Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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Executive Committee Meeting
Tuesday September 26, 2017 ⬩ 3:15pm to 5pm
2425 BISSO LANE, CONCORD- 1st floor conference room

AGENDA

I. **Call to Order / Introductions**

II. **Chair and Vice Chair reports**

III. **Public Comments-**
***Please note that all members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission, in accordance with the Brown Act, if a member of the public addresses an item, not on the agenda, no response, discussion or action on the item may occur. Time will be provided for public comment on the items on the agenda, after commissioners comments, as they occur during the meeting.**

IV. **Commissioner Comments**

V. **APPROVE minutes from August 22, 2017 meeting**

VI. **REVIEW and DISCUSS, the draft for the Commissioner's site visit policy and procedures**

VII. **DISCUSS deadlines regarding the completion and submission of the 2015 Data Notebook and the assignment of tasks for the completion of the 2016 Data Notebook**

VIII. **DISCUSS the Commission's Annual Report, completion deadline is 12/31/17**

IX. **DISCUSS Commissioner's thoughts regarding the 2017 Mental Health Commission retreat/training on Saturday September 16, 2017, what was learned, and areas for improvement, moving forward**

X. **DISCUSS inviting county school districts to discuss current mental health awareness programs and services in schools, along with possible gaps and needs, and how to assist schools in reducing mental health stigma on campus.**

XI. **Adjourn**

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers. The Commission is pleased to make special accommodations, if needed, please call ahead at (925) 957-5140 to arrange.

MENTAL HEALTH EXECUTIVE COMMITTEE
MONTHLY MEETING MINUTES
August 22, 2017 – First Draft

Agenda Item / Discussion		Action /Follow-Up
I.	**Call to Order / Introductions** Chair Duane Chapman meeting called to order at 3:18pm. **Members Present:** Chair- Duane Chapman, District I Barbara Serwin, District II Sam Yoshioka, District IV Gina Swirsding, District I **Commissioners Absent**: Diana MaKieve, District II **Other Attendees**: Margaret Netherby, NAMI member Joe Partansky, advocate Jill Ray, Board of Supervisor field rep, District II Adam Down, BHS Administration	**EA-Transfer recording to computer**
II.	**Public Comments:** • A public member reported on attended a meeting of the National Criminal Justice Association. Shared handout, see attached.	*See attachment
III.	**Commissioners Comments:** • All Board of Supervisors and there staff were invited to attend the Mental Health Commission retreat. District II Supervisor Andersen and her Chief of Staff have confirmed their attendance.	
	Chair comments: • Three District Supervisors donated funds towards the Mental Health Commission's retreat luncheon. The California Association of Local Behavioral Health Boards and Commissions (CALBHBC) have also donated funds towards refreshments. • A board and care facilities has filed for bankruptcy, which provides services for older adults. An update will be provided at the next meeting	***MHC Retreat/training will be held at the IBEW Union Local 302 hall at: 1875 Arnold Drive in Martinez, from 9am to 3pm.**
IV.	**MOTION to APPROVE the minutes from the July 25, 2017 meeting. Sam Yoshioka moved to motion, Gina Swirsding seconded the motion.** ***No corrections required.** **VOTE: 4-0-0** **YAYS: Duane Chapman, Barbara Serwin, Gina Swirsding, Sam Yoshioka** **NAYS: none** **ABSTAIN: none** **Absent: Diana McKieve**	***Post approved final minutes to the website**

V.	**DISCUSSION regarding Commissioners appropriate conduct during meetings** • Discussion regarding meeting ground rules for everyone to adhere to and forward to the full Mental Health Commission. All present were in agreement **MOTION to forward the attachment, to the full Mental Health Commission, for approval** **Barbara Serwin moved to motion, seconded by Sam Yoshioka** **VOTE: 4-0-0** **YAYS: Duane Chapman, Barbara Serwin, Gina Swirsding, Sam Yoshioka** **NAYS: none** **ABSTAIN: none** **Absent: Diana McKieve**	***See attachment Forward attachment to the full Mental Health Commission meeting on 10/4/17**
VI.	**DISCUSS policies and procedures regarding site visits** • Commissioners should start documenting site visits and a formal reporting process will begin in 2018 • The Chair and Vice Chair will work in partnership, with the Behavioral Health Services Director, towards finalizing the new policies and procedures for site visits • Commissioners are mandated to do, at least, one site visit per year **MOTION to forward all forms, to the next full Commission meeting in October, along with other examples from other counties.** **Gina Swirsding moved to motion, seconded by Sam Yoshioka** **VOTE: 4-0-0** **YAYS: Gina Swirsding, Sam Yoshioka, Barbara Serwin and Duane Chapman** **NAYS: none** **Abstain: none** **Absent: Diana McKieve**	***Site visit forms will be forwarded to the full Mental Health Commission for approval at the next meeting on 10/4/17**
VII.	**DISCUSS the integration of advisory boards report by Commission members Sam Yoshioka and Gina Swirsding** • Discussion regarding dual diagnosis and the implementation of the Drug Medical Waiver, that recently was approved and in process of implementation. Offering additional funding to provide appropriate treatment • It is important to include the Alcohol and Other Drugs (AOD) Program Chief in the discussion • Behavioral Health Administrative staff will reach out to AOD and inquire when a presentation will be feasible • AOD can provide pertinent information and an overview of the Drug MediCal waiver • Further investigation is needed, on the subject matter, and will continue. • Information to be considered and gathered in the investigation of the integration of boards. **"Why integrate, what is the benefit to integrating advisory boards."** • Some attendees wondered if integrating will affect the funding of different programs.	***BHS will contact the AOD program to inquire regarding scheduling presentation for a future meeting, possibly November**

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VIII.	**DISCUSSION to determine and request regular updates from the County's Financial Officer throughout the year** • Commission needs to understand the financial picture of the County's programs and services. Would like there to be more consistency, from the County's Financial Office, in providing updated financial information and obtain a greater understanding of the financial milestones in terms of formulating the budget. Would like to have a "high level" of input in terms of what the Commission sees as important for the community, like the "White Paper", being able to identify and express concerns. The Director of Behavioral Health suggested that the MHSA/Finance Committee be entrusted to understanding the full budget, identifying key questions and then, bringing that forward to the full Commission, providing updated information on an ongoing basis, from the MHSA/Finance Committee. There are more details happening within the Finance Committee but there are also broader concerns going on with the Commission. The Commission would like the request, to be made important and to be presented to the County's Finance Department. • The MHSA/Finance Committee, at the committee level, can do a deeper dive, into issues that the Commission deems as necessary. • The Vice Chair will work with the Committee Chair and discuss the objectives, timing and present the ideas to the full commission for the commission to respond to and then be able to define on how the commission would like to be part of the process with the county and acknowledges that there are internal process and departmental timing of the milestones, which are equally important. • The Commission agrees to partner with the Behavioral Health and Finance departments • The Vice Chair will do additional research regarding the Commission's request for information, make a list of the Commission's inquiries to initiate the process and submit it to the Behavioral Health Director to forward to the County's Finance Department	
IX.	**DISCUSS updates from the ad hoc Bylaws Committee meeting on July 28, 2017** • They ad hoc Bylaws Committee will meet on Thursday September 14 at 3:30 at the Behavioral Health Administrative offices at: 1340 Arnold Drive in Martinez.	***Updates will be provided at the next meeting in October**
X.	**Adjourned at 5:07 pm**	

Minutes submitted by:
Liza Molina-Huntley
Executive Assistant to the Mental Health Commission
CCC- Behavioral Health Services Administration

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Site visit purpose, policy and protocol

1. PURPOSE:

Site visits provide an opportunity to review the community's mental health needs, the services being provided, and the program facilities and obtain a better understanding and knowledge regarding the County's services that are being provided. Mental Health Commissioners will identify potential areas for growth and make recommendations to Behavioral Health Services, with the objective to partner in improving and strengthening the lives of the residents of Contra Costa County.

2. *POLICY and PROTOCOL*:

2.1 Each Commissioner should participate in at least one site visit per year

2.2 A maximum of three Commissioners, per site visit

2.3 Commissioners should wear their identifying Commission name badges

2.4 An updated list of programs will be provided by Behavioral Health Services staff annually.

2.5 The Executive Committee and Behavioral Health Services will approve site visit schedule and attendees.

2.6 The site visit schedule will be done in collaboration with Behavioral Health Services upper management and with approval of the Director of Behavioral Health Services.

2.7 An annual site visit calendar will be created, by the Executive Committee, at the beginning of each year, and forwarded to the Behavioral Health Services Director for review and after to the full commission for approval.

2.8 The Executive Assistant, Chair and Vice Chair of the Mental Health Commission will confirm the appointment for the site visit, with the appropriate contact person and forward the confirmation to the attendees.

