REPORT ON COUNTY MENTAL HEALTH BOARD COMPOSITION

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

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Each county in California has a mental health board or commission (MHB/C) that advises its governing body and local mental health department on issues concerning the public mental health system. The duties of a MHB/C include complying with statutory requirements that the board reflect, through the composition of its membership, the client driven, culturally competent values held by the state mental health system.

METHODOLOGY

In July 1998, the California Mental Health Planning Council (CMHPC) sent a survey to chairs of Mental Health Boards and Commissions (MHB/Cs). The survey requested that chairs report the number of members currently on their board, the number of vacancies, the number of direct consumers, the number of family members, and the ethnic composition of the boards. In cases where the board chair did not respond, the information was obtained from the county mental health director. Responses were received from all 59 boards.

The statute requires that at least 20 percent of members on a mental health board or commission be consumers, at least 20 percent be family members, and the two categories combined comprise at least 50 percent of the board. Compliance with the requirements was calculated for each county based on both full board size and current board size, which excluded vacant positions. Each of these numbers was multiplied by 20 percent and 50 percent and rounded up to the nearest whole number to determine the required number of consumers and family members. These figures were then compared to the actual number of consumers and family members on each board. Any county that fell below the 20 percent and 50 percent requirements was considered to be out of compliance.

To determine whether ethnic populations are adequately represented, the figures for current and full board size for each county were multiplied by the percentages of the countywide population for each ethnic category. The resulting figures represent the ideal ethnic balance for each county's mental health board. The ideal board composition was compared to the actual composition. If board representation of each ethnic population was within at least 95 percent of the proportion for the county, the board was considered to be in compliance.

In November 1998, a telephone follow-up was conducted with counties that were not in compliance in terms of direct consumer, family member, or ethnic composition. The purpose of the follow-up interview was to discover the reasons for non-compliance in order to develop appropriate recommendations. Fifty-three interviews were attempted; forty-four were completed. Finally, counties that were in compliance were interviewed to determine best practices for recruitment strategies and leadership development.

In 1994, the CMHPC conducted a similar study on mental health board composition for its report, *The Effects of Realignment on the Delivery of Mental Health Services*. The results of that study are reported here for purposes of comparison.

REPRESENTATION OF DIRECT CONSUMERS AND FAMILY MEMBERS

Finding

Thirty-nine percent of counties are not complying with the statutory requirement to have adequate representation of direct consumers of mental health services and their families on local mental health boards.

In keeping with the philosophy that values a client-driven mental health system, Welfare and Institutions Code §5604(a) imposes the following requirements on counties:

> (2) Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.
>
> (B) Not withstanding subparagraph (A), a board in a county with a population under 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

Table 1 reveals that based on an assessment of current board size (excluding vacancies), 61.0 percent of MHB/Cs are in full compliance with the statutory requirements governing representation of direct consumers and family members. In counties that are out of compliance, a shortage of direct consumer members is more common than a lack of family members; in 13[1] counties, failure to meet statutory requirements derives from a shortage of direct consumers versus five[2] counties that lacked only family members. Five additional counties fell short for both groups. The table also shows that level of compliance is virtually the same as it was four years ago. In 1994, 61.2 percent of mental health boards were in full compliance of the statutory requirements governing representation of direct consumers.

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[1] Six boards are comprised of at least 50 percent direct consumers and family members and at least 20 percent family members but less than 20 percent direct consumers; seven are comprised of at least 20 percent family members but less than 20 percent direct consumers and less than 50 percent direct consumers and family members combined.

[2] One board is comprised of at least 50 percent direct consumers and family members and more than 20 percent consumers but less than 20 percent family members; four boards are at least 20 percent direct consumers, but less than 20 percent family members and less than 50 percent direct consumers and family members combined.

Table 1: Compliance with Statutory Requirements for Composition of MHB/Cs Based on Current Board Size

	1994[3]		1998	
	Number of Counties	**Percent of Counties**	**Number of Counties**	**Percent of Counties**
Full compliance: combined Total >= 50%; both >= 20%	30	61.2	36[4]	61.0
Combined Total >= 50%; Family Members >= 20%; Direct Consumers < 20%	7	14.3	6	10.2
Combined Total >= 50%; Direct Consumers >= 20%; Family Members < 20%	1	2.0	1	1.7
Combined Total < 50%; Both >= 20%	1	2.0	0	0
Combined Total < 50%; Family Members >= 20%; Direct Consumers < 20%	4	8.2	7	11.9
Combined Total < 50%; Direct Consumers >= 20%; Family Members < 20%	3	6.1	4	6.8
Combined Total < 50%; Both < 50%	3	6.1	5	8.5
Total	49	100	59	100

Source: Survey of Mental Health Boards/Commissions

Table 2 evaluates the degree of compliance based on full board size in 1998. Comparable figures were not available for 1994. Statewide, 15.3 percent of board positions are vacant. When the full board size is used as the basis for evaluating compliance with the statute, the compliance rate decreases from 61 percent to 40 percent.

