get per year, on average? • **Steve-** In the last three years we had 85, the amount does vary per year, it was a total of 85 for the last three years. • **Barbara-** How are they distributed across the topics? • **Steve-** I did not bring the data with me but it does vary. The form will be part of the welcoming packet; we will have them in each packet. I expect that we will receive more grievances and more people will be made aware of the grievance process earlier on, with their services. • **Barbara-**Is there a "hold back" for potential beneficiaries to take the grievance process, is that an issue that you have to deal with? For some people it's hard for them to even get to that point, they can feel intimidated or don't think that they're problem is going to be solved? • **Steve-** There are some grievances that there is not identifying information, anonymous, so we can look at the issue but we cannot communicate back if there were any changes on a smaller level. It stays clear that your service would not be adversely affected, in any way, by filling out a grievance. They are confidential and they don't go in the chart. Only the people that are directly affected by the grievance are made aware. A manager can choose not to identify the beneficiary making the grievance. It should only state that a grievance was made against the services that were provided. If they do identify the beneficiary, it's easier to make a resolution that's satisfactory where they can communicate together and help problem solve, a better working relationship, instead of just an anonymous grievance. • **Barbara-** Can caregivers or loved ones file a grievance for the consumer or patient? • **Steve-** Only if they are designated by the beneficiary. The beneficiary has to say who the representative for the grievance process and signs a	

Agenda Item / Discussion	Action / Follow-up
consent form. You cannot file a grievance on behalf of someone else, without their knowledge or without their explicit expressed consent to do that. • **Barbara-** How do you consent? • **Steve-** By signing consent form and we would talk to the beneficiary to make sure that they agree. There are times when we have had people filling out the grievance form, as a family member, but they don't have the authorization to do so from the beneficiary. The beneficiary has to be informed and in agreement to file the grievance. We also have a "yellow suggestion form." Anyone can fill out a suggestion form, it wouldn't be a grievance, it wouldn't be logged as such but if a family member has something that they want to express, whether it's a complaint at their level, they have that option. Again, if the beneficiary hasn't given a family member, the right to express and file a grievance on their behalf, the feedback wouldn't go back to the person or beneficiary. • **Barbara-** So where are the yellow forms located or obtained? • **Steve-** in all the lobbies of the clinics and hospital, next to the grievance form, they are part of the "informing materials" which are statewide. • **Barbara-** How well do you think the grievance process works for the consumer? Do you feel like there are any issues that you would like to see resolved in the process? Do you want to file a grievance with the grievance process? • **Steve –** With grievances there's such a wide range of what they are regarding. Sometimes it's more beneficiary and consumer information. Money managed clients, they are upset and sometimes they feel like the money manager is not giving them enough money, but there is no money left to give, they are actually held to a budget that is allotted to them. Some of it is about reeducating a consumer what their budge is and what their rights are and most of the time the money manager is acting accordingly and clinically sound practice. There is a wide range. We do not get too many staff behavior or something really amiss and that needs to be rectified. • **Barbara-** Which are the most difficult to resolve? • **Steve-** Again, they really vary with all the different topics. Where there are not a lot of specifics, it is a very generalized grievance, then it's a more general resolution. Sometimes they will express that they want a certain staff member fired and based on just a grievance, it's not going to happen. If there is not a change in provider to provide a change, then they have to continue on, even though a grievance has been filed. Some consumers use the grievance process quite frequently; the same person is filling out multiple grievances, within the same month or year, regarding multiple issues. The forms are readily available and it's each person's right to file as many grievances that they like, but sometimes, there is nothing to be done when there's a large quantity of grievances from the same person. • **Barbara-** Did you say that the 60 days is state mandated? How do you feel about that? Is hard to meet that requirement? • **Steve-** For the most part it's ample time. Most of the grievances are resolved as soon as possible, but sometimes we do need the 60 days to collect all the information or to have program managers to have time to make a change or really examine what's going on.	

