



**Summary Report**  
**MHSOAC Community Forum – Ventura County**  
**Crowne Plaza Hotel, Ventura – November 6, 2014**

The Mental Health Services Oversight and Accountability Commission (MHSOAC) hosted a Community Forum at the Crowne Plaza Hotel in Ventura, California on November 6, 2014 from 3:00 PM – 6:30 PM.

Commissioner Ralph E. Nelson, Jr., M.D. introduced several members of the Ventura and Santa Barbara Counties Behavioral Health staffs and staff members for Senator Hannah Beth Jackson (Field Representative Stanley Tzankov) and Assembly Member Das Williams (Field Representative David Tovar). Ventura County Behavioral Health Director Meloney Roy provided welcoming remarks to the opening session of the forum. In addition to Commissioner Nelson, two other MHSOAC Commissioners were in attendance: Sheriff Bill Brown and Tina Wooton. Commissioner Wooton introduced a speaker, Kimberly Stanford, to the forum audience and Ms. Stanford shared her story. Commissioner Wooton provided a PowerPoint that detailed the background of the Mental Health Services Act (MHSA) and the MHSOAC, identified the goals for the community forums, and explained the roles of the various MHSOAC participants, including the Community Forum Workgroup members. MHSOAC staff described the forum process for the rest of the day.

Following the PowerPoint presentation, forum attendees were invited to organize into smaller discussion groups that included clients, family members, transition age youth (TAY), Spanish speakers, peer providers, county staff, parent-caregivers, and contract providers. Each discussion group was provided with a set of questions to help focus and guide discussions as well as provide another opportunity for participants to record input. Community Forum Workgroup members and MHSOAC staff facilitated the eight discussion groups and acted as note takers.

Each discussion group identified at least four themes, including positive comments and challenges that emerged in their discussion group. These themes were reported back to the entire general session. Following an open comment period, Commissioners Nelson and Wooton offered a summary of the report out, closing remarks, and thanked the attendees and Workgroup members for their participation.

**Attendance**

The forum produced a large turnout with estimated attendance of over 250 participants. Most of the participants came from Ventura County with some participants coming from Santa Barbara County. A few participants came from Los Angeles, Sacramento, San Bernardino, San Luis Obispo, and Yolo counties.

## **Accessibility**

The MHSOAC provided interpreter services in Spanish and American Sign Language.

## **Information Gathered from Discussion Groups/Completed Questionnaires/Open Comment Session**

The discussion group facilitators gave each participant a copy of the questions being discussed and made fifteen minutes available for discussion group members to begin answering the questions in writing. Participants who chose to do so could continue filling out the questionnaire during the forum and then could deliver the contents to the MHSOAC staff. The facilitators collected a total of 92 written surveys from individual attendees. As previously mentioned, in addition to gathering information from questionnaires, note takers documented the content from individual discussion groups. For the most part, attendees at this Forum were well aware of the MHSA and Proposition 63. What follows is information gathered from the eight discussion groups, the questionnaires, the report out, and the open comment session.

## **Summary of Client Group Input (15 participants)**

The Client Group had the following themes in their report out:

### Positives

1. Several mental health programs are having a positive impact in the county including: Turning Point, National Alliance on Mental Illness (NAMI), and the Wellness Centers.
2. Mental health information is getting out to the community in partnership with consumers and families.

### Challenges

1. Peers are not getting into the workforce with the necessary supports.
2. There is a need for more early intervention.

Of the individuals who identified themselves as clients in their questionnaires, seven reported that they had previous knowledge of Proposition 63 (MHSA) and four noted that they had not heard of Proposition 63. Of the client respondents, seven reported they or a family member were receiving mental health services and three stated that they or a family member were not receiving mental health services.

Clients made several suggestions regarding strategies, services, and supports to help engage people, including: care, love, information, education, advertising, consumer employment, upward mobility for consumer employees, group activities between families, more social activities, and housing.

Client suggestions regarding the improvement of services included providing more: mental health literature, education, advertising, support for the wellness center, grassroots

engagement, data collection, input from families, outings, social events, activities, access to clinics, housing, employment and tax support.

### **Summary of Parent Group Input (Group Intended for Parents of Children/Youth) (10 participants)**

The Parent Group reported out on the following top issues:

1. Health Insurance—One family lost Medi-Cal when the parents recovered from a mental health challenge and then got jobs and had to start paying medical bills out of pocket.
2. Need more parent involvement with children’s mental health care.
3. Suggest sharing more mental health information in schools.
4. Suggest more outreach to churches.
5. Need more mental health services for children.

