VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

November 29 & 30, 2022

COMMUNITY PLANNING PROCESS (CPP)

Overview and Findings

Introductions

The MHSA Team

- Dr. John Schipper – Division Chief, MHSA and Adult Services
- Dr. Jamie Rotnofsky – Sr. Manager MHSA
- Hilary Carson – Program Administrator
- Greg Bergan – Program Administrator
- Katie Stefl – Program Administrator
- Esperanza Mata – Community Service Coordinator
- Monica Neece – Suicide Prevention Coordinator
- Juan Sanchez – Management Assistant

Codes of Conduct

Codes of Conduct During Presentation and Community Sharing

We want to create space where everyone is treated with respect and dignity and a safe place to share

- Only one person speaks at a time
- “I” statements are preferred; speak for yourself, not for a group
- Everyone’s voice matters
- Creating space for others to have an opportunity to communicate
- Everyone has different levels of knowledge and experiences related to mental health and substance use and all voices are welcome
- Comment in order to share information, not to persuade
- Avoid any assumptions about any member of the group or generalizations about social groups
- Is there anything you would like to add?

We all have a common purpose – to improve the services of our community

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What is MHSA?

California's Mental Health Services Act (MHSA), also known as Proposition 63, placed an additional 1% tax on personal incomes exceeding $1M.

- MHSA funds mental health programs across treatment, prevention and early intervention, innovation, infrastructure, and workforce development.
- There are five "buckets" of MHSA funding:

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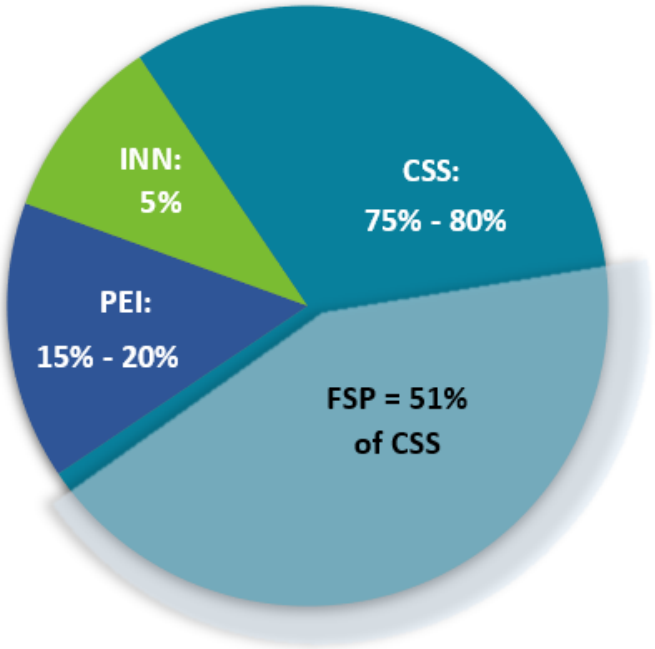
Annual Update and 3-year plan

3 Year Plans: Outlines the department needs, goals, program plans and spending for the next three years.

Annual Update Reports: Reports on all MHSA funded programs from the prior fiscal year and anticipated changes for the next year always links back to the current 3-year plan.

Community Planning: Counties are required to meaningfully involve stakeholders in program planning (e.g., Annual Updates, Three-Year Plans), implementation, evaluation, and budget allocation



Required break down of spending

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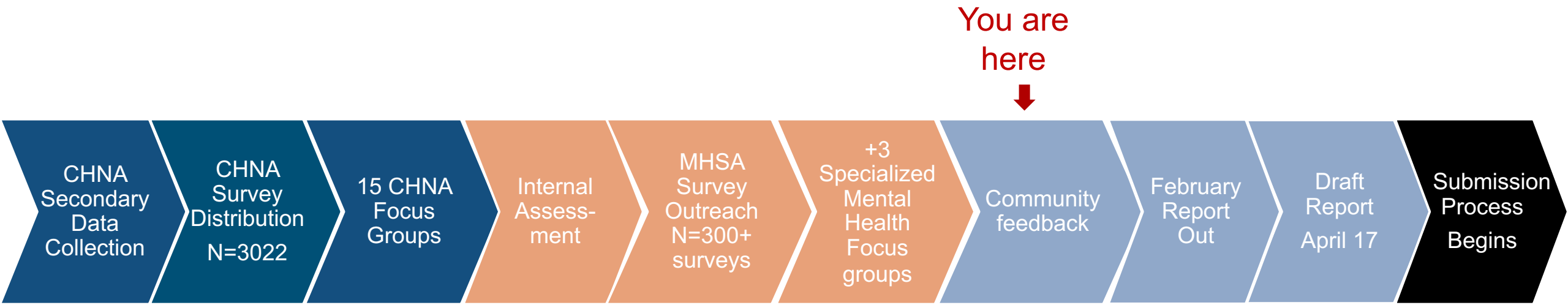
Summary of the CPP Process



Phase 1: January 2022 – June 2022

Phase 2: July 2022 – October 2022

Phase 3: November - June 2023

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COMMUNITY NEEDS ASSESSMENT FINDINGS

Phase 1

Phase 1: Background

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COMMUNITY HEALTH
IMPROVEMENT COLLABORATIVE
(VCCHIC)

CONDUIT
OVERVIEW OF FINDINGS

For additional information, the full report can be found on www.Healthmattersinvc.org

MENTAL HEALTH SERVICES ACT
PROPOSITION 63
CALIFORNIA

VENTURA COUNTY
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Phase 1: Primary Data

Primary data means data collected directly from individuals and included:

- Community Survey Responses (N=3,000+)
- 15 Focus Groups

Community Survey, Key Stakeholder & Community Member Focus Group Discussions

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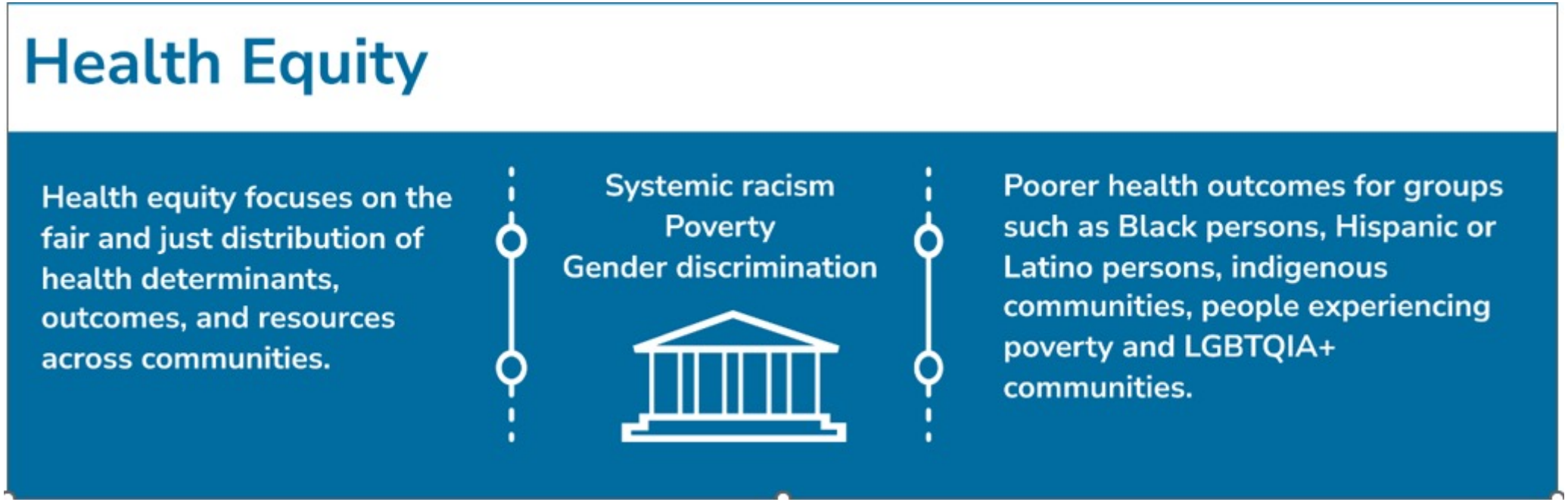
Phase 1: Demographics of the CHNA Respondents

- All age groups were represented in the survey - 0-17 (5%), 18-24 (11%), 25-34 (18%), 35-44 (22%), 45-54 (16%), 55-64 (14%), and 65+ (14%)
- Gender Identity – Female/Woman (77%), Male/Man (20%), Another Gender Identity or Prefer Not to Answer (3%)
- Household Income – 25% of respondents had a household income less than $30K per year
- Race or ethnicity – 63% of respondents were Hispanic/Latino (4% Indigenous from Mexico, Central or South America), 30% Non-Hispanic White, 4% Non-Hispanic Asian, 1% Non-Hispanic Black, 1% Non-Hispanic American Indian or Alaska Native, 1% another race or ethnicity
- Marital Status – Married (48%), Not Married/Single (33%), Domestic Partner (9%)
- Education – Less than high school graduate (11%), high school graduate or GED (13%)
- Language – Spanish (23%), English (72%), Mixtec (2%); 16% of surveys were completed in Spanish
- Military – Currently serve or served in the past (4%)
- Physical or Mental Disability - 12%
- Insurance – Medi-Cal (18%), No insurance (7%), Cash Pay (6%)
- Industry/Business – Agriculture (5%), Construction (1%), Education (6%), Food Service or Retail (5%), Government (30%), Healthcare (39%), Technology (2%)

Phase 1: CHNA Considerations, Health Equity Index

6 Socio-economic detriments of heath – Health Equity Index

- Income
- Poverty
- Unemployment
- Occupation
- Educational Attainment
- Linguistic Barriers



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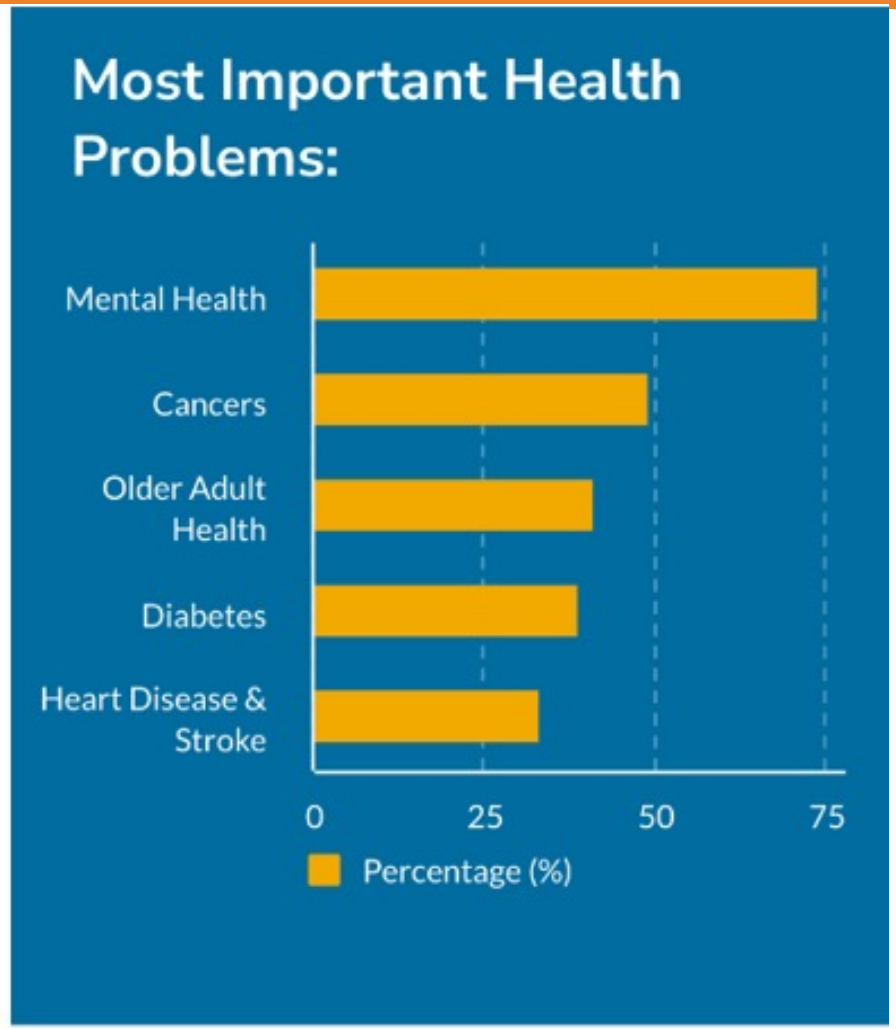
Phase 1: Need Assessment Findings