Agenda Item / Discussion	Action / Follow-up
• **Connie-** Do you do presentations to staff or to consumer groups, either at the clinics or at RI (Recovery International) do you go out and talk about the grievance process? • **Steve-** We talk about it at the Quality Management meeting and discuss the summary of the grievances per quarter. We really don't go out the clinics. That would be more for Ziba, who is in charge of provider relations and that the informing materials are in place at all the clinics and all the CBO's, the beneficiary guides are then and it's included in the welcome packet, so it's readily available from the beginning. • **Connie-** Do you get many complaints about, or threats of retaliation actually occurred after a grievance was filed? • **Steve**- none that I'm aware of, no. All of you have a copy of the policy and the form in your meeting packet.	
VII. DISCUSS hospitalization for Children/Teens/TAY-Vern Wallace, Children/Teen/TAY Program Chief • **Barbara-** We have discussed some of this at different times and we've talked about it – teens and TAY (Transitional Aged Youth from 16 to 25 years old). Liza, the Oak Grove project, that's TAY correct? • **Liza-** Yes, it is a residential project for the TAY population. • **Barbara-** I am confused on that project. • **Vern-** Ann is here and she wrote the RFI but I will explain that it is conceptualized as a TAY, transitional program, not transitional housing, although they will be residential there. It's transition into adulthood. There's residence for them, therapy, workability training, social skills training, activities of daily living training, it's targeted for 18 to 25 years old. Because you cannot house kids that are under than 18 years old, with anyone over 18 years old. It is a facility that we have used, it could house as many as 26? We ran it for years as a children's crisis residential and then as a community treatment facility, we have never been able to get more than 20 in the facility. There would be an opportunity to do post discharge groups and groups for TAY in the community that maybe coming to the center to participate in socialization groups or anger management groups or anything like that, because there is a classroom complex, up front at the facility, that we paid for with money from a federal grant 20 years ago. That is the concept behind the program and bids closed on Monday, May 15, and we had two bidders and we will be moving forward with the looking at those two bidders. • **Barbara-** Where did the kids come from, into that program? • **Vern-** From several places- Child and Family Services each year has about 250 kids that are in AB12 status. Approximately 10% to 15% of them need mental health services and some of them need residence because of their mental illness. The children's clinics see about 2500, the total children's system of care provides services to about 7500 kids (under 18 years old) a year. The regional clinics, the core programing, they see around 3300 kids, of that 7500. Of the 3300 about 5%, around 165 kids per year really need to transition to more services, at least need services until 21 years old. But at least half of them (80 to 90 kids), will have to transition on to the adult system of care, because they are seriously mentally ill and will continue receiving services in the adult system of care. The referrals will come from each of the regional TAY programs in the adult clinics and from my regional programing,	• **Vern will update committee regarding any changes in Children's/TAY programing**

Agenda Item / Discussion	Action / Follow-up
probation and social services that are under 18. For the most part these will be kids from social services and mental health. I would expect that there would be some that frequent PES. It will require a lot of team work between my transition team and the PES liaison and the regional managers. It's a really important program and we need to spend more time and attention on the TAY system of care and really develop it. Because they are those transition years where kids either end up in the adult system, long term, or get a job. When you ask that population what they want, they want a job and a girlfriend; those are things we don't provide. We have to get the stable enough and functioning well enough that they can get a job and a girlfriend. • **Liza-** that is the invitation that was sent out to you and Duane • **Barbara-** I will do it, I want to do that. I will have to rearrange my kid's schedule. What happens to the kids that are not going into your program? • **Vern-** We had a very strict rule that youngsters had to leave the children's system of care at 18. With AB36/32 we could actually go to 21 years old using the special education allowable portion of it. Those who qualified would continue and receive individual/group therapy and medication management. Approximately 100 kids per year receive these types of benefits and then transition them into the adult system of care. Previously the adult system of care was receiving only three types of diagnosis: bipolar, psychotic or major depression with psychotic features. The other 20 diagnosis where not utilized, therefore it was difficult for 18 year olds to enter into the adult system of care. That is no longer true and has changed with the new Adult Program Chief, Dr. Jan Cobaleda-Kegler. She previously worked, with me, as a Program Manager in Children's; therefore, her thoughts are similar, regarding the TAY population and how best to handle treatment services. We meet regularly and discuss which kids are ready to cross over to the adult system. We are making significant improvement in transitioning kids that are not ready for adulthood, until they are ready. There are TAY teams in each of the adult regional clinics that try to connect TAY youth into the adult system of care or into some other resource that provides support. The TAY team is a trained group of mental health professionals. In the Children's system, a lot more is available regarding funding and programs, except for inpatient crisis residential beds. They adult system is limited: no family therapy and limited individual therapy, because of the number of need versus available resources. • **Barbara**- the Oak Grove project will be a TAY population residential treatment facility? • **Vern**- Correct, the concept was from the Director and Deputy Director of Behavioral Health. The TAY population is more reluctant to therapy, than adults and children. The proposal has requested a budget, so we will wait until the panel evaluates and then continue the process. Residential facilities are extremely structured with a lot of intervention-group, individual and family therapy. We are required to serve children's, TAY and the county's population mental health needs. As a county, we are responsible for the population we serve. Kids that require a large amount of services, lose their benefits from the insurer when they become adults. It's better now that parody is here. We do have many children that we are able to treat and remove from the adult system of care. We do have good clinicians that do good work and the kids do get	