All except two parents stated in their questionnaires that they had heard of Proposition 63. Eight parents stated they or a family member were receiving mental health services and four parents stated they or a family member were not receiving services.

Suggestions for strategies, services, and supports to help engage people included: community based services; letters and flyers to the public and the schools; media contacts; bulletin boards; working with peers; handouts at juvenile courts; timeliness to assessment and first appointment; family friendly clinic hours; community forums; contacting churches and faith based organizations; and establishing places to meet.

Suggestions regarding the improvement of services included providing: more one-on-one therapy; lighter load for case managers; more services; services closer to home; better insurance for working class; more prevention and early intervention; and providing services earlier.

### **Summary of Family Member Group Input (Group Intended for Family Members of Adults) (12 participants)**

The Family Group reported out:

#### Positives

1. The County is doing a good job with cultural differences.
2. Every city and sheriff’s department is trained in Crisis Intervention Team (CIT) training.
3. NAMI Ventura County is doing a good job with education about mental health.

#### Challenges

1. The County needs more interpreters/translators for multiple languages.
2. The mental health community needs to avoid speaking in acronyms.
3. The County needs more education about services and collaboration among agencies.

Three Family Members reported they had heard of Proposition 63 and one had not. Three Family members or members of their families reported they were currently receiving mental health services.

Suggestions for strategies, services, and supports to help engage people included: developing trust with clients; outreach to schools, workplaces, doctors, clinics and churches; and warm hand offs.

Suggestions regarding the improvement of services included providing: more mental health information; and more outreach and services to the homeless.

### **Summary of Unspecified Clients/Family Members/Parents/Caregivers in Questionnaires**

Of the group of clients/family members/parents/caregivers who did not specify their sub-group in their questionnaires, two had heard of Proposition 63 and one had not. One member of this group was either receiving services or had a family member who was receiving services and one was not receiving services.

Suggestions for strategies, services, and supports to help engage people included having relevant outreach.

Suggestions for improving services included providing more education about how to effectively interact with psychiatrists.

### **Summary of Peer Provider Input (40 participants)**

At the Community Forum Report Out, the Peer Providers noted the following three positives and three challenges:

#### Positives

1. Change in culture—movement from medical model to recovery model.
2. Peers have enabled change in culture through hope and empowerment, cultural change, and normalization.
3. Peers are now integrated into the mental health system.

#### Challenges

1. Peers asked for more money for employment compensation.
2. Stigma still attached to peers.
3. Peers need more empathy from decision makers.

Peer providers reported on the various duties they perform including: promoting recovery culture (4)<sup>1</sup>; providing one-on-one counseling (4); providing emotional support (4); empowering parents and families (5); teaching parenting skills; passing on hope (7); serving as an example of

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<sup>1</sup> Multiple comments on the same topic are listed in parentheses throughout the document.

recovery to others; providing advocacy (5); linking to community resources (7); empowering people to recover by supporting them in choices; driving clients when needed (2); supporting peers at appointments; identifying barriers; helping people identify goals and ways to work toward them; providing and facilitating classes based on interests and needs; providing outreach and engagement at Juvenile Hall and the Main Jail; providing a safe place for recovery; providing CIT assistance to law enforcement; helping clients discover their own meaning and purpose; and providing classes in self-advocacy.

The policies and strategies the peers identified that have produced positive outcomes included: peer run and peer driven centers (2); Recovery Innovations program (MHSA funded) (3); Turning Point program; stigma reduction; County workers using recovery model—Rapid Integrated Support and Engagement (RISE) program; county pushing for voices of clients; getting Latinos into clinics; moving clinics to clients in South Oxnard; peers have a say in decision making in Ventura County; recovery specialists doing a great job; peers showing non-discrimination to clients; focus on recovery rather than symptoms; focus more about trauma rather than symptoms; connection to programs like food stamps; use of recovery language (2); peer to peer support (2); Pacific Clinics TAY Tunnel program; Wraparound programs; and CIT training.

When asked to describe the biggest changes in the mental health system since the implementation of the MHSA, peer responses included: establishment of peer employees (2), use of the recovery model (3), reduction in stigma (3), better communication among agencies, better communication between clinics and peer support, increased treatment for individuals with mental health diagnoses, fewer homeless with mental illness on the streets, more consumers and family members hired, and more wellness and recovery activities.