- **Access to Health Care**
- **Alcohol and Drug Abuse**
- Cancer
- Diabetes
- Education
- Heart Disease and Stroke
- **Housing**
- **Mental Health**
- Nutrition and Healthy Eating
- **Older Adults**
- Physical Activity
- Weight Status



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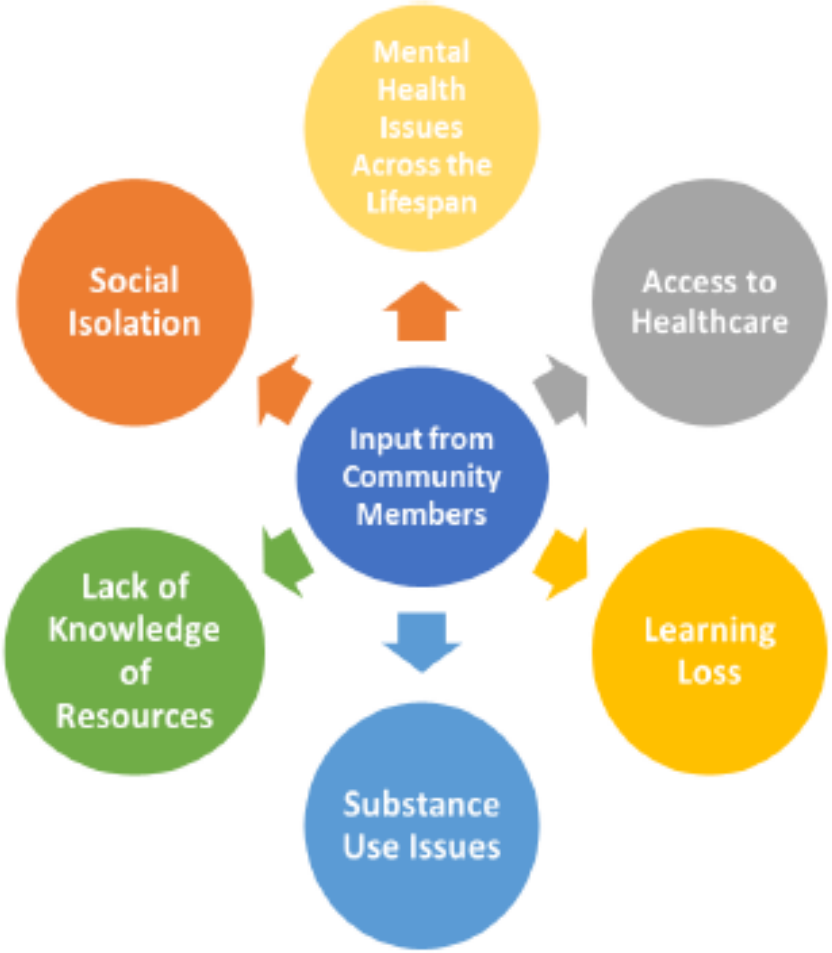
Phase 1: Key Themes from Focus Groups

> **Substance Use increase and normalization is higher than ever.**
> - Focus Group Participant

> **At a very early age they are starting to consume drugs and alcohol. So now you see a lot younger people.**
> - Focus Group Participant



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Phase 1: Top Reported Finding

Mental Health

Key Themes from Community Input

- Mental health problems (trauma, depression, bipolar, etc.) was the #1 most important health problem by both the general population (74%) and student respondents (82%)
- Mental health issues across the life span discussed in focus groups
- Suicide was most important health problem for 32% of student respondents

Life Expectancy Analysis

Suicide ranked #7 in leading causes of premature death (2019-2021) for males and #9 overall for Ventura County

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Phase 1: Community Health Implementation Strategy

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ENHANCED MENTAL HEALTH DATA COLLECTION

Phase 2

Phase 2: Background

- The CHNA identified zip codes area with the lowest life expectancy (Oxnard and Santa Paula).
- The MHSA prioritizes unserved and underserved populations. Based on the above CHNA findings, additional data collection effort were made in these areas.
    - Additional surveys (+300) were collected in these areas.
    - 3 additional focus groups were held in these areas (total N=30). Populations participating included behavioral health clients, community members and the unhoused.
- Next, we will present a summary of these findings. Full findings can be found on www.wellnesseveryday.org in video format.

