Marin County MHSA
Three-Year Community Planning Process
FY2017-FY2020
Mental Health Services Act

Historical Overview

- Local systems stretched beyond capacity
- Consumers and family members without adequate care
- Need for mental health to be addressed with the same urgency as health care
Proposition 63

The Mental Health Services Act

- Grassroots advocates statewide gathered signatures for an initiative on the November 2004 ballot
- The proposition passed, and became the Mental Health Services Act (MHSA)
- 1% tax on income over $1 million
Mental Health Services Act: Transformational Concepts

- Community Collaboration
- Cultural Competence
- Client and family-driven programs and interventions
- Specific attention to individuals from underserved communities
- Integrated service experience for individuals and their families
- Wellness recovery and resilience
- Outcomes-based program design
Client Driven Programs and Services

• Client driven programs and services use clients’ input as the main factor for planning, policies, procedures, service delivery, evaluation and definition and determination of outcomes
Mental Health Services Act: The Purpose

- Define serious mental illness as a condition deserving priority attention
- Reduce long-term adverse impact on individuals resulting from untreated mental illness
- Expand successful innovative services, including culturally and linguistically competent approaches for underserved populations
- Provide funds to adequately meet needs of children/adults /older adults who can be identified/enrolled in programs under this measure
- Ensure funds expended in the most cost-effective manner and services provided in accordance with recommended best practices
Mental Health Services Act
Components

• Community Services & Supports (CSS)
  o Full Service Partnerships (FSP)
  o Systems Development
  o Outreach and Engagement
  o MHSA Housing Program
• Prevention & Early Intervention (PEI)
• Workforce Education & Training (WET)
• Capital Facilities & Technology Needs (CFTN)
• Innovation (INN)
Community Supports and Services

- Target populations:
  - Seriously Emotionally Disturbed Children and Youth
  - Adults and Older with a Serious mental disorder, which is severe in degree and persistent in duration examples include: schizophrenia, bi-polar disorder and major affective disorder

Full Service Partnerships
Doing “Whatever it Takes”
Full Service Partnerships

- 282 consumers served FY2015/16
  - Five Full Service Partnerships now fully staffed
    - Two additional BOS-approved positions in recruitment
    - New positions will increase Full Service Partnership capacity by 30 treatment slots
    - New clinic site opening in Novato to house Full Service Partnership teams
  - Thirty Seven (37) new consumers entered Full Service Partnership services since February 2016

282
Consumers served FY2015-16

37
New Consumers entered Full Service Partnership services since Feb. 2016
Support and Treatment After Release (STAR) Outcomes - Residential Status Full Service Partnerships

- N=54
- Increased housing
  - 1,973 days homelessness
- Increased community living
  - 2,072 days incarcerated
- Increased outpatient treatment
  - 294 days hospitalization
Support and Treatment After Release (STAR) Outcomes – Emergency Events
Full Service Partnerships

- N=54
- Fewer arrests
  - 87% decrease
- Fewer mental health (MH) emergencies
  - 73% decrease
Reaching Out: Three New Teams

Responding to the Community

**Transition Team**
Short-term (60 day) case management to stabilize and connect individuals with ongoing services

**Mobile Crisis Response Team**
Responds to mental health/substance use crises in the community seven days/week

**Outreach & Engagement Team**
Supportive outreach to individuals not engaged in services and to their families/friends
Impact of the Three New Teams
Community Crisis Response Teams

- Majority of contacts initiated by Family/Friends and Law Enforcement
- Reduced use of acute and crisis services (hospital, PES, detoxification) and increased use of planned services (medication support, case management and FSP)

754 Individuals treated by the three teams

2,659 Services provided in FY2015-16 by the three teams
Prevention and Early Intervention

• Programs and Services designed to prevent mental illnesses from becoming severe and disabling
  o Early Intervention Programs provide treatment and other interventions to promote recovery and improve function for mental illness early in its emergence
  o Prevention programs reduce risk factors for developing a serious mental illness and build protective factors for at risk populations
  o Outreach for increasing recognition for early signs of mental illness programs, teach responders to recognize and respond to early signs of mental illness
  o Access and Linkage connect individuals with SED or SMI with medically necessary care
  o Reduction in Stigma and Discrimination are aimed at reducing negative stereotypes or discrimination associated with mental illness
    • Suicide Prevention Programs
Workforce Education and Training

Develop a diverse workforce

- Training for clients and families/caregivers to develop the skills to work collaboratively to deliver client and family-driven programs and services
- Provide outreach to unserved and underserved populations
- Provide services that are linguistically and culturally competent and relevant

5822. The Office of Statewide Health Planning and Development shall include in the five-year plan:
- Loan forgiveness, stipends and scholarship programs
- Staff training
- Employment and inclusion of mental health consumers and family members
- Promotion of meaningful inclusion of diverse racial and ethnic communities
- Cultural competence training programs

(a) E (Amended by Stats. 2012, Ch. 23, Sec. 57. Effective June 27, 2012. Note: This section was added on Nov. 2, 2004, by initiative Prop. 63.)
Marin County BHRS Workforce Education and Training (WET) Program 2016-2017

**Graduate Clinical Internship Program**
Recruit and retain culturally/linguistically diverse interns to provide services throughout the division.