The biggest challenges identified by peers were: the need for better communication between Ventura County Behavioral Health and Hospitals (3); need for more hiring of peers due to great benefits from peer work; Ventura County needs to be more organized; more accessible services needed; need to investigate the impact of budget cuts; long wait time to be seen; sometimes qualified therapists are not present—using interns; need to introduce peer support early on; need more recovery coaches; too many bureaucrats become numb to the needs of clients; more cultural and linguistic competence needed (2); supervisors need to go out at night and see what peers see; more walk-in services needed; more career ladder opportunities needed for peers; more collaboration needed with less conflict among agencies; normalizing “mental health” help (2); improved outreach to the homeless; clinical staff not understanding the benefits of peer support; need for more recovery coaches; lack of housing (2), and need more staff, especially psychiatrists (2).

If peers could change anything about MHSA services they would have: more single-occupancy housing, more employment opportunities, increase to the speakers bureau, increase to clinical staff, more programs like RISE, more agency collaboration (2), more mental health information to the public, more recovery groups, more walk-in services, more peer positions, less stigma for peers, reduced wait time for appointments, more services to those with private insurance.

## Summary of Contract Provider Input (42 participants)

Contract providers reported out on:

### Positives

1. Providers see more Community Based Organizations (CBO's) being able to provide services to children, youth, and families.
2. Funds are being used in flexible ways.
3. Peer services are strong.
4. MHSA promoted collaboration with schools.

### Challenges

1. There are not enough services for 5-18 year olds; in particular, there are not enough services for children with substance abuse issues and mental health issues.
2. Agencies are too bureaucratic; contract providers suggest more funds should go to CBO's.

Contract providers indicated that some of the best policies and strategies for obtaining positive outcomes are: one deaf provider does monthly mental health outreach presentation to outside agencies so that majority can understand the importance of equal communication access for the deaf; stakeholder process in MHSA and Non-MHSA services; employment of Peers in Peer based programs; MHSA funded "Triple P Parenting" programs has produced positive outcomes (2); outreach and engagement services; Ventura Early Intervention Prevention Services program for 16-25 year olds that are at risk for psychosis; linguistically competent services; client and family involvement in programs; "never give up on a client" strategy; positive behavior supports (CHAMPS); clients being served with no insurance or Medi-Cal; outcome measurement; incorporating case management into service plan; utilizing Family Development Matrix to engage families; providing services to undocumented youth and families; MHSA funds spent on children/youth as part of PEI; collaboration among agencies including law enforcement and schools; respecting those served; extended foster care services (EFC); new programs for adults; data collection; electronic health records (EHRs); quality assurance policies and procedures; 24/7 mental health crisis hotline and response team for youth under 21; using evidence based practices with experts in the field.

Regarding the best strategies for engagement, county contract providers identified: outreaching to deaf and hard of hearing community to reduce stigma; utilizing small Ethnic Community Based Organizations (ECBO's) to provide services; non-clinical approaches that favor strategies that are truly culturally appropriate; training direct service staff to improve community relationships; using Family Assertive Community Treatment (FACT)—go into the community and meet clients where they are at; motivational interviewing; building relationships; having culturally competent services; informing clients and families of low or no cost services; housing funds; funding for youth activities and clothes; community education programs like NAMI's "In Our Own Voice"; community based support services; respecting individuals; peer model (3); parents relate to other parents; Positive Behavior Intervention and Supports (PBIS) and

CHAMPS approaches; engaging with entire family using culturally and linguistically appropriate staff; using crisis services and linkage to community and home-based services; trauma informed care; “no wrong door”; maintaining Community Connect; and using Promotoras.

Regarding the most positive changes seen in the mental health system because of the MHSA, contract provider staff identified: Deaf and hard of hearing moved from unserved to underserved in Ventura County; more knowledge about recovery; some wonderful PEI programs; use of peers (3); awareness of mental illness has increased but the amount of services has not; services have expanded through a variety of providers with some fragmentation and duplication; more clients and families are staying together; more hope to clients (3); initially more funding to mental health but now cuts to mental health; more funding for early intervention; programs for adults have expanded in Ventura County; more services for families; increase in inclusion of family input into planning; increase in Wraparound services; increased transparency; time gap to enrollment in services through Screening, Triage, Assessment and Referral (STAR) program is 4-6 weeks; increase in services is needed but no increase in funding; increased funding to foster youth and children; increase in inter-agency collaboration; more support to schools; reduction of stigma (2); increase in school attendance and reduction in suspensions and expulsions; funding for training in Evidence Based Programs (EBP’s); younger populations requiring services; dramatic increase in county programs run by county staff; new research based programs; “Triple P” program a resource for undocumented families; and partnership with schools has increased access to services.