2.9 After the site visit, each attendee will complete the program observation form and forward the report to the Executive Committee and the Behavioral Health Services Director for review

2.10 Site visit attendees will adhere to the purpose of the site visit and the observation form, in an unbiased and respectful manner.

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The Mental Health Commission and Behavioral Health Services

Site visit purpose, policy and protocol

1. *MHC-Bylaws:*

Under the "General Provisions" article III, section 2 states the following:
"Mandated Roles and Responsibilities- 2.1 Mandates

a) ***Pursuant to Welfare and Institutions Code Section 5604.2 (a) and (b), as it may be amended from time to time by the Commission, they shall do the following:***
   1) ***Review and evaluate the County's mental health needs, services, facilities and special problems."***

2. *PURPOSE:*

Site visits provide an opportunity to review the community's mental health needs, the services being provided, and the program facilities and obtain a better understanding and knowledge regarding the County's services that are being provided. Mental Health Commissioners will identify potential areas for growth and make recommendations to Behavioral Health Services, with the objective to partner in improving and strengthening the lives of the residents of Contra Costa County.

3. *POLICY and PROTOCOL*:

a) Site visits scheduling and appointments will be coordinated, approved and made by the Behavioral Health Services Program Chief's or their designated staff, in conjunction with the Chair and Vice Chair of the Mental Health Commission.

b) Commissioners may only attend **authorized** site visits

c) Two Commissioners may attend a site visit, alongside a designated Behavioral Health Services staff member.

d) Requests for site visits must be made at least two weeks prior to the desired date. The request can be made via email to **Chair and Vice Chair of the Mental Health Commission** and they will forward the request to the Executive Assistant. The Executive Assistant will forward the request to the corresponding Program Chief.

e) The request should include the names of the Commissioners to be attending, the tentative desired date, the name and/or location of the facility to visit.

f) Each Commissioner is responsible for attending at least one site visit per year

g) Commissioners will wear their identifying Commission name badges during the site visit.

h) An updated list of programs will be provided by Behavioral Health Services staff annually.

i) The Executive Committee, at the beginning of each year, will forward a tentative calendar year with monthly desired facilities to visit to the Behavioral Health Services Director to be reviewed with both Program Chiefs.

j) A Behavioral Health Services staff member, will forward confirmation of the appointment to the Chair, Vice Chair and attendees.

k) After the site visit, each attendee will complete the program observation form and forward the report to the Executive Committee and the Behavioral Health Services Director for review.

l) Commissioners are to adhere to the Observation form. Any additional questions or concerns should be made separately, in writing, and submitted to the Chair and Vice Chair, to review with the Behavioral Health Services Director.

m) The Mental Health Commission, Behavioral Health Director, Deputy Director, Program Chief or management of the facility, has the right to refuse the attendance of anyone that behaves in a disrespectful manner or acts with malice to discredit the facility, its staff or the services being provided without evidence.

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MHC –SITE VISITS

In accordance to the Contra Costa County Mental Health Commission Bylaws, under the "General Provisions" article III, section 2 states the following:

"Mandated Roles and Responsibilities- 2.1 Mandates

a) Pursuant to Welfare and Institutions Code Section 5604.2 (a) and (b), as it may be amended from time to time by the Commission, they shall do the following:
    1) **Review and evaluate the County's mental health needs, services, facilities and special problems."**

As per the above statement regarding the Commission's mandate, it does not mention that Behavioral Health Services cannot set boundaries or the rules regarding site visits.

Standardization:

1) All scheduling/appointments for site visits must be coordinated and approved by the Behavioral Health Services Program Chief of Adult/Older Adult Services and the Program Chief of Children's, Teens and TAY and/or their designated staff.

2) Commissioners will not attend any further "impromptu" site visits and no more than three commissioners attending a site visit, preferably two.

3) The Program Chief will assign a staff member to host and attend the site visit

4) Requests for site visits will be sent to the designated site's management at least 1 week in advance for their approval, along with the names of the parties to be attending, a purpose for the visit and a copy of the protocol and observation form.

5) All Commissioners are to adhere to the observation form. Any additional questions will have to be made in advance and approved by the appropriate Program Chief and the Behavioral Health Services Director.

6) The Program Chief, Behavioral Health Director or the facility management have the right to refuse attendance of anyone that behaves in a disrespectful manner or acts with malice to discredit the services being provided to the community without evidence.

CONTRA COSTA COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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CONTRA COSTA COUNTY: DATA NOTEBOOK 2017
FOR CALIFORNIA
BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2017): 1,143,494

Website for County Department of Mental Health (MH) or Behavioral Health:

www.cchealth.org

Website for Local County MH Data and Reports:

www.cchealth.org

Website for local MH Board/Commission Meeting Announcements and Reports:

www.cchealth.org/mentalhealth/mhc/

Specialty Mental Health Data[1] from calendar year (CY) 2015: Table 1. Race/ethnicity detail for total Medi-Cal beneficiaries who received Specialty Mental Health services.

Table 1—Contra Costa MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	38,500	18.45%	3,878	29.33%
Hispanic	76,184	36.52%	3,230	24.43%
African-American	33,623	16.12%	3,131	23.68%
Asian/Pacific Islander	28,137	13.49%	866	6.55%
Native American	557	0.27%	55	0.42%
Other	31,622	15.16%	2,063	15.60%
Total	208,621	100%	13,223	100%

**The total is not a direct sum of the averages above it. The averages are calculated separately.*
The actual counts are suppressed for cells containing n ≤11.

[1] See county Mental Health Plan Reports at http://www.caleqro.com. If you have more recent data available for either calendar year or fiscal year, please feel free to update this section within current HIPAA compliant guidelines.

Supplemental County Data Page

Contra Costa County: 2008-2012 American Community Survey 5-year estimates[2,3]

Population (2010): 1,052,047

Adult population over 18: 791,701

Civilian veterans: 60,108 (7.6% of the adult population)

Total civilian noninstitutionalized population: 1,046,170

With a disability, all ages: 102,971 (9.8%)

Under 18 years with disability: 8,065 (3.1% of those within this age group)

Age 18-64 years with a disability: 49,585 (7.5% of those in this age group)

Total population age 65 years and older: 129,912 (12.3 % of total population).

Age 65 and older with a disability: 45,321 (34.9% of those in this age group)

Total households: 373,145 (100%) Population in households: 1,040,898 (98.5%)

Households with a member 65 years or over: 94,686 (25.4%)

Householder living alone, age 65 years and over: 34,104

Grandparents living with own grandchildren under 18 years: 24,881

Responsible for grandchildren: 7,644 (30.7% of those living with grandchildren)

Grandparents who are female: 4,670 (61.1%)

Grandparents who are married: 5,687 (74.4%)

Percentage of all families whose prior year income was below poverty level: 7.4%

Percentage of all persons living under the federal poverty level: 10.2%

Percentage of aged 65 and over with prior year income under poverty level: 6.4%

Statewide: of those age 65 and over, 10 % live below the federal poverty level.

[2] All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 1,052,047 in the year of the last U.S. census, 2010.

[3] http://www.labormarketinfo.ca.gov/file/census2012/contrdp2012.pdf, see pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc.

INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the “Data Notebook?”

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. The topic for our 2017 Data Notebook reviews behavioral health services and needs in the system of care for older adults. This topic follows our yearly practice of focusing on a different part of the behavioral health system.

The Data Notebook is developed each year in a work group process with input from:

- CA Mental Health Planning Council members and staff,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB/C),
- County Behavioral Health Directors Association of California (CBHDA) through both staff and individual county directors,
- Subject matter experts on the topic of the Data Notebook and stakeholders with lived experience.

Local mental health boards/commissions are required annually to review performance data for mental health services in their county and to report their findings to the California Mental Health Planning Council (CMHPC). To provide structure for the report and to make the reporting easier, each year the CMHPC creates a Data Notebook for local mental health boards/commissions to complete.

The Data Notebook structure and questions are designed to meet important goals:

- To assist local boards to meet their legal mandates[4] to review performance data for their county mental health services and report on performance every year,
- To serve as an educational resource on behavioral health data for local boards,
- To obtain opinion and thoughts of local mental health boards on specific topics,
- To identify unmet needs and make recommendations.

We encourage the members of all local mental health boards to participate in reviewing and developing the responses for this Data Notebook. This is an opportunity for the local boards and their public mental health departments to work together on critical issues. This process may help identify what is most important to your local board/commission and stakeholders and inform county leadership planning for behavioral health needs.

[4] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

After the Data Notebook reports are submitted to the CMHPC, staff compile the responses from the local boards/commissions so that the information can be analyzed to create a yearly report to inform policy makers, stakeholders and the general public. These Statewide Overview reports are posted at:

http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

Our goal is to promote a culture of data-driven quality improvement in California's behavioral health services and thereby to improve client outcomes and function. Data reporting helps provide evidence to support advocacy and good public policy.