Agenda Item / Discussion	Action / Follow-up
better. With all the services we have, with one of the leading systems of care counties in the state, we still have a population with more needs than we have resources. • **Margaret**- All kids that suffer a lot of trauma do need the extra support to be able to deal with adult hood, be productive, so they can feel good about themselves. It is worth the effort and investment. • **Connie**- I know of consumers that didn't get the services that they needed when they were children and I know that would have helped them now. People need the support to help manage everyday life. The traumas that people had in their childhood seem to be the thing that haunts adults the most, because they didn't get the help when they were younger. What can we do to make that happen? Can we partner with other programs or organizations? Is it too late to get the help for our aging generation that did not get the help they needed when they were young? • **Vern**- we do have an aging adult system of care but I do think that this is a great idea for a self-help group. I do think that there a lot of traumas that people experience, that as they get older, it may not make sense and it can be from their childhood. Traumas can become crystalized in a person's personality over time and become part of who the person is. It is difficult. One of the reasons that the budget for Children's system of care has increased regularly is because we do receive a federal grant that added to the funds and that helped us to develop the system of care that we have, along with the other nine Bay Area counties. There is a steady increase in the seriousness of the behavior of the kids that we are seeing. We have far more kids, today, with pre-schizophrenia, bipolar, major depression with suicidal tendencies then we ever have had. There is a lot more trouble kids, with a trend to increased violence and increased homelessness in children. A lot of kids are not being captured that are experiencing trauma, abuse and neglect. All the Children's Program Chief's, across the nine Bay Area Counties, are very concerned about the kids and the trends that we are experiencing in their behaviors. Thirty years ago, we had 67 kids in the State hospital in Napa. Now, the State hospital has been closed and there is no place for the children that are suffering from severe mental illness to go. There was a place in Walnut Creek that is now closed. There was a hospital at Oak Grove that is also closed, where Jon Whalen was the Medical Director. Managed Care started in the mid 80's and that eliminated many of the psychiatric hospitals because the government would no longer pay for treatment facilities. Previously, it was not unusual to have a child in the hospital for 30, 40, 60 days so they could actually get a regimen of treatment, get stabilized on medication, family therapy would occur. Now, the average hospitalization is 8 days because Managed Care will not pay for more than that. • **Liza**- What are the causes for the trend in the increased behavioral problems in children? • **Vern**- some of the contributing factors can be the disintegration of the nuclear family, personally, I do believe that part of it is today's programing on television and the video games have a roll in the trend. I think for anyone below 13 years of age, should not be watching violent programing or playing violent video games. Even some 13 year olds are not cognitively ready to be able to sort out what is real and what is not	