Table 2: Compliance with Statutory Requirements for Composition of MHB/Cs Based on Full Board Size

	Number of Counties	**Percent of Counties**
Full compliance: combined Total >= 50%; both >= 20%	23	40.0
Combined Total >= 50%; Family Members >= 20%; Direct Consumers < 20%	4	6.8
Combined Total >= 50%; Direct Consumers >= 20%; Family Members < 20%	0	0
Combined Total < 50%; Both >= 20%	2	3.4
Combined Total < 50%; Family Members >= 20%; Direct Consumers < 20%	15	25.4
Combined Total < 50%; Direct Consumers >= 20%; Family Members < 20%	7	11.9
Combined Total < 50%; Both < 50%	8	13.6
Total	59	100.0

Source: Survey of Mental Health Boards/Commissions

[3] In 1994, only 49 of 59 counties responded to the survey

[4] One board in this group only has 40% Combined Total but is in full compliance because it is a small county with a board of five members.

Table 3 shows the degree to which consumers and family members are underrepresented on boards based on current board size. "Combined Categories" refers to the requirement that direct consumers and family members together must comprise 50 percent of total board members. For example, 14 counties are one member short of compliance with the requirement that 50 percent of the board be a combination of direct consumers and family members. Each category is evaluated independently, i.e., a county may be under by three direct consumers, above required number for family members, and under by one member for the combined categories.

Table 3: Degree of Underrepresentation of Consumers and Family Members Based on Full Board Size

	Direct Consumers		Family Members		Combined Categories	
Under by:	#	%	#	%	#	%
1	14	24.1	9	15.5	14	24.1
2	8	13.8	4	6.9	7	12.1
3	3	5.2	0	0.0	6	10.3
4	0	0	1	1.7	3	5.2
5	0	0	0	0	1	1.7
At or above required number	33	56.9	44	75.9	27	46.6
TOTAL	58	100.0%	58	100.0%	58	100.0%

(Note: Total is 58 because Alpine County does not have a board)

The table shows that based on full board size direct consumers are underrepresented on 43 percent of boards. Nineteen percent of boards underrepresent consumers by two or more members. In the family member category, the problem is less severe; family members are underrepresented on 14 boards, 24 percent. Nine percent of boards underrepresent family members by two members. Fifty-three percent of boards are comprised of less than 50 percent direct consumers and family members

The majority of mental health boards are in compliance with the statutory requirements. However, the 23 counties that are not in compliance may be experiencing adverse consequences. For example, inadequate representation by direct consumers and family members may mean that actions by those boards do not reflect the client-driven philosophy of the mental health system. In some cases where direct consumers are underrepresented, some mental health board chairpersons we interviewed expressed concern that the few consumers on the board may feel uncomfortable due to underrepresentation.

Interviews with mental health board chairs and local mental health directors revealed that the causes of underrepresentation vary by county. For example, some small counties had difficulty recruiting consumers due to stigma against mental health clients in the communities. In large counties, Boards of Supervisors sometimes failed to appoint appropriate candidates, even when mental health boards recommended candidates that met statutory requirements. Some MHB/C chairpersons and local mental health directors stated that consumer members have frequent "episodes" which, because of by-laws governing attendance, result in the need to resign. Others cited difficulty in finding consumers with the necessary knowledge and meeting skills to participate meaningfully in meetings. Some counties were simply not aware of the statutory requirements governing composition or felt that accepting enthusiastic volunteers was more important than complying with the requirements.

Problems such as stigma against direct consumers in some communities point to the need for community wide public education campaigns. Other problems, such as consumers

having to resign due to problems related to their mental illness or not being able to find qualified consumers, points to the need to educate MHB/Cs and program staff about reasonable accommodation and promoting leadership development and training.

REPRESENTATION OF ETHNIC POPULATIONS

Finding

Seventy percent of county mental health boards do not reflect the ethnic diversity of their counties, especially for Latinos and Asians.

Recognizing the importance of a culturally competent mental health system, the Welfare and Institutions Code imposes the following requirements on counties:

> §5604(a) The board membership should reflect the ethnic diversity of the client population in the county.
>
> §5604.5 The local mental health board shall develop bylaws to be approved by the governing body which shall ensure that the composition of the mental health board represents the demographics of the county as a whole, to the extent feasible.