This year, we present data and discussion for review of behavioral health services for older adults, which is organized in these four main sections:

1) An integrative view of "whole person care" for older adults in the overall system of care for behavioral health.

2) Discussion of demographics and challenges presented by expected increases in total number of older adults and increased needs for behavioral health services; we also want to know about different groups of older adults in order to promote appropriate outreach and engagement with services.

3) Conditions that can create barriers to accessing services (language, geographic or other social isolation, and disabilities, etc.) and therefore call for specialized attention and effort.

4) Data and information about the continuum of care for older adults with mental health and/or substance use treatment needs, including those providing care to dependent loved ones, those facing crises and/or significant changes in their ability to care for themselves.

How Do the Data Sources Define Older Adults?

It is common to refer broadly to adults age 60 and over as "older adults." However, discussions of data require precise definitions which differ depending on the information source and its purpose. Researchers may define age subcategories to describe psychological or biological[5] stages of development and aging, for example: the "young old" (60-75), the "medium old" (75-85), and the "older old" (86 and older). These categories are used widely in the mental health and medical literature, because the likelihood of frailty, chronic disease and disability increases across these age spans.

[5] Biological development loosely refers to the stages of physical, cognitive and emotional growth and aging.

Therefore, we keep these age groups in mind even though many state and federal data sources reduce the number of categories to simplify the statistical analysis.

Also, there are relatively few older adults receiving specialty mental health or substance use treatment services, so only broad categories of age are reported in some datasets to avoid the small numbers problem. Thus, we cannot always get data for all the categories desired, which affects not only age but race/ethnicity or other items.

Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the public data sources that are available to us. That means data reports on different topics use different age criteria to define older adults.

Resources: Where do We Get the Data?

We customize each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide data are provided for comparison for some items. Other issues are highlighted by information from research reports. County data are taken from public sources including state agencies. Special care is taken to protect patient privacy for small population counties by "masking" (redaction) of data cells containing small numbers. Another strategy is to combine several small counties' data (e.g., counties under 50,000 population).

Many questions in the Data Notebook request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. That information may be obtained from local county departments of behavioral health or mental health.

This year we present data from California Departments of Aging, Health Care Services (DHCS), the California External Quality Review Organization, the American Community Survey and other sources listed in Table 2. We also consulted the recent reports on the Older Adult System of Care by Drs. Janet Frank and Kathryn Keitzman at UCLA for their contract with the Mental Health Oversight and Accountability Commission.[6]

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[6] Frank JC, Kietzman KG, Damron-Rodriguez J, Dupuy D. *California Mental Health Older Adult System of Care Project: Proposed Outcomes and Indicators for Older Adult Public Mental Health Services.* UCLA Center for Health Policy Research. 2016, June 30. California Mental Health Older Adult System of Care Project: Proposed Outcomesand Indicators for Older Adult Public Mental Health Services. http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559

Table 2. Who Produces the Data and What is Contained in these Resources?

CA DHCS: Mental Health Analytics Services and Performance Outcomes Systems,[7] http://www.dhcs.ca.gov	Data for Specialty Mental Health Services provided for adults and youth with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI) funded by the Medi-Cal system. One unit analyzes the data for adults of all ages. A separate group analyzes data for services provided to Medi-Cal covered children/youth through age 20 (federally defined EPSDT[8] benefits).
CA DHCS: Office of Applied Research and Analysis (OARA)	Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the "Cal-OMS" data system.
CA Department of Aging	Administers programs and services for older adults in partnership with the federal government and federal funding. See www.aging.ca.gov for information.
External Quality Review Organization (EQRO), at www.CALEQRO.com	Annual evaluation of the data for services offered by each county's Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.
American Community Survey 5-year Estimates	The 2008-2012 ACS report is a detailed survey of communities based on the 2010 U.S. Census.
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: National Survey on Drug Use and Health (NSDUH), which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.
County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the "Measures Outcomes and Quality Assessment" (MOQA) database. Also used by counties to report some data for MHSA programs and outcomes.

[7] See: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.
[8] EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

HEALTHY AGING AND THE OLDER ADULT SYSTEM OF CARE

Social Supports and Community Engagement for Mental Health

These services are vital to mental health and sustaining recovery, as well as physical health and maintaining the functions of daily living. A number of services are available to support healthy aging in the community.

Examples of services for older adults include:

- Senior centers (social, exercise, special interest groups)
- Shuttle vans/Paratransit (transportation is a critical barrier for many across all age groups, but most especially for older adults with limited mobility).
- "Meals on Wheels" (programs and volunteers provide more than nutrition: brief socialization and a check on the person's welfare or wellness, etc.).
- "HiCAP:" counseling and information about insurance issues, often conducted by volunteers who are older adults trained to assist their peers in navigating confusing problems with insurance (including Medicare).
- Medicare Supplement information and support: may cover gym memberships, where available.
- In-Home Supportive Services (IHSS), which are services provided to allow one to remain in the community and live safely in their own home.
- Grief/Loss Support Groups (maybe supported by county MH or MHSA funds).
- Care Coordination (may also be provided by county MH and include information or help linking to specific services, financial supports, or insurance issues).

The above services are part of the social safety net and a foundation to promote the well-being and mental health of older adults living in the community. Because of the accumulated effect of personal losses, it is helpful to provide support for those experiencing grief, trauma, or depression in response to such losses.

County agencies also provide a variety of mental health and social supports to promote continued engagement of older adults with the larger community. The goals for older adults' mental health are to prevent profound isolation, depression, anxiety and to avoid re-triggering of trauma or serious mental health issues from one's earlier life.

California strives to provide coordinated care for behavioral health and physical health care. This objective can be more challenging to achieve for the older adults, due to complex health care needs and changes in the individual's life and family circumstances. Some have suggested a need for more collaboration between Aging program service providers and county behavioral health and social service programs as one way to help support an Older Adult System of Care (OASOC).

Integrated Health Care for Older Adults: Treating the Whole Person

The CA Department of Health Care Services has implemented the Whole Person Care (WPC) Pilot Program. WPC is a five-year program authorized under the Medi-Cal 2020 waiver. It coordinates physical health, behavioral health, and social services in a patient-centered manner, with the goals of improved member health and well-being through more efficient and effective use of resources. It is anticipated that the WPC Pilot Program will result in better health outcomes through enhanced comprehensive coordinated care provided at the local level. In late 2016, 18 counties were approved to participate and in March, 2017 more counties have applied.

1. Has your county applied or been approved to participate in the Whole Person Care Pilot Program?
   Yes ___ No ___

   If so, will older adults be served in your county's program? Yes ___ No ___

2. In a prior Data Notebook (2014), counties provided examples of efforts to ensure integrated physical health care with behavioral health care. Please check which services or activities your county provides for older adults.

   ____ Procedures for referral to primary care
   ____ Procedures for screening and referral for substance use treatment
   ____ Program or unit focused on the Older Adult System of Care (AOSOC)
   ____ Linkage to Federally Qualified Healthcare Center (FQHC) or similar
   ____Links to Tribal Health
   ____Case management/care coordination to other social services e.g., housing, CalFRESH, Meals on Wheels, In-Home Supportive Services (IHSS)
   ____ Health screenings, vital signs, routine lab work at Behavioral Health site
   ____Health educator or RN on staff to teach or lead wellness classes
   ____Training primary care providers on linking medical with behavioral health
   ____ Use of health navigators, *promotores,*[9] or peer mentors to link to services
   ____Other, please specify. ______________

[9] In the Hispanic/Latino community, these are health 'promoters' and representatives, who may also assist in navigating the complexities of the health care system.

DEMOGRAPHIC TRENDS : CHALLENGES FOR SERVICE ACCESS
Who are California's Older Adults?

> "Older Adults comprise a substantial portion of the people in California. In 2016, approximately 5.5 million Californians, or 14% of the population, were age 65 or older.[10]
>
> Of those, "approximately 1.6 million (30 per cent of California's total older adult population) was foreign-born."[5]

It's well-known that there are disparities in access to health services, especially behavioral health care. To help us plan outreach and services, we want to know the cultural and race/ethnicity backgrounds of California's older adults, among other characteristics. The table below provides some of this information.[11]

Table 3. Race/Ethnicity of Older Adults in CA age 65 and over, 2011

Race/Ethnicity	Age 65 to 74	Age 75 and Older	Total # of All Adults $\geq$ 65	Percent of All Adults $\geq$ 65
White, Not Hispanic	**1,398,928**	**1,295,788**	**2,694,716**	**61.3 %**
Asian, Not Hispanic	**333,396**	**261,954**	**595,350**	**13.5 %**
Black, Not Hispanic	**135,329**	**97,018**	**232,347**	**5.3 %**
All Others[12], Not Hispanic	**51,323**	**30,844**	**82,167**	**1.9 %**
Hispanic (any race)	**462,706**	**330,420**	**793,126**	**18.0 %**
Totals	**2,381,682**	**2,016,124**	**4,397,806**	**~ 100.0 %**

> "California's older adults will continue to grow more racially, ethnically, and culturally diverse. While 62 percent of older adults were White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities."[11]

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[10] California Department of Finance, Demographic Reports and Projections, 2017. www.dof.ca.gov.