Agenda Item / Discussion	Action / Follow-up
and what the consequences of the actions are. It will be interesting to see the future generation results, due to cell phones, that are somewhat disconnected as adults, for children its worse. Since we have the Continuum of Care Reform, there will no longer be any long term residential treatment facilities for children. Treatment will be limited from 90 to a maximum of 180 days. The children's program is more labor intensive than the TAY programing. There is more staffing per shift, than the TAY. • **Liza**- Do we have more children that need treatment or TAY population? • **Vern**- Children are really not in need of short term residential treatment. What we really need are temporary holding places where kids can be stabilized and kept safe. We need crisis residential where kids can stay 30 days or patient units where we can keep kids a week or two. It takes a couple of days, now, just to find a hospital bed. Sometimes we happen to get lucky and find a bed for a child, which is unacceptable. • **Margaret**- What does the county do with kids that have to be removed from their home for their safety? There was a "J" ward, which was better than 4C. There are not enough beds in 4C or space. Currently, society is very stressed and unstable. If adults are having trouble, the kids are affected and feeling worse. • **Vern-** Social Service will remove the child from the home, if the environment is deemed unsafe for the child to remain at home. They are taken to a receiving center, where they can stay for 23 hours and our staff performs an assessment within the first 72 hours. After 23 hours, the children are placed in either an emergency Foster Care or a long term Foster placement. One of the reforms, under Continuum of Care, is to limit the number of Foster placements for each child. There was Adams and Summit Center, which we had to close in 2008, due to funding. In 2010 the community treatment locked facility was closed, also, due to funding. We did reduce our adult beds by more than 50%, approximately 10 years ago, so both adults and children's have been affected due to the reduction in facilities and beds. • **Margaret-** Stressed the recidivism that occurs when children are not cared for properly that continues on into adulthood. Ultimately, this puts more stress on the community and the system and it wastes resources.	
VIII. PRESENTATION regarding the Focus Groups Results-Dr. Ann Isbell and Christina Boothman for Quality Improvement • **Ann-** In October of 2016, a series of seven focus groups were done, throughout seven clinics. A form to collect consumer satisfaction information is through our State mandated -Consumer Perception Surveys. We revisited last year's group discussions, with consumers receiving adult mental health services and with parents or caregivers of the children consumers. • **Christina-** The survey is called –"The Consumer Perception or Consumer Satisfaction" survey. It is required by the state and it is offered to all consumers, twice a year, during the months of May and November. • **Ann-** It is a weeklong survey period, therefore anyone who is seen at one of the outpatient clinics or community based organizations, are asked to complete the survey. We did two focus groups in Spanish, one for adults and one for children. We did do a specific focus group for the TAY	•

Agenda Item / Discussion	Action / Follow-up
(Teens and Adult Youth 18-25 years old) population. During the focus group, we had one person assigned at each clinic to do the recruitment of participants. For adults we had a total of 27 and for children's we had 21 parents participate and they represented 24 of our youth. Each participant signed a voluntary consent form and informed that answering will not affect them from receiving services. Participants received a Safeway gift card and some transportation assistance. A series of five questions were asked, we recorded them and analyzed them. We look for congruencies and identify per clinic and at least four out of seven clinics a theme was prevalent to the questions. • **Christina-** some of the themes you will notice in the handout attached to the packet. The first question asked was: **"what is Contra Costa Mental Health currently doing to help you or your family to achieve goals and make progress?"** The vast majority stated that they were receiving the services that they needed. The need was being met by the service rendered. Most were grateful and enjoyed their individual therapy sessions. There was a great amount of positive feedback regarding peer provider support: Family Partners and CSW's (Customer Service Workers) really help out a lot of consumers and families. They do a lot for the community in helping out to navigate through the system. Also, it was stated that Contra Costa Mental Health had quality staff, overall. **The second question was: "what can Contra Costa Mental Health do to help you achieve you or your family's goals and make progress?"** Consumers did state that they would like to see more social activities and more groups. There is a need for more education on medications and a need for more dialogue regarding the side effects. People would like more education on how to advocate for themselves within the mental health system. There is a need for transportation support. Consumers would like it if Contra Costa Behavioral Health would take the lead in educating the public, and agencies, regarding mental health. Especially and specifically: educators, education administration and law enforcement. There is a greater need for more case management and therapy. The third question is about communication; we asked about how we can better communicate services and programs offered by the mental health system. "**What can we do to let the public know what is going on?"** During the focus groups, the consumers shared resources with each other. Most participants learned about services through "word of mouth". One of the primary suggestions, from the consumers in the focus groups, is for Behavioral Health Services to provide written materials regarding services, have them published and distributed throughout the county; in schools, colleges, community centers, agencies and other organizations. Consumers would also prefer for staff to provide information on other services; such as, vocational, DMV, housing assistance, utilities assistance and a person to help them navigate through the different services throughout the county. The fourth question is: **"what has our staff done to show that they are aware and sensitive to you and your child's background and are they including parents in the decision making process?"** We inquired regarding cultural and language sensitivity as well. The common theme amongst the groups was that our consumers want to be seen as individuals, not just as a case file or medical chart. The final question was: **"What have you or your family done to better connect to your family or community as a result of the**	