EVALCORP
Measuring What Matters℠

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ENHANCED COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY FINDINGS

Phase 2 (continued)

Phase 2: Demographic Profile of Survey Respondents

- Age groups
  - 0-17 (5%), 18-24 (11%), 25-34 (18%), 35-44 (23%), 45-54 (15%), 55-64 (14%), and 65+ (14%)

- Gender Identity
  - Female/Woman (77%), Male/Man (20%), Another Gender Identity or Prefer Not to Answer (3%)

- Household Income
  - 49% of respondents had a household income of less than $50K per year

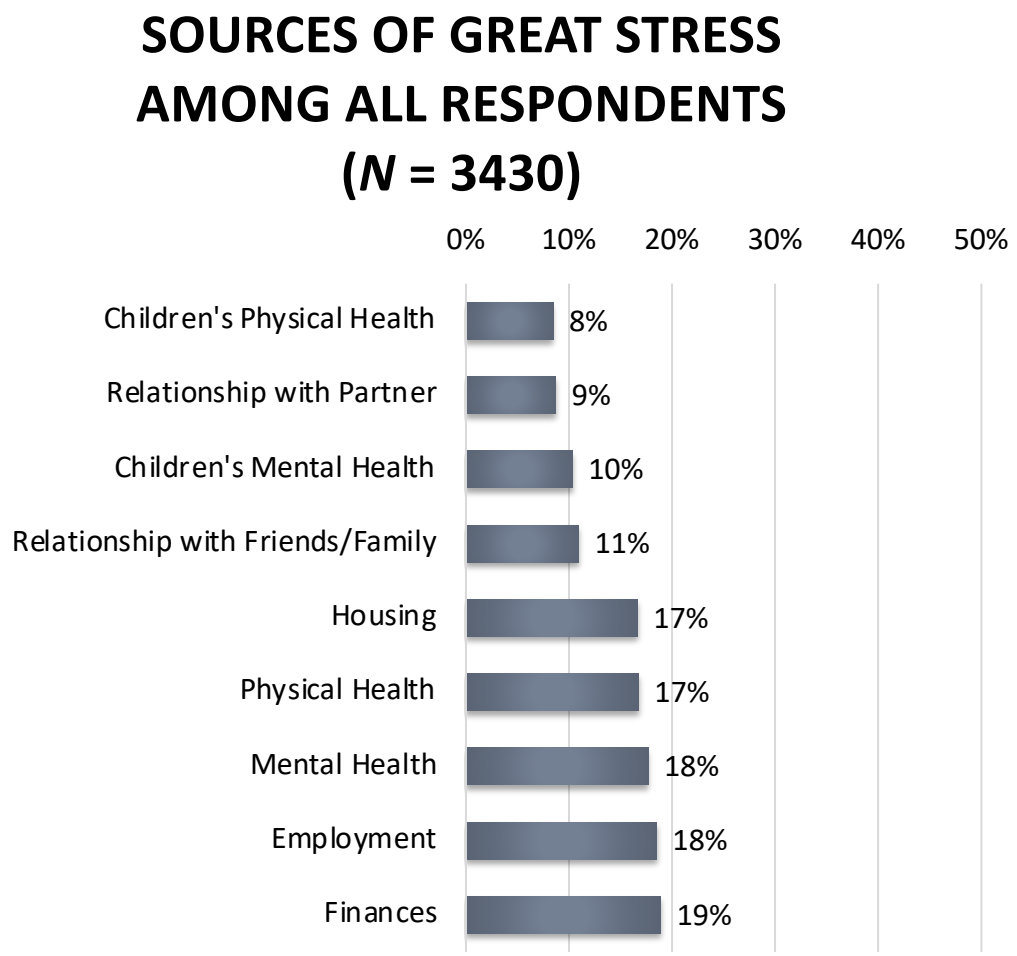
- Race or Ethnicity
  - 75% of respondents identified as Hispanic/Latino, 71% White, 4% Asian, 3% American Indian or Alaska Native, 2% Black/African American, 1% Native Hawaiian or Pacific Islander, 13% another race, and 6% more than one race.

- Primary Language
  - English (65%), Spanish (27%), Mixtec (4%), Other (2%), Tagalog (1%), Arabic (1%)

Phase 2: Demographic Profile of Survey Respondents

- Marital Status
  - Married (48%), Not Married/Single (32%), Domestic Partner (9%), Other (4%), Prefer not to answer (4%)
- Education
  - Less than high school graduate (18%), high school/GED (14%), bachelor's degree or higher (43%)
- Military
  - Currently serve or served in the past (4%)
- Physical or Mental Disability
  - Has a disability (11%)
- Insurance
  - Medi-Cal (17%), Medicare (5%), Medi-Cal and Medicare (2%), Cash Pay/No insurance (8%)
- Industry/Business
  - Healthcare (37%), Government (28%), Education (5%), Agriculture (8%), Food Service or Retail (5%)

Phase 2: Sources of Great Stress



The top sources of great stress among all surveyed were:

- Finances
- Employment
- Mental Health
- Physical Health
- Housing

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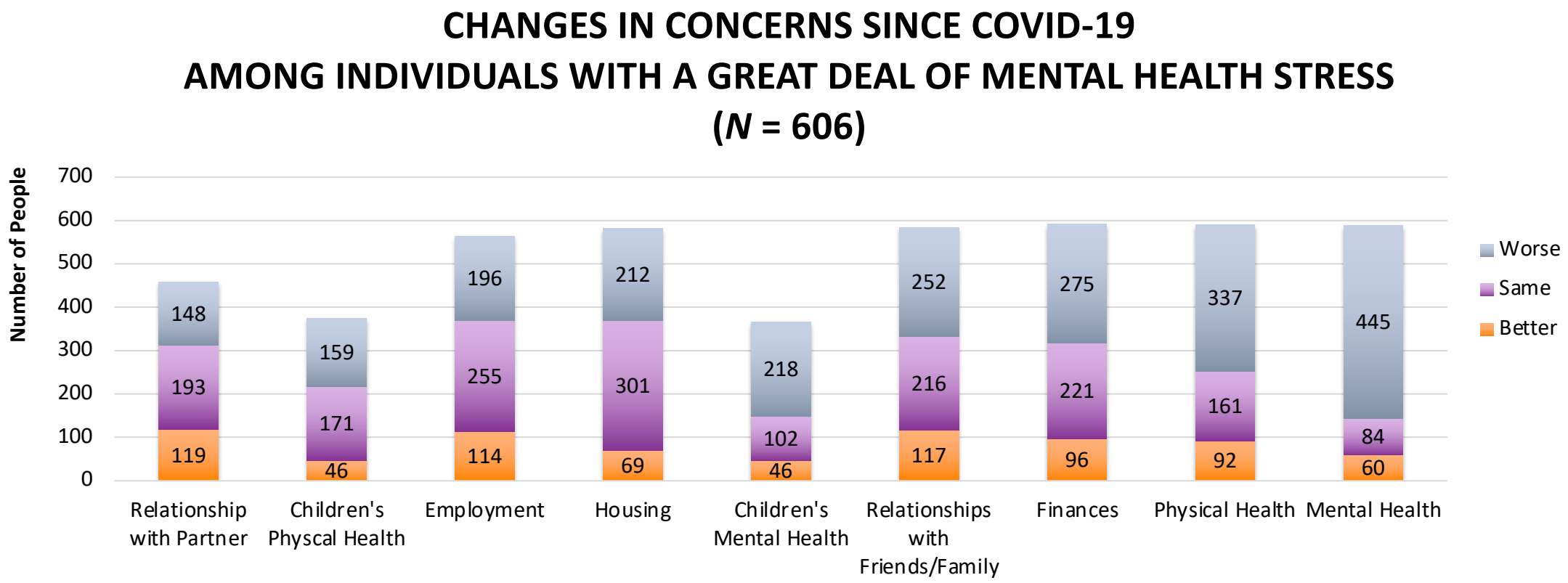
Phase 2: Changes in Concerns Since COVID-19



- Among those who reported a great deal of mental health stress, a large proportion also reported that COVID-19 worsened their mental health and children's mental health

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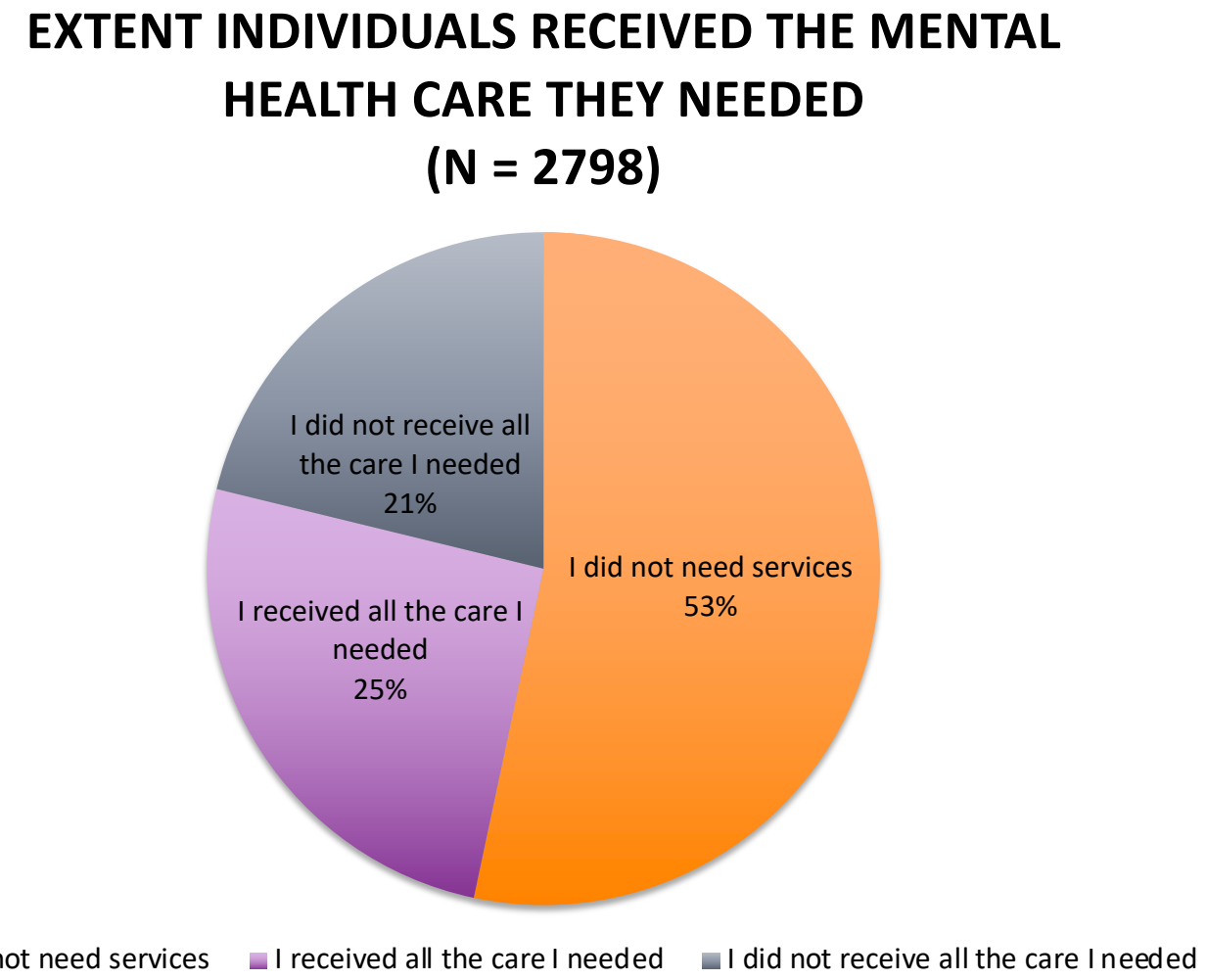
Phase 2: Receipt of Mental Health Services