[11] California State Plan on Aging – 2013-2017, California Department of Aging, www.aging.ca.gov.

[12] Due to statistical reasons regarding sampling, this report combined totals into "All Others, Non-Hispanic" for the following categories: American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Some Other Race, and Two or More Races. Due to rounding, percentages may not sum to 100 %.

How do We Plan for Future Needs in the Older Adult System of Care?

Most counties obtain data that forecasts population numbers for groups by age and race-ethnicity in order to plan for future needs. It is predicted that the numbers of older adults will surge, sometimes referred to as the "silver tsunami." Interdisciplinary and cross-agency collaboration at local, state, and federal levels will be essential.

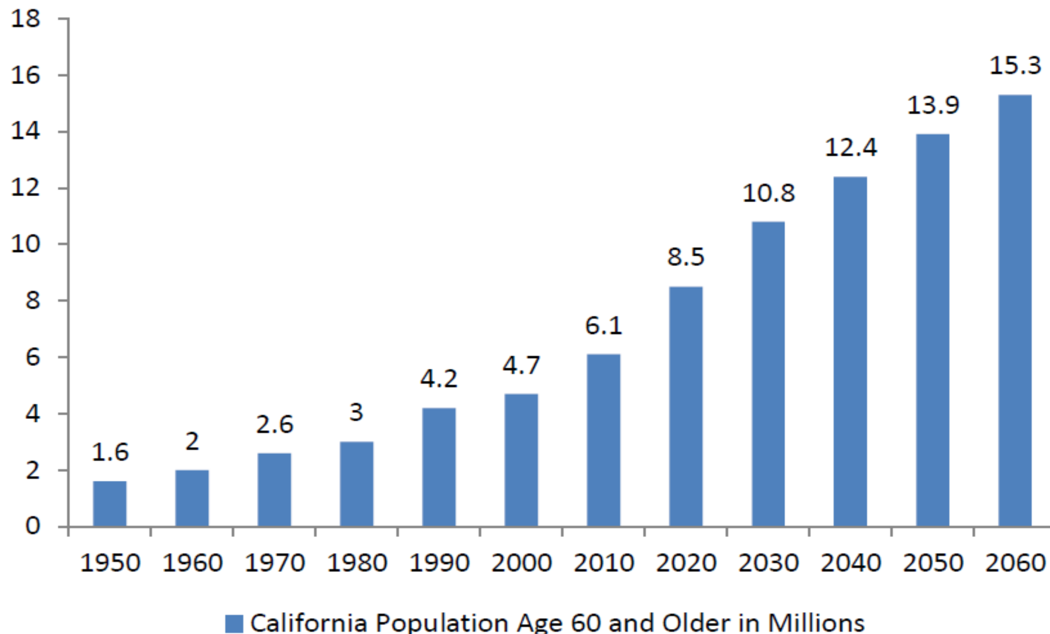

Figure 1. Projected Increases in Population Age 60 and over in California. [13]

Compare the predicted numbers for your county with those for the state:

	2010 Population age 60+	2030 Population age 60+	Per Cent Change over 20 years
Contra Costa County	**192,112**	**347,248**	**81 %**
California	**6,016,871**	**10,879,098**	**81 %**

3. Is your county doing any advanced planning to meet the mental health and substance use service needs of your changing older adult population in the coming years? Yes___ No___ If yes, please describe briefly.

[13] California State Plan on Aging 2013-2017, California Department of Aging, www.aging.ca.gov.

Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

Statewide, about 40% of adults age 65 or over have a physical or cognitive disability.

Table 4. Disability Status by Age and Sex in California, 2011

Age Group	Male		Female		Total	
	With a Disability	Percent of Age	With a Disability	Percent of Age	With a Disability	Percent of Age
Under 5	9,476	0.7%	9,977	0.8%	19,453	0.8%
5-17	167,058	4.8%	97,471	3.0%	264,529	3.9%
18-34	220,823	4.8%	169,127	3.7%	389,950	4.3%
35-64	723,401	10.2%	770,865	10.4%	1,494,266	10.3%
65-74	266,215	24.3%	306,784	24.2%	572,999	24.3%
75+	388,394	49.0%	623,855	54.3%	1,012,249	52.1%
Total	**1,775,367**	**9.7%**	**1,978,079**	**10.5%**	**3,753,446**	**10.1%**

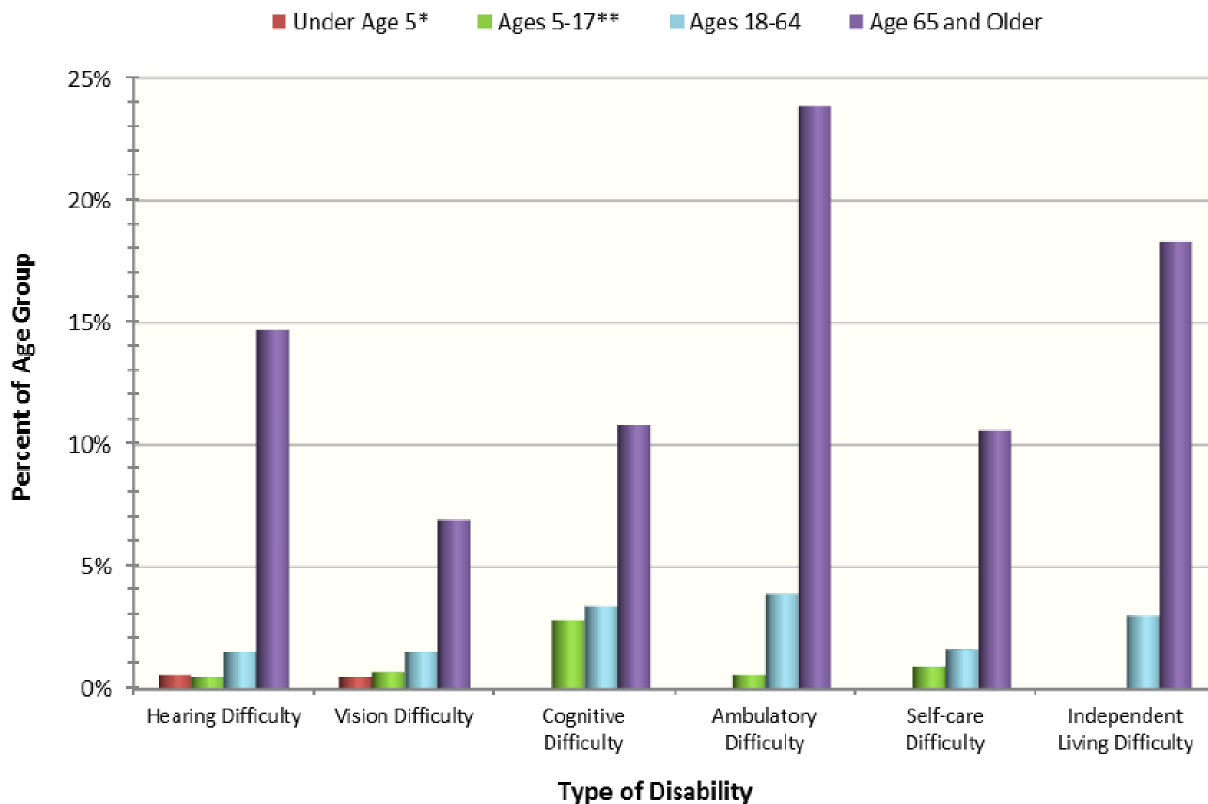

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Figure 2. Type of Disability in Different Age Groups in California (2011), above.

The data shown above only shows specific types of disability and does not account for co-occurring chronic illnesses such as heart disease, diabetes, hypertension, or conditions associated with chronic pain such as arthritis or other musculoskeletal disorders. Our mental health and well-being intertwine inseparably with the experience of physical disability and disease.

In your county, the data show:

Contra Costa County (2011): There were 129,912 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 45,321. That number represents 35 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

Next, we consider some data about the older adults that describe some challenges for mental health and well-being that also can present obstacles to accessing mental health services. These challenges include: living alone, in geographical isolation, in poverty or near poverty, disability status (SSI/SSP support indicator), whether the individual is from a historically underserved minority or cultural group, or communicates primarily in a language other than English.

The California Department of Aging prepared the following demographic projections[14] for 2016 for your county:

Contra Costa County (2016):

Age 60+: 241,196	Age 75+: 68,866
Nonminority:[15] 152,953	Minority:[16] 88,243
Low income: 88,150	Non-English proficient: 5,430
Medi-Cal: 31,0038	SSI/SSP (65+): 9,573
Lives alone (60+): 43,510	Geo-isolation (60+): 1,769

[14] California Department of Aging, 2015, www.aging.ca.gov.
[15] Using federal data guidelines, the Department on Aging defines "nonminority" as non-Hispanic Whites.
[16] The federal data guidelines used by the Department on Aging define "minority" as everyone else, that is, all race/ethnicities that are not Caucasian and are not Hispanic.