Agenda Item / Discussion	Action / Follow-up
mental health services that you have been receiving?" The common themes were that families in general were pretty supportive and felt that it was their support system with a lot of structure as well. Consumers did identify a need for more family and/or relationship counseling. Recommendations were listed and attached to the meeting packet and some of the actions are currently in process. Some of the actions are: producing a "Welcome" packet for consumers, providing a smoother transition into the system that is more welcoming and assuring that the information is readily available regarding the availability of services and where to go. • **Barbara- what were some of the challenges that you experienced with the focus groups?** • **Ann-** As facilitators, we did have a couple of participants that were going through a particularly difficult time and it was difficult for them to answer the questions and address their issues. Keeping them on target and recognizing what the participant was going through and staying within our roles as not clinical providers. Some clinicians had a challenging time recruiting people for the focus groups. • **Barbara-** are focus groups mandated? • **Ann-** it is a "best practices" procedural. Approximately eight participants is considered a "good" number, if you get too many then it can become one person dominating the conversation. No, it is not mandated, we decided this time to include seven of our main clinics. Teresa did bring up, before she left, if we were planning to do a focus group with our adult consumers and we will be considering it, depending on staff availability. • **Christina-** Our program is growing and there are now six Evaluators, as of last week. • **Ann-** Christina and another Evaluator are our two Spanish speaking Evaluators. • **Christina-** The focus groups with parents were a bit more challenging because we did not have childcare, so a lot of them brought their children to the group. We did hear afterwards that it was a positive experience. Our actual last question was **"do you have any additional comments? And what should we have asked that we didn't ask?"** Consumers did like the opportunity to provide feedback. We are looking at doing another set of focus groups this year. • **Ann-** if you have any questions to be considered for the next round of focus groups, inform us. • **Barbara-** Every year you have the EQRO, are you involved in the State's audit? • **Ann-** There is a quality improvement section that the State auditors look into. • **Barbara-** Is there an area that you feel that has not been dealt with? Particularly in quality of care, since that's our focus, that you haven't been able to access? • **Ann-** Sometimes someone will think of an issue and we try to figure out how we would evaluate that or how we would phrase that to ask the right questions and if the question is representative of the majority of the population. • **Christina-** there are some considerations, for our next groups, would be	

Agenda Item / Discussion	Action / Follow-up
to include the adult family members or those who support adult consumers. We also need to consider that we didn't do any with actual children that are in the system. It is always interesting to see what a child's perception of the care that their receiving and it might differ from their parent's perception. There are a lot of things to consider, regarding doing a group including minors regarding consent and confidentiality. • **Liza-** The minors would be segmented, by age groups, correct? • **Ann-** Yes, we would have to- elementary vs middle schoolers and high school. • **Christina-** Yes, we would have to consider how we would capture more of their voices. Another threshold would be to cross more language barriers. • **Margaret-** NAMI might be able to help with that because they do have someone that speaks Mandarin. • **Liza-** Farsi was a predominant language in East County when I worked at the PHC (Pittsburg Public Health Clinic) and in the Brentwood area too. • **Christina-** Vietnamese was the third language. In our staff we only have English and Spanish represented at this time. • **Liza-** Do you evaluate trends? What kind of trends would you be looking for? • **Ann-** We could in the future; this is the first focus group we've done in quite some time? During the focus groups we do want to take that opportunity to ask questions that would impact future programing, so they may not necessarily be the same set of questions. It would probably vary, regarding the kind of trends that we would identify. We would want to look at what we are doing right and what can be improved and what changes there are, if any. • **Barbara-** I like the way the questions were framed, they were framed in a positive • **Ann-** we did probe on some of the questions to obtain more dialogue. For example, on the TAY group that we did- the discussion included the request that they wanted vocational support. • **Barbara-** this was very helpful, thank you for your time and information.	
IX. DISCUSS and CREATE Action Plan for 2017	• **CHAIR MOVED ITEM to the June agenda and will email EA the goals for 2017**
X. Adjourned at 5:12 pm	

Respectfully submitted,
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration

2016 Consumer and Family Member Focus Groups Summary

Background

Consumer and family member/caregiver satisfaction is an important factor when considering the quality of our mental health services. There are two main ways that Contra Costa Behavioral Health assesses satisfaction. Twice a year for a one week period, consumers and parents/caregivers of youth consumers receiving services at an outpatient mental health clinic are given the opportunity to complete a consumer perception survey of closed-ended and open-ended questions that collects demographic information, service history, and consumer satisfaction across several domains. Another means to gather satisfaction data is through focus groups. A focus group is a facilitated group discussion that allows for in-depth input on a select number of issues. In 2016, a focus group was held at each of 7 County-operated clinics. At our 4 Adult or Older Adult clinics, the focus groups were conducted with consumer participants. At our 3 Children's clinics, focus groups were held with parents and caregivers of consumers. Two focus groups were conducted in Spanish, one each at an Adult and Children's clinic. In addition, one of the Adult clinic focus groups was held specifically for transition aged youth (TAY) consumers ages 18-25.

Methodology

Facilitator Guide Development

To develop the Facilitator Guide, the Research and Evaluation Team began by reviewing the domain findings from recent consumer perception surveys and considered current quality improvement efforts. A list of potential questions was compiled and presented to the Quality Management Committee. The questions were narrowed down and reviewed by the Children's Chief and Adult and Children's Family Services Coordinators before being vetted again by the Quality Management Committee. The Guide is comprised of the following sections:

- Welcoming Participants
- Getting Consent
- Introductions
- Questions
- Closing and Distribution of Incentives

About the Participants

Adult consumer participants (*n* = 27) ranged in age from 20 to 76 years old (*mean* = 43 years old). The majority of adult participants was female (59%) and was White (52%) or Hispanic (37%). Youth (*n* = 24) of parent/caregiver participants (*n* = 21) ranged in age from 8 to 19 years old (*mean* = 13 years old). The majority of youth was male (58%) and was White (45%) or Hispanic (25%).

Themes

Question 1: What is Contra Costa Mental Health currently doing to help you [your family] achieve your goals and make progress?

Common Themes[1]

- In General Received Needed Services
- Individual Therapy / Counseling
- Peer Provider Support
- Quality Staff

Question 2: What else can Contra Costa Mental Health do to help you achieve your [their] goals and make progress?

Common Themes

- More Social Activities / Groups
- Provide Education on Medications
- Educate on How to Advocate
- Transportation Support
- Educate Other Agencies on Mental Health
- More Case Management / Therapy

Question 3: How can we better communicate services and programs offered by the mental health system?

Common Themes

Note that at all focus groups, participants shared information on resources with each other. It was also noted that participants tended to hear about services through word of mouth.

- Provide Written Materials on Services
- Staff Provide Information on Services

[1] Common Themes are themes that emerged in at least 4 or the 7 focus groups.

Question 4: What has the Contra Costa staff done to show you that they are aware and sensitive to you and your [child's] background? Are you included in decisions?

Common Theme

- See Them as a Person, Not Just a Case

Question 5: What have [has] you [your family] done to better connect to your [their] families or community?

Common Themes

- Family Is Supportive
- Need Family / Relationship Counseling

Recommendations

The focus groups are intended to lead to improvements in the services that individuals receive. Based on the results of the focus groups, it is recommended that the following areas be addressed.

- Welcoming Environments
  - Pilot Welcoming Packet materials
  - Ensure that informational materials like brochures on diagnoses are available in waiting rooms
- Overcoming Transportation Barriers
  - Compile transportation resources
  - Assess consumer readiness to use public transit and set up necessary supports for use
- Groups
  - Communicate groups to both staff and consumers (e.g., consider distributing monthly calendar)
  - Attain consumer and caregiver feedback on what group topics they are interested in
- Staff Training
  - Mandatory orientation for all staff emphasizing division structure and trauma-informed care
  - Consider trainings on active listening techniques, non-judgmental language, rapport building, and available resources for consumers
- County and Community Education
  - Coordinate with other agencies to educate non-behavioral health staff on mental health issues
  - Attend community events to distribute materials and convey services
  - Convene a Community Communication Workgroup to plan how to raise public awareness of behavioral health and increase community involvement
- Peer Expansion
  - Consider how peers can initiate new consumers to the mental health system
  - Pair consumers / families with peer(s) so they are a part of the treatment team from the start of treatment
- Family Connection
  - Consider modes to educate families on mental health issues such as producing written materials or hosting seminars similar to EES
  - Grow Family Support Workers positions

In closing, individuals are appreciative of services received but are looking for ways to better engage in treatment.