- Almost 50% of respondents reported needing mental health care in the last 12 months, while more than half indicated that they did not
- More than 20% (n=593) of the respondents reported they did not receive the mental health care they needed



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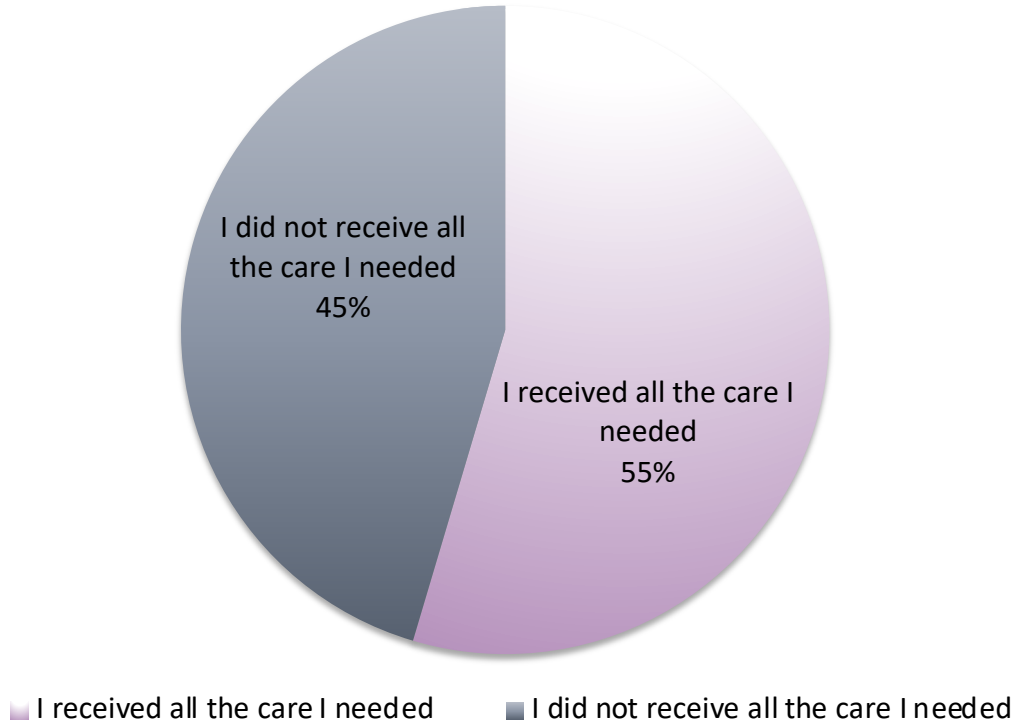
Phase 2: Receipt of Mental Health Services

- Of those who reported needing mental health services, 45% reported that they did *not* receive the mental health care they needed.

EXTENT INDIVIDUALS WHO NEEDED SERVICES RECEIVED THE MENTAL HEALTH CARE THEY NEEDED (n = 1293)



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Phase 2: Receipt of Mental Health Services

DEMOGRAPHICS OF INDIVIDUALS WHO DID NOT RECEIVE NEEDED MH CARE

Age Group (*n* = 566)	%
0-17 years	5%
18-24 years	14%
25-34 years	19%
35-44 years	23%
45-54 years	16%
55-64 years	14%
65+ years	9%

Racial Category (*n* = 473)	%
Black/African American	1%
Native Hawaiian/Pacific Islander	1%
American Indian/Alaska Native	2%
Asian	5%
Multi-racial	8%
Other	12%
White	71%

Ethnicity Category (*n* = 512)	%
Hispanic/Latino	56%
Non-Hispanic/Latino	44%

Individuals most likely to not receive the mental health care they needed were those between the ages of 25-44, those who identified as White or Other, and/or those who identified as Hispanic/Latino.

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Phase 2: Suicidal Ideation and Attempts – Age Comparisons

- Suicidal *thoughts* were more common among younger age groups.
- Suicide *attempts* were more common among individuals: (1) 45-54 years, (2) 0-17 years, (3) 34-44 years, and (4) 65+ years
- Older age groups were less likely to have suicidal thoughts, but more likely to have made attempts, compared to their younger counterparts

Age Group	Suicidal Thoughts$_1$	Suicide Attempts$_2$
0 – 17 Years (n_1 = 133, n_2 = 99)	15%	15%
18 – 24 Years (n_1 = 292, n_2 = 76)	12%	7%
25 – 34 Years (n_1 = 502, n_2 = 62)	6%	7%
35 – 44 Years (n_1 = 629, n_2 = 56)	5%	11%
45 – 54 Years (n_1 = 427, n_2 = 31)	5%	16%
55 – 64 Years (n_1 = 388, n_2 = 35)	4%	3%
65 Years and Up (n_1 = 370, n_2 = 18)	2%	11%

Phase 2: Suicidal Thoughts and Ideation

- About 6% of survey respondents reported having thoughts of suicide in the past 12 months, among those 9% reported having attempted suicide, and among those, more than half did not get medical attention.