Limited English Proficiency is a Barrier for Behavioral Health Access

One major barrier for older adults' access to behavioral health care is the language spoken at home and whether the individual speaks English "less than well." Due to the state's historical origins and the large inflow of immigrants, California "is one of the most language-diverse in the nation,"[17] with more than 100 languages spoken.

One-third of older adults age 65 and over speak a language other than English at home, but about half of those (or one-sixth of elders) speak English "less than well." Many counties have difficulty finding behavioral health staff who speak Spanish, the language spoken most frequently in California besides English. Using translators (if available) or the telephone-based translation service can be awkward for addressing highly personal issues in mental health and substance use treatment.

Several counties have high rates (between 12 and 21 percent) of older adults who have difficulty communicating in English. These include Alameda, San Francisco, San Mateo, Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange, and Imperial counties.[5]

4. Are there groups in your county who are at significant risk of being unserved or underserved due to limited English proficiency?

   Yes___ No___

   If yes, please list the top three major language groups or communities in greatest need of outreach for behavioral health services in your county.

5. Describe one strategy that your county employs to reach and serve various cultural and/or race-ethnicity groups within your population of older adults?

6. Are there other significant barriers to obtaining services for older adults in your county? Yes___ No ___ If yes, please check all that apply.

   ___Transportation
   ___Geographic Isolation
   ___Lack of awareness of services
   ___Mobility issues due to co-occurring physical conditions or disabilities
   ___Lack of geriatric-trained practitioner

[17] http://www.dof.ca.gov/Reports/Demographic_Reports/documents/2011ACS_1year_Rpt_CA.pdf

BEHAVIORAL HEALTH: OLDER ADULTS CONTINUUM OF CARE

Substance Use Treatment for Older Adults: Barriers and Stigma

This section may be relevant only if your board has integrated co-occurring substance use disorders into its mission. If not, you may choose to skip this topic and question.

Addiction and late-onset alcoholism are more common for adults over the age of sixty than many think. Often the problem is invisible to the family or larger society, particularly if the person is not working, lives alone, or is a member of a social group that uses marijuana or drinks "recreationally." Some "baby boomers," now age 55 and over, grew up experimenting with drugs and have fewer reservations about drug use. Treatment of chronic pain conditions can lead to unintended misuse and addiction to narcotics or opiates. Some older adults are forgetful and may take their pills again or mix them with alcohol, and may become "accidental addicts." Depression and anxiety in older adults may lead to inappropriate "self-medication."[18]

Stigma, denial, lack of awareness, and nominally acceptable social use (e.g. alcohol, marijuana, prescription drugs) all play some role in both the problem and in the barriers to treatment for older adults. All these factors lead clients and family members to place considerable importance on effective strategies to identify, reach and engage older adults in substance use treatment that is specifically designed for older adults.

How large is the problem? National reports show that there are significant unmet needs for substance use disorder (SUD) treatment in older adults. Very few older adults enroll in SUD treatment, and yet the need is well-documented.

In the U.S. (2015) it was reported[19] that there were at least 1.7 million adults aged 50 or older who had both mental illness and SUDs in the past year. That number corresponds to 1.6 percent of all adults 50 and older. Of these, 57 percent received mental health care or SUD treatment at a specialty facility in the past year. Mental health care only was received by 47 percent of these, both mental health care and SUD treatment were received by 7 percent, but less than 4 percent received SUD treatment alone.

Next, we consider some data for older adults in California.

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[18] Addiction in Older Adults: Why It's Prevalent. What Can Be Done. – Hazelden. https://www.hazelden.org/web/public/document/older-adults-prescription-medication-abuse-addiction-generic.pdf

[19] Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (NSDUH). www.samhsa.gov. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, 2016.

Focus on Fifty-five (and over) in California: Analyses[20] of SUD services for clients age 55 and over yielded these findings for those admitted to treatment in FY 2014-2015.

- About 11,000 unique clients ages 55 and over were admitted to publically monitored SUD treatment. This age group accounted for only about 10% of total clients. Very few--about 80 clients--were age 75 or older.

- Most were admitted to the Outpatient Narcotic Treatment Program (NTP) -- maintenance service type (33%), or to the Outpatient Drug Free service type (27%). Residential Detoxification was next at 17%, and then Residential Treatment at over 16%.

- About 47% reported only drug (other than alcohol) problems, about 29% reported both alcohol and drug use, and 24% alcohol only.

- The top four drugs of abuse that are most commonly reported include heroin (35%), alcohol (34%), methamphetamine (almost 12%), and cocaine/crack over 6%). These four drugs accounted for 87% of substance use in adults over 55.

- For clients under 55, methamphetamine is the most commonly-reported drug.

Some SUD clients had co-occurring mental health disorders. Although the Cal-OMS-Tx data system does not collect DSM-V diagnoses, the clients were asked questions about mental health services received in the 30 days prior to entering treatment. Responses were taken as indicating likely mental health issues occurring in the prior 30 days.

- The combined percentages for clients reporting ER (emergency mental health use) or 24 hours or more psychiatric facility days are small: 3-4% range.

- About 24% reported psychiatric drug use. This is a concern because SAMHSA estimates the same 24% for all adults nationally (not just older adults).

Those SUD treatment clients, age 55 and over, with a co-occurring mental health condition were found to be somewhat less successful than other SUD clients on standard outcome measures. These outcome measures included primary drug abstinence, employment, stable housing, and participation in social support recovery days. Those with co-occurring disorders were also more likely to have been arrested.

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[20] Findings from the Cal-OMS Tx data system were provided by the Office of Applied Research and Analysis, California Department of Health Care Services. (Tx = treatment).

TABLE 5. Data below show how many older adults (age 55 +) received different types of SUD services relative to other age groups in your community and the state.

Your County: CONTRA COSTA

Number and Percent of Clients by SUD Treatment Type (FY 15-16)

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	20 7.72 %	98 37.84 %	61 23.55 %	80 30.89 %	259
Age 37-54	34 3.94 %	220 25.46 %	282 32.64 %	328 37.96 %	864
Age 26-36	12 1.25 %	306 31.97 %	317 33.12 %	322 33.65 %	957
Age 15-25	6 1.08 %	118 21.34 %	297 53.71 %	132 23.87 %	553

CALIFORNIA: Statewide

Number and Percent of Clients by SUD Treatment Type (FY 15-16)

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	3,005	3,674	3,363	2061	12,103
Age 37-54	8,395	7,340	16,475	9,148	41,358
Age 26-36	7,442	7,719	20,216	11,170	46,547
Age 15-25	3,555	2,974	18,467	6,014	31,010
Column TOTALS:	22,397	21,707	58,521	28,393	131,018

In the state and county data above, the age break for older adults was lowered to 55 because SUD problems in older adults may have roots in late middle age, with increased impairment in subsequent years. Examination of the data across many counties results in two key observations (among others possible):

- The number of adults age 55 and over who received SUD treatment of any type is generally much less than for other age groups, even though older adults represent an increasing share of the total population.

- In the majority of small counties with populations <100,000, there are relatively few options for types of SUD treatment besides outpatient treatment (non-NTP). The large number of “zeroes” shown under other types of treatment may indicate a disparity in access to those services.

7. One of our goals is to identify unmet needs for substance use treatment in older adults. Based on local community needs assessments or other reports, what substance use treatment services are available in your county for older adults?

   Please check all that apply.

   ___Outpatient NTP (narcotics treatment program (methadone, etc)

   ___Outpatient (non-NTP)

   ___Detoxification

   ___Residential Treatment

   ___Dual Diagnoses Programs

   ___Workforce licensed/certified to treat co-occurring MH and SUD disorders

   ___Safe housing options for clients working to be clean and sober

   ___SUD Treatment program designed for older military veterans

   ___Other, please specify.__________________

Mental Health Services for Older Adults[21]

Although our main focus here is on serious mental illness, we keep in mind that major depression shortens lives due to interactions with medical conditions and due to suicide. Untreated depression in older adults also increases the risk for developing dementia.

Major depression and anxiety disorders are the most prevalent mental health concerns in older adults in the U.S. Approximately 11 percent of older adults have anxiety disorders.[22] About 15-20 percent of older adults have experienced depression at some point.[23] Within one year (2015), about 4.8 percent (or 5.2 million) adults over 50 experienced a major depressive episode, and 62% of those experienced major impairment.[24] About 67% of those with major depression received treatment.[25]

Even mild depression lowers immunity and compromises a person's ability to fight infections and cancers.[23] Untreated depression results in worse disease progression and increased risk of death following a heart attack or stroke or in congestive heart failure.[25] Nearly half of all treatment for depression occurs in the primary care setting and often involves medication, but doctors report difficulty and long waits getting appointments for patients to speak with a therapist.

