

## Consultant's Report

### Marin County Older Adult Mental Health Services (Mental Health Services Act, Community Services and Supports Plan, Full Service Partnerships)

#### Strengths:

The Marin County Department of Health and Human Services, Division of Community Mental Health Services (CMHS) demonstrates a strong commitment to providing mental health services to older adults, and expanding those services through funding from the Mental Health Services Act (MHSA). This commitment is evidenced by the energy and thoughtfulness of both administrative and clinical staff as they describe the services they would like to see provided. The depth of knowledge about older adult mental health issues among both sets of staff is impressive.

CMHS has both a strong volunteer older adult peer counseling program and an unpaid psychology internship which provide significant services under the supervision of paid clinical staff at a minimal cost. Thirty-five peer counselors and 3 psychology interns provide ongoing services to 150 older adults experiencing mental illness, with 3 part-time professional staff providing assessment and supervision. Another 99 receive some minimal assessment or other service. Many of those served would be at risk of developing symptoms of more serious mental illness were it not for these volunteer services; this is an example of a best practice related to early prevention and intervention.

Additional CMHS strengths include a history of successful and innovative programming with target populations similar to the proposed older adults to be served in full-service partnerships (FSP) through MHSA, and a history of successful leveraging of funds to maximize services available.

The stakeholder process related to MHSA has included a variety of community members, and CMHS has incorporated their feedback into its plan for older adult services.

The administrative structure of Marin County is another major strength. With all of the county divisions that provide services to older adults as part of one department, the potential for effective collaboration and blending of funding is unique. There is a history of that effective collaboration in other types of services such as the STAR program, the elder abuse multidisciplinary task force, children's services, etc. Assistant Directors in charge of each of the divisions seem highly motivated to partner with one another in organizing the provision of services, both generally for older adults and specifically to older adults who meet the criterion for MHSA FSP's. The focus on ideal programming rather than departmental politics surrounding funding was remarkable.

## Challenges:

There are several challenges evident in creating the proposed FSP programming.

While the county divisions seem willing to collaborate, and good services exist for older adults generally, resources are currently somewhat spread out. There is no centralized system for identifying who is being served in what capacity by which division, nor are services centrally located.

Public mental health services for older adults are limited. Mental health penetration rates indicate that older adults are the most unserved age group in Marin, and these penetration rates may even be inflated by the number of individuals who have only received an assessment and then been referred for peer support due to lack of additional resources. While peer counseling is an important piece of a FSP, it cannot replace professional mental health services for the seriously mentally ill elder.

The current cohort of older adults tend to underutilize and reject mental health services in general which presents its own unique set of clinical challenges, which again supports the need for more mental health professionals' direct involvement in outreach, engagement and treatment services.

There are competing needs among the various age ranges and needed older adult mental health services are unlikely to be fully funded through MHSA allocations to Marin County. Related to this, the poverty index used by the state to allocate these funds is unrealistic for residents of Marin County and it will be challenging to provide adequate mental health services to elders who are outside of those state poverty guidelines but still living with inadequate resources as they age in place.

Specific to the MHSA itself, the requirement to provide 24 hour per day, 7 days per week access to a FSP team member known to the client will be a financial challenge to CMHS.

## **Recommendations:**

As envisioned by the Assistant Director in charge of CMHS, an older adult system of care model where members of all county divisions serving elders are centrally located would provide a strong base for a full service partnership with seriously mentally ill elders. A central database that tracks all services provided by each county division to any particular individual would be helpful in avoiding duplication of services and confusion on the service recipient's part. This would also be helpful in identifying individuals who are utilizing resources in a way that indicates that they would be good candidates for a FSP.

For example, if an elder is referred to APS for self-neglect, is assessed by APS to have mental health issues, refuses services, and is re-referred 2 months later, etc., mental health could begin active outreach to that person and ideally enroll them in a FSP with the goal of breaking that cycle and providing “whatever it takes” to keep that person from further deterioration and potential institutionalization, and to aid in the person’s recovery from the mental illness causing the self-neglect in the first place. A treatment team in this type of case might include a clinician and a psychiatrist from mental health, a nurse practitioner from public health, and a case manager from aging services. As the elder improved in mental health functioning, the professional staff involvement might be lessened and the clinician might be replaced by a volunteer peer counselor.

In order to create the above Older Adult System of Care (OASOC), an infrastructure will need to be developed. One piece of that will be finding a space where staff can all be located, leading to a natural, daily collaboration among team members. A database program to track all of the various services being provided to an individual will also be necessary. Sharing of staff and budget resources will require the active efforts of all of the Assistant Directors. Some specific staff resources that might be shared include physicians, nurses, and other healthcare staff, case managers, and volunteers.

**Recommendations specific to the MHSA FSP services to be provided to the seriously mentally ill older adult subgroup of those who could be served by the OASOC:**

In order to develop sufficient relationships with the older adults to be served in the FSP model, CMHS will need to add more professional staff with expertise in older adult mental health. These staff can continue to supervise the psychology interns and volunteers, but will need to have time to provide direct service as well. The service will include: outreach and engagement, assessment, ongoing case management and treatment. Ideally, the same clinician will be involved in providing all of these services to a particular individual older adult in a primary care model. Often, the outreach and engagement process will be extended as older adults may be more resistant to mental health treatment, particularly if they have either not had mental health services before, or if they have and those services were provided in restrictive settings many years ago.

This person will be the main point of contact for the older adult, leading to less transitions and more stable attachment. He or she will liaise with a treatment team comprised of both mental health and other available Older Adult System of Care staff to ensure that the consumer’s needs for housing, health care, etc. are being met. Ideally, an intern or volunteer might also be assigned to each consumer in order to add social support and, perhaps a psychology intern could provide on-call support by someone known to the consumer when the primary clinician is unavailable.

In this model, a 1:15 ratio of professional mental health staff to consumers would probably be adequate as there is strong support from other team members.

Because the engagement process may be extensive and the suggestion is to use the long term clinician from the beginning, this model is costly in its initial phase with decreases in cost as the consumer becomes more stable. These cost decreases will potentially impact several county agencies, including APS and health services, creating a synergy of resource use countywide and making it more fiscally plausible to work together from the beginning in a system of care model.

Some older adult consumers will not require this level of care, which is where **system development** investments will also be important in developing the county's older adult system of care. When describing the role of the professional mental health staff above, supervision of psychology interns and volunteer peer counselors was mentioned. Both of these groups could have a strong role in providing services to consumers with less need, and could also serve as a "step down" in service intensity for the FSP's as they recover. Conversely, if an older adult being served in peer counseling appears to have more need, there would be available resources to meet that need in the FSP.

It is important to note that in order for the above services to be effective, they need to be deliverable in appropriate settings, i.e. homes, senior residences, senior centers, congregate meal sites, etc. and that cultural issues need to be addressed clearly in all services provided.

A budget for these services has not been attached as that would require specific detail about salary level for various positions. Additionally, if it is possible to use existing nursing and physician staff from other county departments as part of the treatment team as suggested here, this will impact budget.

Attached is a paper authored by Center for Aging Resources staff with some specific suggestions regarding the service delivery model described above.

Thank you for the opportunity to participate in Marin County's process; I certainly learned a great deal from all of you and look forward to hearing how things move forward.

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