**Peer Mentoring**
Support for people to mentor consumers who are entering the BHRS workforce. Mentors could be peers or professionals.

**Training/Workshop Initiatives**
- Motivational Interviewing
- Non-Violent Crisis Intervention Training
- Mental Health First Aid
- Trauma Informed
- BHRS Team Development (Isoke)
- Cultural Competence Consultation Clinics
- Appropriate use, effectiveness and benefits of peer counselors/specialists

**System-wide Dual Diagnosis Training**
- Develop a system-wide AOD training series and consultation to BHRS clinical staff and mental health contract agency partners
- Develop and implement Co-Occurring Peer Education (COPE) course for peer specialists/counselors

**Scholarships for Consumers and Family Members**
Offer scholarships to culturally diverse consumers/family members to complete a certificate course in mental health, AOD and/or domestic violence peer counseling.

**Peer Specialist and AOD Intern Stipend Program**
Offer internship stipends to mental health peer interns and AOD training graduates who are placed in public behavioral healthcare settings.

**Consumer-Focused Trainings**
- Develop and implement advocacy training course for peer specialists/counselors and adult BHRS consumers
- WRAP course

**Development of BHRS Peer Counselor Positions**
In collaboration with Human Resources, develop Peer Counselor I, II and Peer Supervisor job classifications and positions.

**Culturally and experientially diverse workforce that is skilled to provide services to people with co-occurring substance use and mental health disorders.**
Capital Facilities and Technological Needs

- Funds for the creation of facilities used for the delivery of MHSA services to clients and families or for administration
- The development of technological infrastructure to facilitate the highest quality and cost-effective services and supports for clients and their families
Housing

• Provided funds to acquire, rehabilitate, or construct permanent supportive housing for clients with serious mental illness and provide for operating subsidies.

California Code of Regulations, 3200.225
Innovation

• 5% of MHSA funding, is allocated towards Innovative Programs and Services in order to:
  • Increase Access to Care
  • Increase Access to Underserved Communities
  • Improve Outcomes of Care
  • Provide for Interagency Collaboration
Community Planning Process

- Identify the mental health and substance use services needs of the community
- Identify and reprioritize strategies to meet these mental health and substance use services needs
- Ensure client participation
- Ensure inclusion of the racial, ethnic, linguistic and sexual orientation of the community
- Link component parts into a continuum of care
Marin County MHSA Community Planning Process

**Stakeholder Input**
- Community Meetings
- Key Informant Interviews
- Focus Groups
- Online Surveys

30 day Public Comment

BHRS

MHSA Advisory Committee

Public Hearing at Mental Health Board
- Mental Health Board Recommendations

Board of Supervisors for Approval
## MHSA Funding Estimates

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. CSS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated - 3-Year Average Marin County MHSA Allocation</td>
<td>$9,202,872</td>
<td>$9,202,872</td>
<td>$9,202,872</td>
<td>$27,608,616</td>
</tr>
<tr>
<td>CSS Programs Currently Funded (FY 16/17)</td>
<td>$7,725,675</td>
<td>$7,725,675</td>
<td>$7,725,675</td>
<td>$23,177,025</td>
</tr>
<tr>
<td>WET Programs Currently Funded</td>
<td>$333,333</td>
<td>$333,333</td>
<td>$333,334</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Unallocated Funds</td>
<td>$1,143,864</td>
<td>$1,143,864</td>
<td>$1,143,863</td>
<td>$3,431,591</td>
</tr>
<tr>
<td><strong>Total CSS Funds Available</strong></td>
<td>$9,202,872</td>
<td>$9,202,872</td>
<td>$9,202,872</td>
<td>$27,608,616</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>II. PEI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated - 3-Year Average Marin County MHSA Allocation</td>
<td>$1,996,433</td>
<td>$1,996,433</td>
<td>$1,996,433</td>
<td>$5,989,299</td>
</tr>
<tr>
<td>PEI Programs Currently Funded (FY 16/17)</td>
<td>$1,900,500</td>
<td>$1,900,500</td>
<td>$1,900,500</td>
<td>$5,701,500</td>
</tr>
<tr>
<td>Unallocated Funds</td>
<td>$95,933</td>
<td>$95,933</td>
<td>$95,933</td>
<td>$287,799</td>
</tr>
<tr>
<td><strong>Total PEI Funds Available</strong></td>
<td>$1,996,433</td>
<td>$1,996,433</td>
<td>$1,996,433</td>
<td>$5,989,299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th>2018-19</th>
<th>2019-20</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>III. INN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated - 3-Year Average Marin County MHSA Allocation</td>
<td>$517,765</td>
<td>$517,765</td>
<td>$517,765</td>
<td>$1,553,295</td>
</tr>
<tr>
<td>INN Programs Currently Funded (FY 16/17) (Note: Existing INN funded programs will not be funded with INN funds in the next 3-year plan)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Unallocated Funds</td>
<td>$517,765</td>
<td>$517,765</td>
<td>$517,765</td>
<td>$1,553,295</td>
</tr>
<tr>
<td><strong>Total Estimated INN Revenues - County</strong></td>
<td>$517,765</td>
<td>$517,765</td>
<td>$517,765</td>
<td>$1,553,295</td>
</tr>
</tbody>
</table>
Building an Integrated, Evidence-based System

- Building multi-disciplinary teams to support seamless, scale-able and cost-effective delivery of integrated mental health and substance services.
- Launching first county-operated outpatient treatment program to address co-occurring substance use and mental health disorders.
- Recruiting first Board-Certified Addiction Medicine Specialist.
Trauma

“What happened to you? replaces “What’s wrong with you?”