Many older adults experience cultural barriers that deter them from seeking treatment for behavioral health issues. However, the greatest barrier to accessing mental health services is financial and applies across the life span, including older adults. Those over age 65 rely on Medicare, which covers some outpatient mental health services (Part D). Some older adults have both Medicare and Medi-Cal coverage.

In the following pages, we examine Medi-Cal-funded Specialty Mental Health Services which are targeted for those with serious mental illness.

The total count of unique clients age 55 and over who received Specialty Mental Health Services was 69,087 in CY 2015; about 41% were male and 59% were female.

The Affordable Care Act (ACA) enabled 28% of these older adults (total 19,376) to access mental health services. Nearly all of those clients fell into the age group 55-69.

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[21] We express appreciation for the Specialty Mental Health Services data in this section, which were prepared by Behavioral Health Concepts, Inc. (the current External Quality Review Organization, EQRO) and were presented by Dr. Saumitra SenGupta to a committee meeting of the Planning Council on April 20, 2017. Data analysis and graphs were constructed by Rachel Phillips, M.S.

[22] American Psychological Association, 2005. http://www.apa.org/about/gr/issues/aging/mental-health.aspx

[23] Geriatric Mental Health Foundation, 2008.

[24] Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2015 National Survey on Drug Use and Health, 2016. http://www.samhsa.gov.

[25] Preparing for Mental Health Needs of Older Adults, by B. Forester, MD et al, webinar (2017), www.samhsa.gov.

The following data shows which age groups of older adults were most likely to receive Specialty Mental Health Services in CY 2015. Ages 55-69 account for the majority of older adults who received services. Of those, the age group 55-59 had the largest number of individuals who received services. Age 80 and over had the fewest services compared to the other categories of older adults.

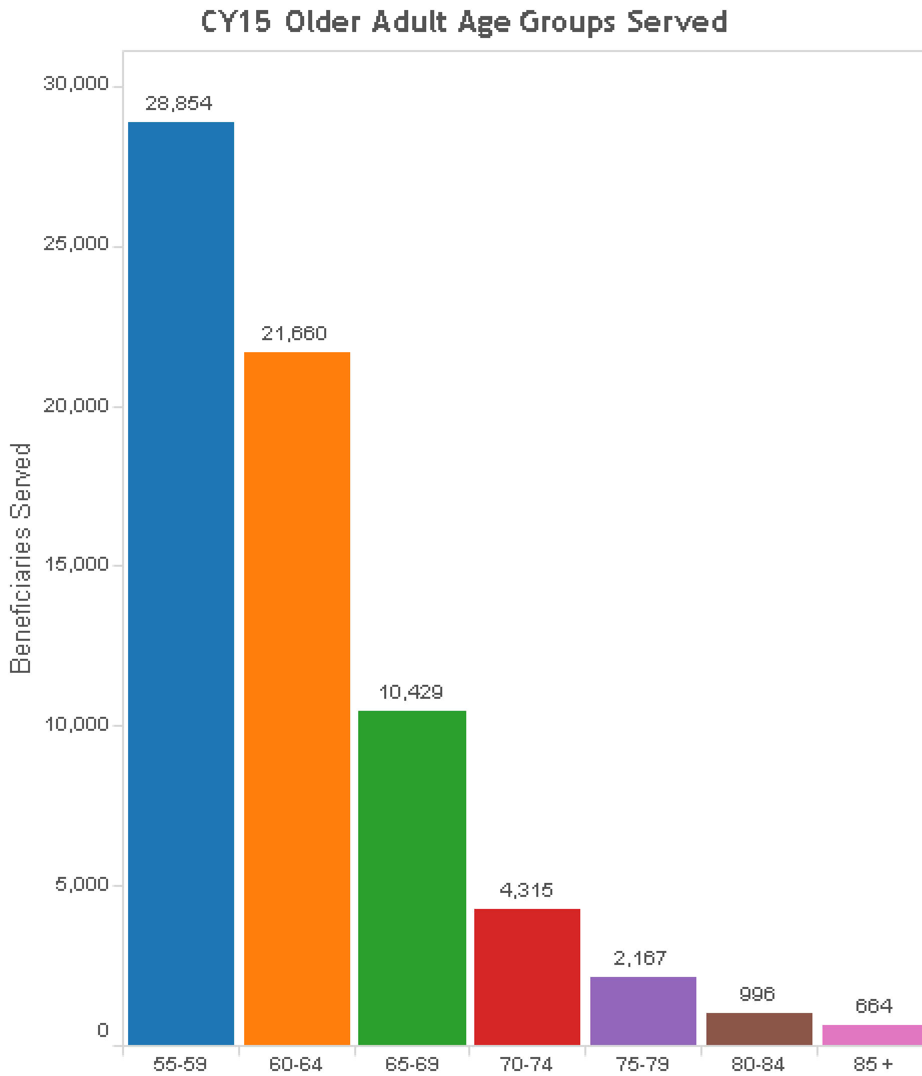

Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).

Older adult (age 55 and over) Specialty Mental Health clients were found in greatest numbers in L.A. County, followed by the Southern region and Bay Area counties, [26] as shown in the next figure. The Superior region had the lowest number of older adults who received these services, which reflects this region's composition of mostly small-rural and small-population counties spread over large geographic areas.

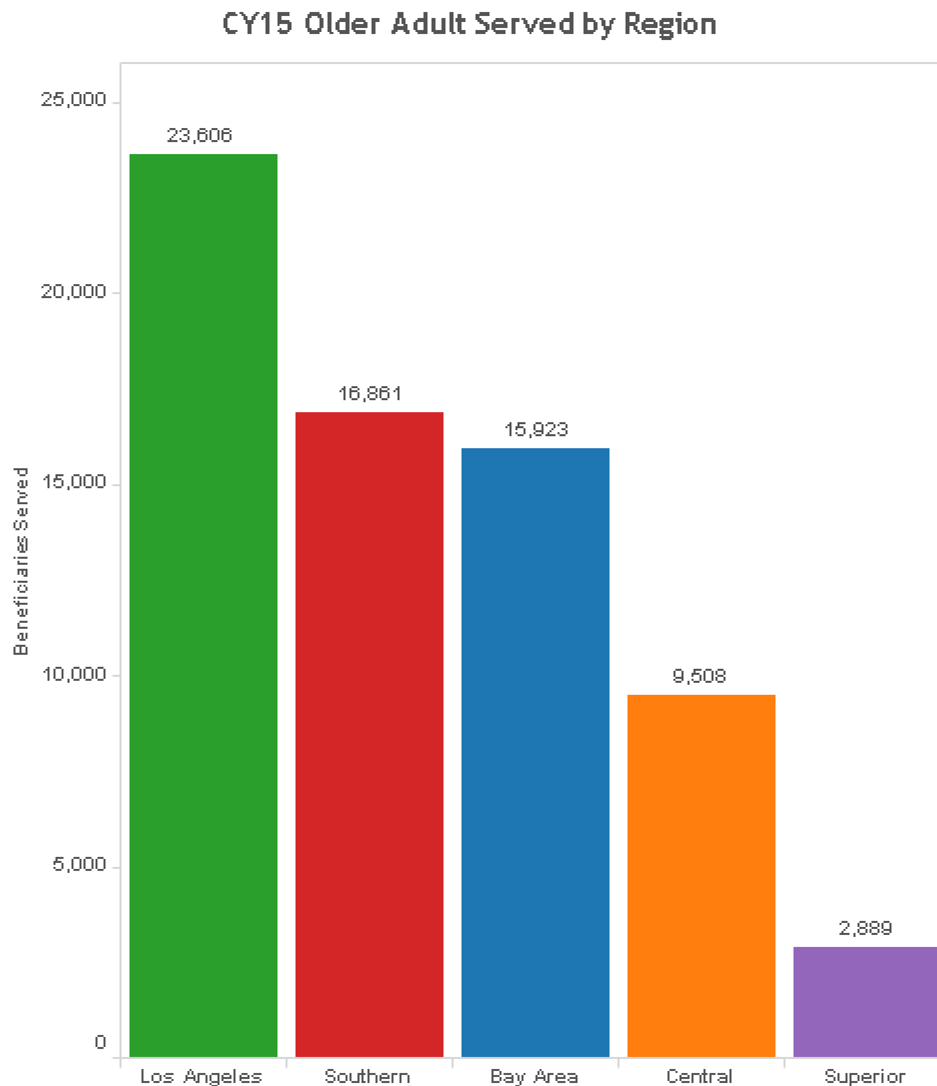

Figure 4. The numbers of persons in each region who received Specialty Mental Health Services ("beneficiaries", CY 2015). Los Angeles County is taken to be its own region.