- Suicidal thoughts and suicide attempts were more common among individuals who did not identify as a man or woman (Note: sample sizes are lower in these categories)

Gender Identity	Suicidal Thoughts$_1$	Suicide Attempts$_2$
Woman (n_1 = 2094, n_2 = 220)	5%	9%
Man (n_1 = 539, n_2 = 62)	6%	5%
Transgender Man (n_1 = 5, n_2 = 3)	20%	33%
Transgender Woman (n_1 = 3, n_2 = 2)	67%	50%
Non-Binary (n_1 = 25, n_2 =14)	32%	21%
Other (n_1 = 6, n_2 = 3)	33%	0%

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Phase 2: Survey Discussion

Mental health was a top source of stress across all respondents, but especially among younger individuals and those with a lower income.

COVID-19 exacerbated concerns regarding personal and children's mental health.

Suicidal thoughts were more common among younger respondents and those who did not identify as cis-gendered men or women.

More than half of all survey respondents, as well as those who had suicidal thoughts, received the MH care that they needed.

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Phase 2: Survey Recommendations

Expand mental health services across the county. Find ways to target individuals who report having unmet mental health needs.

Help individuals experiencing mental health stress identify factors in their life that are contributing to the stress and provide co-occurring, integrated services.

Outreach to individuals for mental health services should target individuals who identify as Hispanic/Latino or non-CIS gendered individuals between the ages of 25 and 44.

Almost 1 out of 5 respondents who reported having suicidal thoughts also indicated that they attempted suicide. Training to potential responders should acknowledge this high risk of dying that people are in when having suicidal ideation.

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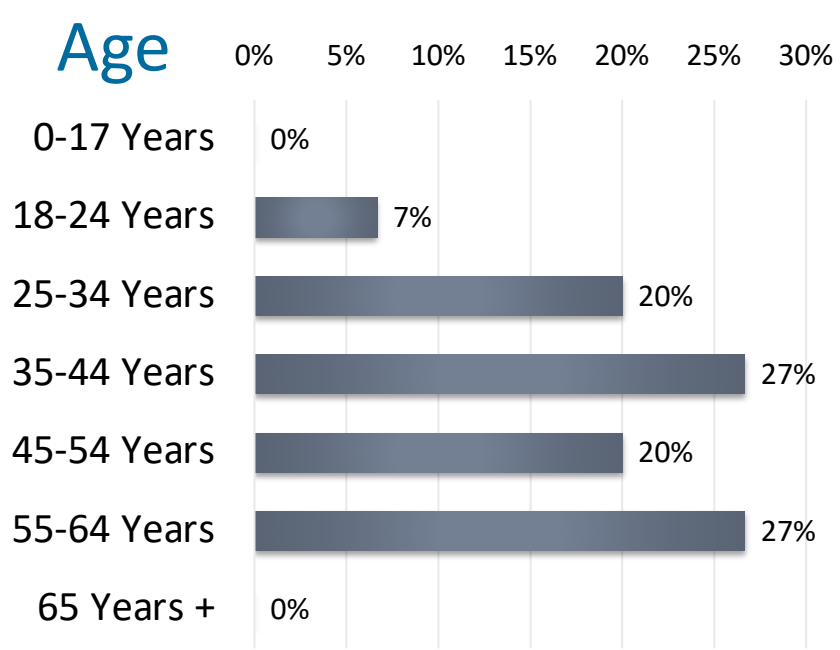
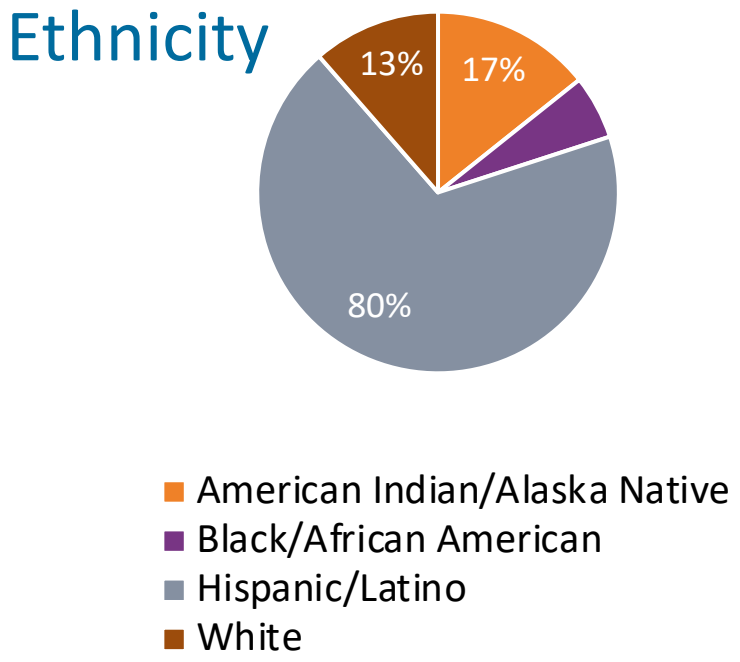
ENHANCED FOCUS GROUP FINDINGS

Phase 2 (continued)

Phase 2: Participant Demographics

- Three additional focus groups (N=30) were conducted among unserved/underserved people including behavioral health clients, community members, and housing challenged, in both English and Spanish, and conducted in zip codes identified on VCHNA as having the lowest life expectancy.