Based on an assessment of current board size (excluding vacancies), 69.5 percent of mental health boards are not in compliance with statutory requirements governing representation of ethnic populations. Appendix A provides a view of the degree of underrepresentation for each ethnic population for which census data is available. As in 1994, Latinos are the most severely underrepresented. Of 58 boards[5], eight represent Latinos at a rate consistent with the population of Latinos in the county population. Another six boards overrepresent Latinos by one member. The rest of the counties, 76 percent, underrepresented Latinos by as many as five board positions. Asians are underrepresented in 20 counties, 33.9 percent. African Americans are underrepresented by one member on eight boards; the rest have adequate or more than adequate representation.

Table 4 shows that in comparison with 1994 representation of Latinos has decreased, while representation of Asians has improved. The table is based on full board size; thus the drop in representation for some groups between 1994 and 1998 can be attributed, in part, to higher vacancy rates in 1998. Whites, in particular, appear to show a marked decrease; as they represent the single largest ethnic group in most counties, vacancies have the greatest effect on the White board member category.

[5] The total number is 58 because Alpine County does not have a board.

Table 4: Percent of Counties at or above Parity Based on Full Board Size

	1994	1998
Latinos	27.7	24.1
Asians	51.0	65.5
African Americans	89.3	86.2
Native Americans	Not Available	93.1
Whites	87.2	56.9

WIC §5600.2 states that "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are…culturally competent." In many counties, members of some ethnic communities are under-utilizing mental health services. Without representatives of ethnic populations on the boards, board actions may not adequately represent input of minority communities, and boards may not know how to improve service delivery to these populations.

Board chairs and county mental health directors offered a variety of reasons for their inability to comply with statutory requirements. Some believe, for example, that Latinos do not use the mental health system due to cultural beliefs, so recruiting them is difficult. Others stated that recruiting in general is challenging and said that they do not want to turn away volunteers because they are not from the correct ethnic population. In some cases, ethnic communities are geographically distant from the location of the meetings. One director said that a large number of community boards in the county are competing for the same small pool of ethnic community members. Another director said that the Latino population is very new to the state and frightened of contact with any government agency. Still another said that Latinos cannot attend meetings because they work long hours. Language barriers were also cited several times.

Several explanations for lack of consumers and family members also appeared in the discussion of representation of ethnic populations. Some counties were simply not aware of the statutory requirements governing composition or felt that accepting enthusiastic volunteers was more important than complying with the requirements. Likewise, Boards of Supervisors sometimes failed to appoint appropriate candidates even when mental health boards recommended candidates that met statutory requirements.

CREATING AN ENVIRONMENT THAT VALUES DIVERSITY

The key to success in developing a balanced board lies in demonstrating to potential members that the board has developed a cultural competency plan and is genuinely interested in benefiting from the different perspectives that ethnic populations and consumers and family members bring to the board. The proper spirit must be in place in order for best practices recommendations to be effective. Otherwise, ethnic populations and consumers and family members will feel like recruitment efforts are token efforts.

Board members must be willing to admit that ethnic populations and consumers have been and still are underrepresented on boards and that the boards are open to making changes. They must demonstrate openness to truly new ways of doing business rather than simply hoping to find someone that meets the diversity criteria who thinks the same way they do. To this end, recruiting ethnic minorities and consumers should be an ongoing and a long-term goal. Boards need training in order to understand the benefits that a diverse board brings in terms of effective mental health planning. This practice will ensure that minority community members and consumers are retained once they are recruited.

RECOMMENDATIONS

Recruitment and Retention

1. Since several counties stated that consumers often have to resign from the board due to illness, mental health directors and MHB/Cs need to discuss reasonable accommodation for consumers in terms of attendance. Mental health bylaws should be designed so that direct consumers may take leaves of absence, if necessary, rather than resigning if their mental illness prevents them from attending meetings for awhile. Mental health boards should establish a procedure to replace members on long-term leaves of absence temporarily with alternates.
2. Consumers should be provided with training to facilitate their effective participation in meetings. Some county mental health programs provide training in communication skills through role-plays and other methods. The skills learned through these training programs are reflected in board meetings.
3. Recruitment efforts need to go beyond advertising in the local newspaper. For example, MHB/Cs can work with existing consumer networks in the county or support development of consumer networks where none exist. Boards could do presentations at mental health service centers to familiarize clients with the functions of the board.
4. Efforts to recruit ethnic populations also need to expand. Working with a variety of professionals and organizations in the community can help. For example, the County Ethnic Services Coordinator often has ties to local community groups. Ethnic community consultants and directors of ethnic-specific clinics are another source of assistance. The board could also ask the Chief of Systems of Care to contact consumers from ethnic populations and encourage them to join. Mental health staff from ethnic populations can identify people in their communities and ask these community members to spread the word further. This will ensure that recruiting by "word of mouth" employs a variety of individuals to help spread the word. In addition, local boards and county mental health departments can work with local community-based non-profit agencies to develop a pool of ethnically diverse candidates for boards.
5. Taking time to bridge language barriers is also very important. Counties might try offering conferences on mental health issues in Spanish and other languages. Often what is perceived as "lack of interest" in the public mental health system is simply a language barrier. Conferences on ethnic population specific mental health issues should also be held in English. Boards should be willing to address positively language diversity on their boards. Members may need to provide translators to expand diversity on their boards. If board meetings are accessible to non-native speakers, doing multilingual