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[26] Bay Area : Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma counties
Central region: Amador, Alpine, Calaveras, El Dorado, Fresno, Inyo, Kings, , Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tuolumne, Tulare, Yolo, Yuba counties
Superior Region: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity counties
Southern: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura.

Next, we present data to address how many older adults in each of the major race/ethnicity demographic groups received Specialty Mental Health Services. Data for older adults in five major race/ethnicity categories plus "Other"[27] are shown below.

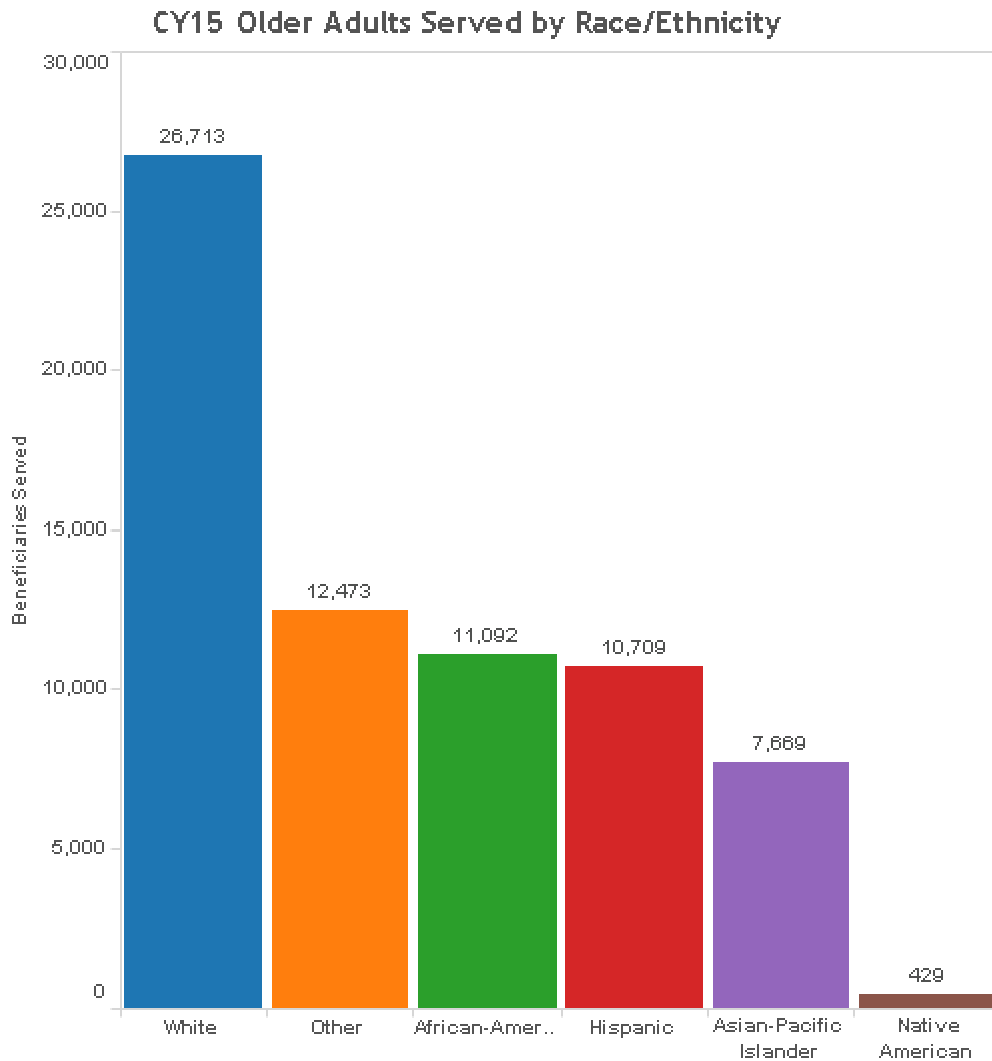
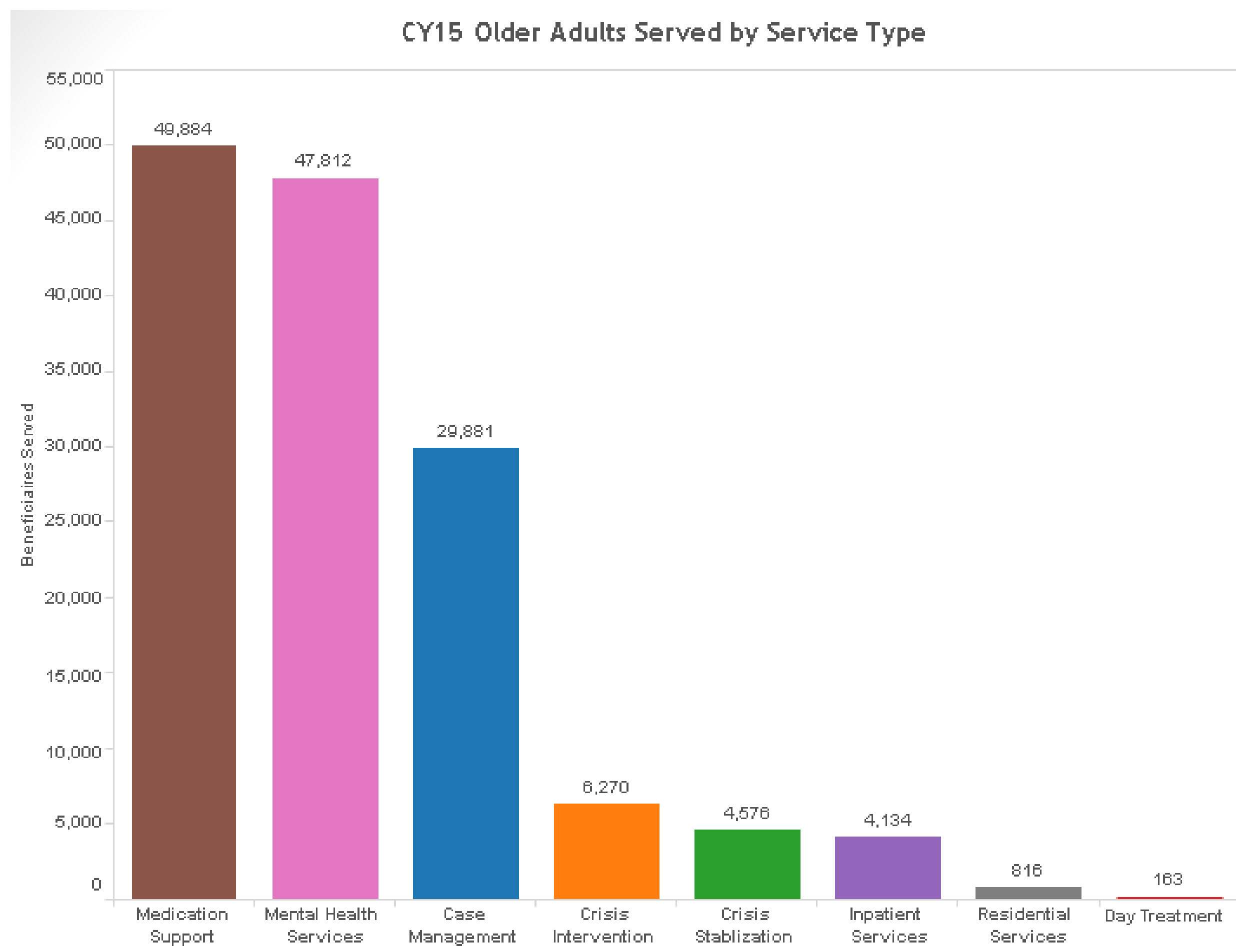


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group ("beneficiaries served").

[27] "Other" was defined to include the categories of one or more races, another category not given as an option, or those for whom this information was not supplied (therefore "unknown").

It is important to know the most common types of mental health services received by older adult clients. These data are shown in the figure below. The top three most frequent types of services were medication support, mental health services, and case management. The numbers of clients who received crisis intervention and crisis stabilization services are not very large, but these services are important in helping to avoid hospitalization and other expensive residential treatment services.

The least frequently-used services were day treatment, residential services, and inpatient services. However, these last three categories are the most expensive services to provide, based on the cost per individual claim for clients who needed those services. High-expense claims can strain county budgets when there is increased use.