No individuals identified as Asian, Native Hawaiian/Pacific Islander, or another race

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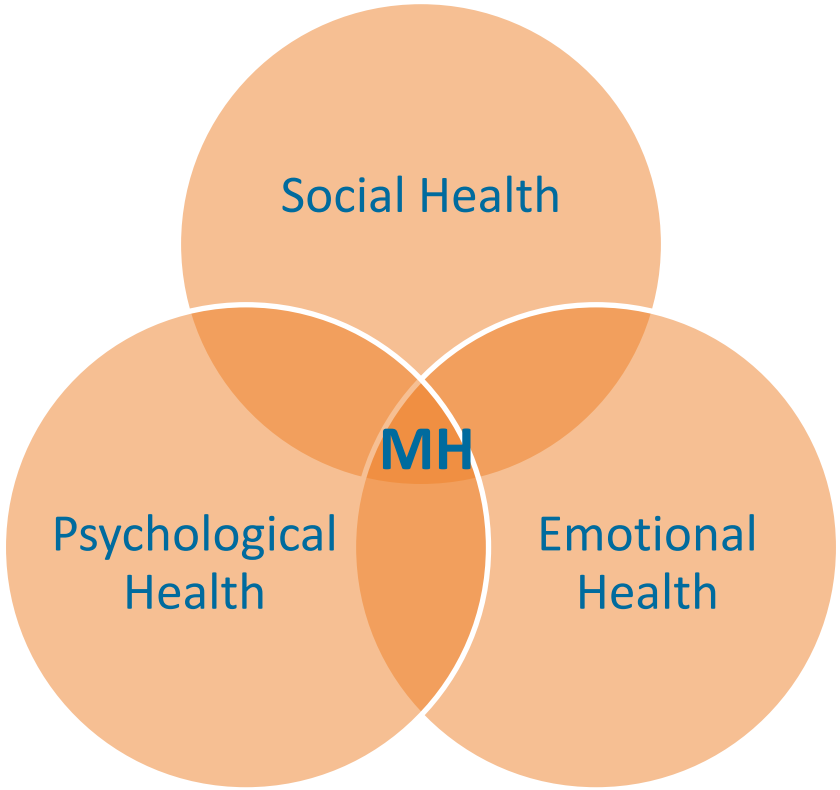
Phase 2: Understandings of Mental Health – Language Used



How did participant language reflect their understanding of MH?

Cultural Influences

- Focused on cultural stigmas and slurs
- Recognized the negative impact of stigma
- Secrecy of Mental Health

> Silence is golden
> -Focus group participant

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Phase 2: Mental Health Needs

What needs do participants feel are most important to them?

Depression

- Mentioned in every focus group
- Driving reasons: loss, loneliness, rumination

Anxiety

- Mentioned in every focus group
- Driving reasons: providing for family, loss, work
- Noted consequences such as poor sleep and panic attacks

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Phase 2: Mental Health Needs

What needs do participants feel are most important to them?

Trauma	• Shared traumatic experiences that drove mental health needs, but did not use the term • Examples: abuse, leaving home country, abandonment
Generational Trauma	• Recognition that issues are passed down to future generations and desire to prevent this • No understanding of why this happens or how to address and prevent it

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Phase 2: Enhanced Focus Group Findings

What is most important to participants in receiving mental health services?

1. Connection to Care
2. Affordability
3. Awareness

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Phase 2: Mental Health Service Considerations

1. Connection to Care

Personal Care

- Culturally- and linguistically-appropriate care
- Attention to common stigmas and implicit bias from providers
- Prioritization of privacy

Patient-centered

- Flexible service hours
- Provider consistency and continuity of care
- More local services

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Phase 2: Mental Health Service Considerations

2. Affordability

- Insurance coverage for services is not reliable
- Eligibility requirements create barriers
- Fears regarding cost prevent engagement in services

Phase 2: Mental Health Service Considerations

3. Awareness

- Power in having awareness of available resources
- No central point to receive information about services
- Lack of updated information discourages connection to care
- Need additional community education on how to identify needs

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Phase 2: Summary of Findings

Cannot separate a conversation about mental health from the cultural stigma that has infused even healthy language around mental health

Although participants' MH concerns are driven by traumatic experiences, they were more comfortable using terms such as depression and anxiety

High level of need for cultivating trust within the community to address the barriers that prevent successful connection to MH services

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Phase 2: Summary of Findings - Recommendations

Rethink how conversations about mental health are held with the community. Bring individuals into conversations about mental health services with terminology that is not already stigmatized.

Educate the community about the mental health risks associated with unmet basic needs and trauma exposure.

At every access point to MH services, as well as connections to new services, allow space and time for connections to be made so individuals trust that they are cared about, that services are affordable, and that they are given accurate information.

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Questions on Needs Assessment Findings

For full details:

- Phase 1: CHNA
  - www.Healthmattersinvc.org
    - Needs Assessment report and Response to the Needs Assessment report
    - Dashboard tools

- Phase 2: Enhanced Mental Health Results:
  - www.Wellnesseveryday.org or www.saludsiemprevc.org
    - Survey findings video
    - Focus group finding video

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COMMUNITY FEEDBACK

Phase 3

Phase 3: Questions for Consideration

Connection to Care | Affordability | Awareness

Questions:

1. How can the topic of mental health be approached in non-stigmatized language?
2. Does the community understand that trauma exposure and unmet basic needs drive mental health risks?
3. How can an emphasis on building trust be integrated into outreach efforts and service provision?

Survey

Please take a moment to fill out this short survey. With your help we can improve upon services to you and our community.

The survey should take **less than 5 minutes to complete**.

You can scan the QR code or connect on the website and take it from a digital device.

English

https://www.surveymonkey.com/r/CPP_English

Español

https://www.surveymonkey.com/r/CPP_Espanol

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THANK YOU FOR COMING

We truly value your time, participation and feedback.