• 90% of people seeking treatment in public behavioral health settings have experienced trauma. A similarly significant number of traumatized individuals are seen in public sector primary care.

• Adverse Childhood Experiences (ACES): 59% of individuals in the US experience at least one adverse childhood experience in their life—9% experience five or more.
  • Psychological, physical, or sexual abuse
  • Community or school violence
  • Witnessing or experiencing domestic violence
  • National disasters or terrorism
  • Commercial sexual exploitation
  • Sudden or violent loss of a loved one
  • Refugee or war experiences
  • Military family-related stressors (e.g., deployment, parental loss or injury)
  • Physical or sexual assault
  • Neglect
  • Serious accidents or life-threatening illness
  • The national average of child abuse and neglect victims in 2013 was 679,000, or 9.1 victims per 1,000 children.
Suicide

A growing problem

• The suicide rate (age adjusted, per 100,000 population) in Marin was 12.8, higher than the CA rate of 9.8 (CHIS 2015).
• Increase in suicide rate for women, has led to a decrease in overall life expectancy for first time.
• (See also attached report regarding suicides and the GGB.)
• Facts About Mental Illness and Suicide:
  • The great majority of people who experience a mental illness do not die by suicide. However, of those who die from suicide, more than 90 percent have a diagnosable mental disorder.
Depression

- An estimated 2-15% of persons who have been diagnosed with major depression die by suicide. Suicide risk is highest in depressed individuals who feel hopeless about the future, those who have just been discharged from the hospital, those who have a family history of suicide and those who have made a suicide attempt in the past.
Bipolar Disorder

• An estimated 3-20% of persons who have been diagnosed with bipolar disorder die by suicide. Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals.
Schizophrenia

• An estimated 6-15% of persons diagnosed with schizophrenia die by suicide. Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Most of these occur early in the onset of the illness. Between 75 and 95% of these individuals are male.
Multiple Disorders

• Also at high risk are individuals who suffer from depression at the same time as another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at greater risk for suicide.
Personality Disorders

- People with personality disorders are approximately three times as likely to die by suicide, than those without. Between 25 and 50% of these individuals also have a substance abuse disorder or major depressive disorder.

http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp
Substance Use

• 40% of clients who came into PES in the past three months tested positive for alcohol and/or non-prescribed substances.
• Between 2010 and 2013, 5,456 hospitalizations and 8,194 emergency room visits involving alcohol and drug use were reported in Marin County.
Alcohol

Marin youth drink too early, too often and too much.

Youth in **non-traditional high schools** are impacted at higher rates.

- 40% of 9th graders had their first drink by age 14.
- Almost 19% of 11th graders have used alcohol three plus times in the last month, and 30% have binged at least once in last month. Almost **40% of youth attending a non-traditional high school** reported binge drinking during the same time period. (CHKS)
- **Improve access by geographic location**: services primarily centered in San Rafael. Limited services in Novato and Marin City, none in West Marin.
- **Improve ability to attract self-referrals**.
- FY 2014/15 < 3% of screenings and/or assessments (RCC) were from self-referrals. Most referrals from criminal justice and social services partners.
- Substance Use Strategic Plan Focus Group Finding: Policies and attitudes in some primary care and mental health settings reveal institutional stigma towards substance use disorders.
Housing

• According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness.

• People with substance and other mental disorders experience even greater barriers to accessible housing than their counterparts: income deficits, stigma and need for community wraparound services.

• The ongoing stigma housing providers, funding sources, and neighborhood groups are reluctant to serve people with disabilities, despite such legislation as the Fair Housing Amendments Act.

• Key clinical barriers include lack of attention to issues of trauma, including childhood and adult physical and sexual abuse; failure to make the newer antipsychotic medications widely available; and lack of integrated treatment for co-occurring mental health and substance use disorders.
Underserved Cultural Communities

- Individuals, families, and communities that have experienced social and economic disadvantages are more likely to face greater obstacles to overall health. Characteristics such as race or ethnicity, religion, low socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.
- Federal and state governments monitor Government funded programs and activities to ensure that access, use, and outcomes are equitable across racial and ethnic minority groups. See Medi-Cal Approved Claims Data for Marin MHP LGBTQ: we do not collect these demographics so cannot track who we are serving and how.
- Latino Medi-Cal beneficiaries: Adult system sees very few monolingual Spanish speakers – as opposed to the Children’s system that sees many. How to increase services to Adult primary Spanish Speakers? [See Attached Marin Approved Claims race/ethnicity edit for detail]
Thank you for your participation in the MHSA Community Planning Process