public service announcements on ethnic radio stations can be an effective way of attracting culturally diverse members.

6. Maintaining a "critical mass" is important in retaining ethnic members. Just as we strive to have a certain percentage of the board be direct consumers, ethnic diversity should not consist of just one person of color, even if demographics indicate that that is enough. At least three is essential for group support. Boards should also be aware that the large ethnic categories employed in the census data contain many subgroups with diverse cultures and mental health needs.

7. Some recommendations offered by MHB/Cs in compliance with regulations can be applied to recruitment of both direct consumers and family members and people from ethnic populations. For example, calling all city agencies, organizations, and clubs and telling them what types of candidates the board is seeking can be an effective way of gaining contacts. One board has tracked down former employees of the mental health system who met the board's needs and invited them to apply. Family support groups for parents of children with emotional disturbances often constitute a diverse group of people with an interest in mental health. Consumers and people of color can recruit others in their communities. One chairperson remarked that when a vacancy announcement mistakenly appeared in the "Help Wanted" section of the newspaper, many more people responded.

8. Finally, MHB/Cs can maintain a pool of non-voting/associate members from which to draw when positions become available. This is an especially useful strategy when a MHB/C does not meet statutory requirements and has no current vacancies.

Training

1. MHB/Cs need training in the client-directed values of the mental health system. This should include methods of providing a supportive environment for consumer members.

2. MHB/Cs need training on the importance of cultural competence. Boards should be monitoring the county's cultural competency plan as a way of staying focused on having ethnic populations on the boards. In addition, each board should maintain a cultural competency committee that keeps the board aware of current issues and identifies potential members. Boards that are in compliance with statutory requirements can be asked to make presentations at the Cultural Competency Summit on techniques for recruiting and retaining ethnic populations on boards in order to provide training to other boards.

3. The CMHPC should assist by creating a statewide task force on MHB/Cs and their training needs. Material on recruitment issues should be included in the California Institute for Mental Health (CIMH) training binders that are being distributed to MHB/Cs.

4. County mental health directors can make a difference in whether MHB/Cs are effective. Many directors are new and need training regarding the role of MHB/Cs. Directors must be aware of the importance of cultural competence and on statutory requirements governing ethnic composition. In addition, CMHDA could facilitate contact with Boards of Supervisors, letting them know the value of having a diverse mental health system at all levels.

APPENDIX A

Difference between Ideal and Actual Number of Members for Each Ethnic Group Based on Current Board Size

	Latino		Asian		African American		Native American		White	
	# of Counties	% of Counties	# of Counties	% of Counties	# of Counties	% of Counties	# of Counties	% of Counties	# of Counties	% of Counties
Underrepresented by 5	3	5.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
By 4	3	5.2%	1	1.7%	0	0.0%	0	0.0%	2	3.4%
By 3	10	17.2%	2	3.4%	0	0.0%	0	0.0%	4	6.9%
By 2	10	17.2%	2	3.4%	0	0.0%	0	0.0%	7	12.1%
By 1	18	31.0%	15	25.9%	8	13.8%	4	6.9%	12	20.7%
Parity	8	13.8%	36	62.1%	37	63.8%	50	86.2%	11	19.0%
Overrepresented by 1	6	10.3%	2	3.4%	10	17.2%	3	5.2%	9	15.5%
By 2	0	0.0%	0	0.0%	3	5.2%	1	1.7%	3	5.2%
By 3	0	0.0%	0	0.0%	0	0.0%	0	0.0%	3	5.2%
By 4	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5	8.6%
By 5	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
By 6	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.7%
By 7	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	1.7%
Total	58	100.0%	58	100.0%	58	100.0%	58	100.0%	58	100.0%

(Note: Total is 58 because Alpine County does not have a board)