Contract providers noted the following challenges that remain for providing effective services: lack of culturally competent services; need services for TAY that are culturally relevant; youth are being sent out of county; psychiatrists are not empowering clients; some old school line staff lack current thinking; opportunities for collaboration (2); opportunity for community based services; lack of sufficient staff a challenge (4); contract funding limits a challenge; not enough outreach to Spanish speaking clients; not considering the needs of children with moderate to severe mental health issues; not enough prevention programs; lack of programming for Co-occurring Disorders (COD); lack of bilingual staff; lack of sustained funding while there is demonstrated need; administrators have a lack of understanding of people in need; diminish funds for services to schools; lack of funding for effective services; opportunity to create a crisis services continuum to prevent hospitalization; need to increase funding to CBO’s; lack of funding for housing (2); and Ventura County non-profits receive 40 percent less income per capita compared to Los Angeles and Santa Barbara counties.

If contract providers could change anything about the delivery of MHSA services in their county they would: have an intern who is familiar with the deaf/hard of hearing culture; have recognition that “diversity” and “cultural competence” are different and diversity does not equal cultural competence; have more programs that are truly innovative; more follow-up after referrals; increase in collaborative meetings; more early interventions; extend Children’s Intensive Response Team (CIRT) services to ensure clients are receiving care; more concern with outcomes; more funds to housing—some from CSS; increase funds for TAY walk-in center in east county; more funding for youth crisis and youth psychiatric beds; better and easier access to services; more funds to support underserved parents; more sustained funding; serve the entire community; increase service delivery through CBO’s; and embed more community based providers in the schools to treat youth with emerging mental health issues.

## Summary of County Staff Input (57 participants)

At the report out, the County Staff reported on several positive themes:

1. County Staff reported out on a primary theme of Transformation.
  - a. There has been a change in culture.
    - i. Wellness and recovery have become integrated.
  - b. There is data driven decision making now.
    - i. This resulted in a Ventura County Behavioral Health (VCBH) move to South Oxnard.
    - ii. Another result is the Electronic Health Record (EHR).
  - c. There is collaboration between primary care and public health.
  - d. There has been an expansion of services, in part due to the MHSA.

County staff indicated that some of the best strategies for producing positive outcomes have been: more staffing has provided outreach and more services; individualized care; “whatever it takes” model (five comments); target services by age (5); FSPs (5); the centralized intake with the STAR system and the integrated adult mobile crisis team have produced effective, timely intake and crisis services countywide (4); employing peers (3); transportation resources for peers (3); the focus on wellness and recovery (1); the Assertive Community Treatment (ACT) model has worked (2); supportive housing (2); supportive employment (1); trauma informed care (1); harm reduction (1); smaller caseloads (6); and the TAY Crisis Team (1). Others stated: peer employment; Success First—Wraparound services for children and adults; TAY shelter; PBIS in schools; services for rural communities; embedding quality improvement staff in the MHSA team in order to track outcomes; recovery coaches; emphasis on prevention; housing funds; COD services; inclusion of families and stakeholders in all processes; Adult Mobile Crisis Team; crisis residential treatment; Wellness Center; TAY program; PEI outreach; and a team approach.

Some of the best strategies for engagement are: going to the client in the community (3), offering transportation (3), looking at the whole person, engaging family and community resources (2), providing housing, stakeholder process—change to a client driven culture with integration of families (2), street engagement (3), service liaisons, involving peers in helping engage new people (3), developing rapport and trust, RISE program, unique client programming, parent groups, rehabilitation groups, trauma informed engagement techniques (2), outreach to home (3); housing first, supported housing (2), early intervention, assistance with supports (food, peer, housing, and Medi-Cal) (2), emphasis on language and culture, Wraparound, integration of mental health and substance abuse services, wellness centers, small caseloads allowing more frequent engagement (5), recovery orientation, no wrong door, PEI services, motivational interviewing, jail outreach, STAR system (3), funds for meetings and refreshments, building trust with families (2), focus on treatment options, implementation in schools, parent partners, cultural competence, one-on-one initial contact, fun groups, and kindness and compassion.

Some of the most positive changes seen in the mental health system since the implementation of the MHSA are: more services (3), more outreach, more integrated services (2), change in culture—focus on wellness and recovery (9), integration of peers in service delivery (4), financial

incentives to increase the number of culturally and linguistically competent staff (2), implementation of the EHR (2), stigma reduction (3), continuum of TAY services, intake centralization through STAR, more treatment instead of triage, infusion of peers (3), increase in outreach and engagement, increase in clinical positions; increase in TAY housing, programming, and residential beds, more community based programs, small caseloads for better results, increase in housing (3), better continuum of care, targeted efforts for enrollment, San Bernardino lacking in services for TAY and adults, San Bernardino took away their case management services, more services for children and parents, diversity in programming (2), FSPs across the lifespan, prevention, mobile crisis added, treatment of the whole person, CIRT, TAY Tunnel, resources still inadequate overall, lack of inpatient beds, and more paperwork.

Challenges and opportunities include: hiring process takes too long (5 comments), too much paperwork for providers and clients (4), how to sustain programs, integration of quality improvement into operations, many caseloads too big (2), challenge with administrators without direct service experience, need more psychiatrists, need more affordable housing (4), lack of board and care and skilled nursing facilities, mental health funding rules overly complex, supervisors and staff need more training, administrators need a clear strategy for new programs, need for improved communication between supervisors and line staff (2), not enough qualified line staff and experienced administrators (3), difficult keeping staff, not enough services or providers (3), not enough middle class services, more hospital beds for TAY, need more bilingual psychiatrists and licensed clinicians (3), lack of licensed board and care (2), challenge with Affordable Care Act (ACA) in meeting demand for services, and finding housing for families.

Suggested changes to the delivery of MHSA services included: have more fully integrated mental health services with substance abuse services (2), increase flexibility in funding for FSPs, reduce caseloads (2), simplify reporting requirements (2), trauma informed care, limiting temporary psychiatrist from changing medication based on one visit, more funding for transitions from acute care to outpatient care, better housing—both independent and supported (3), more mental health education to county and community leaders to support Mental Health Department, step down options for clients, more TAY programs, more education about mental health programs in communities that stigmatize mental health, more PEI emphasis, more staff, and more funding for snacks for groups.

Examples of successes and challenges in reaching out to racial, ethnic and/or cultural communities included: more integration into community needed, success with stipends to bilingual interns but this funding is limited (2), success with mental health integration with primary health, success with moving clinics to clients in South Oxnard, success with providing services in threshold language (2), success with bilingual/bicultural staff (2), success with non-traditional partnership with faith based and law enforcement communities (2), focus on wellness-not symptoms, success with translation to Mixteco population, Wellness Center has expanded services to monolingual Spanish speakers, diverse hiring of all ages, genders and ethnic backgrounds, focus on outreach and engagement to diverse communities, challenge getting out to diverse communities, need more bilingual applicants for staff, challenge to serve more of Latino community, success with services to uninsured, challenge with ongoing stigma in some communities, most services still provided during regular business hours at central clinic sites, and success with Promotoras.

## **Summary of Transition Aged Youth (TAY) Group Input (21 participants)**

At the report out, the TAY group highlighted the following issues:

### Positive

1. County helped TAY with basic needs such as food, hygiene, and job assistance.
2. County staff connect with TAY and encourage them.
3. Services are provided to TAY with loving care.

### Challenges

1. TAY want more social activities outside of clinic.
2. TAY need more housing and outreach regarding housing.
3. TAY need more consistent providers.

The TAY Group indicated that the best strategies for engagement include: more social activities, more TAY housing, more therapy groups, emergency shelters, respect from providers, increase in drop in centers, help with basic needs—food, clothes, money, finding temporary housing, warm family environment, employment assistance, love and care, and an increase in service providers.

The TAY Group indicated that the best ways to let people know about services that are helpful to persons from different races or cultures are to provide: more outreach, more information, outreach to schools, getting more people into activities or groups, and more programs.

## **Summary of Spanish Speaking Group Input (12 participants)**

At the report out, the Spanish Speaking group reported the following:

### Positives

1. United Parents in Ventura County is doing a good job in the Latino Community.
2. NAMI is also helpful; they provide “Family to Family” classes in Spanish.

### Challenges

1. This group wants more information in Spanish.
2. Stigma exists in the Latino Community regarding mental health.
3. Stigma has prevented progress with mental health.

Suggestions for strategies for engagement included treating people with cultural respect, and not being judgmental of people with mental health challenges.

## Public Comment

Public comment included the following statements:

1. There is a need for more clinicians. Sometimes wait times for appointments are overly long.
2. The League of United Latin American Citizens (LULAC) commented about disparate treatment from Ventura County Behavioral Health regarding mental health services. LULAC stated that caseloads for Latinos are higher than in White communities.
3. Request made by Tri-Valley Greater Los Angeles Agency on Deafness (GLAD) for more deaf interpreters.
4. Recovery Innovations employee commented on stigma in jails and prisons. This employee stated appreciation that Sheriff Brown was in attendance.
5. Individual stated TAY need housing support.