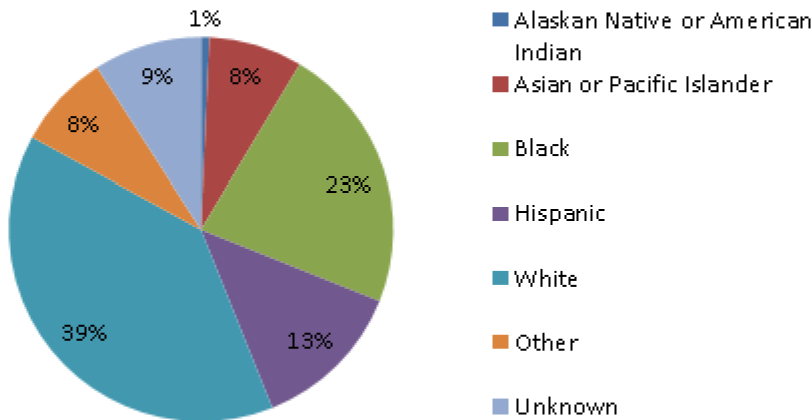


<u>Figure 6.</u> The most frequently used specialty mental health services are shown by the total number of older adults ("beneficiaries served") who received each type of service.

After reviewing the <u>statewide</u> data above, we now examine data from <u>your county</u> for adult and older adult clients served compared to all Medi-Cal certified eligible adults.

Demographic Data for Your County: Contra Costa (FY 2014-2015)

Top: Major race/ethnicity groupings of eligible adults who received one or more specialty mental health services during the fiscal year.



Below: Age Groups of Medi-Cal eligible adults who received one or more specialty mental health services during the fiscal year. Note the percentage for older adults.

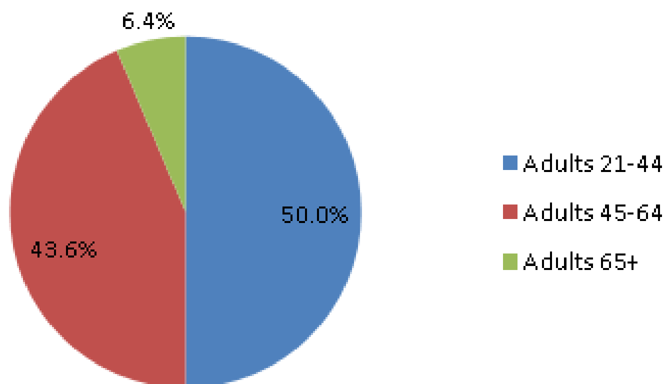


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).[28]

[28] See Performance Outcomes Reports for adults from California Department of Health Care Services , http://www.dhcs.ca.gov/services/MH/Pages/2016-Adult-Population-County-Level-Aggregate-Reports.aspx. Smaller counties with populations under 30,000 only list the numbers if they are within HIPAA privacy guidelines for data reporting. Redacted (or masked) data values are marked by the symbol "^".

Table 6. Data for your County: Contra Costa (FY 2014-2015)
Specialty Mental Health Service Visits (SMHS) and Service Penetration Rates

Top: Adults who received at least one SMHS visit during the year.

	Adults with 1 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	**10,434**	**150,354**	**6.9%**
Adults 21-44	5,218	75,874	6.9%
Adults 45-64	4,546	50,567	9.0%
Adults 65+	670	23,913	2.8%
Alaskan Native or American Indian	72	655	11.0%
Asian or Pacific Islander	821	28,066	2.9%
Black	2,344	25,812	9.1%
Hispanic	1,347	27,734	4.9%
White	4,071	42,134	9.7%
Other	834	16,631	5.0%
Unknown	945	9,322	10.1%
Female	6,049	86,271	7.0%
Male	4,385	64,083	6.8%

Bottom: Adults who received five or more SMHS visits during the year.

	Adults with 5 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	**6,622**	**150,354**	**4.4%**
Adults 21-44	3,054	75,874	4.0%
Adults 45-64	3,063	50,567	6.1%
Adults 65+	505	23,913	2.1%
Alaskan Native or American Indian	51	655	7.8%
Asian or Pacific Islander	560	28,066	2.0%
Black	1,409	25,812	5.5%
Hispanic	801	27,734	2.9%
White	2,675	42,134	6.3%
Other	462	16,631	2.8%
Unknown	664	9,322	7.1%
Female	3,855	86,271	4.5%
Male	2,767	64,083	4.3%

Notes: County data for Medi-Cal eligible adults ("certified") who received Specialty Mental Health Services during the year. The table at top shows numbers for those who received at least one service (one measure of "access"). The lower table shows how many adults received five or more services during the year (one measure of "engagement"). Take special note of data for "Adults 65+."

8. Based on either the data or your general experience in your county, do you think your county is doing a good job of reaching and serving older adults in need of mental health services?

   Yes___ No___

   If 'No,' then what strategies might better meet the MH needs of older adults?

Community Supports for Mental Health Emergencies and Crisis Services

Our understanding is that there are relatively few counties with crisis intervention or stabilization services with specialized training in helping older adults. Instead, they rely mainly on the adult system of care for all adults. In the CMHPC Statewide Overview Report[29] (2015), responses from a number of counties identified needs for crisis services specifically targeted to older adults.

9. Does your county have resources to provide mental health crisis services designed specifically to meet the needs of older adults?

   Yes___ No___ If yes, please check all that apply below.

   ___Mental health providers trained in MH needs of older adults

   ___Crisis Intervention Teams have someone trained in the needs of older adults

   ___Provide training and work more closely with law enforcement in handling MH crisis of older adults

   ___Crisis Drop-In Center with ability to serve older adults

   ___Services for older adults at risk for suicide

   ___23-Hour Crisis Stabilization Services for older adults

   ___Crisis residential treatment for older adults

   ___Psychiatric hospital or unit able to take older adults with complex medical needs, when mental health crises are too serious to be met by other services.

[29] CMHPC Statewide Overview Report on Behavioral Health in California, December 2015, http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

Mental Health Supports for Older Adults who Provide Care for Children or other Family Members

Grandparents may be the primary care providers for children due to a number of circumstances. For example, the state of California has programs and policies to increase efforts to identify relatives who can provide foster care by programs such as "KinCare." Placements may include grandparents, 'great-aunts' and/or 'grand-uncles' or other relatives. Some of these children have complex mental health and behavioral issues that involve systems for juvenile justice, substance use treatment, or special education services. Child welfare or other social services departments may have programs to provide supportive services to family relatives who provide foster care. We do not have data for foster children living with relatives to share with you.

However, the statewide data for grandparents who are responsible for children under 18 may be informative. In some cases, the child's parents are adults who also live in the household but for various reasons are not considered to be the responsible guardian.[6]

Table 7. Grandchildren Living with a Grandparent by Responsibility and Presence of the Parent (California, 2011)[6]

Grandparent Householder Responsibility for Own Grandchildren	Number	Percent
Responsible	310,107	40.0%
Parent Present	228,819	29.5%
No Parent Present	81,288	10.5%
Not Responsible	464,786	60.0%
Total	**774,893**	**100.0%**

The data for your county show:

<u>Contra Costa County</u> (2011):
Total persons age 65 years and older: 129,912 (12.3 % of total population).
Grandparents living with own grandchildren under 18 years: 24,881.
Grandparents responsible for grandchildren: 7,644 (which is 31% of the grandparents living with grandchildren under the age of 18.)

The stresses and demands experienced by elderly foster parents or grandparents also apply to another population of caregivers. Older adults may be the primary care providers for other adults: perhaps an adult child or an aging spouse. Such family members may have cognitive impairment, developmental delay, complex medical or mental health issues, or serious physical disabilities. These elderly caregivers may need emotional support, mental health services, respite care, or other assistive services. We do not have data for how many older adult caregivers are providing extensive care in their home for a close relative.

The following question focuses mainly on mental health or other supportive services for older adults who are the primary care providers for those under 18: most often grandchildren, grandnieces/nephews, or other 'kinfolk' or relatives. However, if you wish, you may also include services or programs that assist older adults who provide extensive care for a dependent adult family member.

10. Does your county have specific services or programs to support older adults who provide extensive care for dependent family members, so that caregivers can meet their own mental health and other needs?
    Yes___ No___

    If yes, please check all that apply below.

    ___Group therapy or support groups

    ___Counseling/parenting strategies

    ___Respite care services

    ___In-home supportive services (IHSS)

    ___Stress management program

    ___Mental health therapy, individual

    ___Other, please specify: _____________.

Significant Changes in Behavioral/Cognitive Function in Older Adults

This section builds on the continuum of care for older adults experiencing urgent mental health conditions who exhibit a sudden change in their behavioral health and ability to care for themselves. Planning Council stakeholder discussions identified major concerns about experiences with mentally ill (but stable) older adult family members who exhibit a sudden worsening or new behavioral and cognitive symptoms.

These conditions may present diagnostic challenges for professional care providers to tell the difference between severe depression, early dementia, or medical delirium related to change in physical or medical condition (including prescription medication issues). The diagnosis will (1) differentiate those clients who need primarily mental health services from other types of services, and (2) those who have medical or cognitive issues that interfere with the tasks of daily living and self-care.

Major depression affects up to 20 percent of elderly adults, some of whom may exhibit "pseudodementia:" cognitive impairment arising from the depressive disorder itself.

Delirium is an acute confusional state caused by an underlying medical disorder which usually resolves promptly in response to medical treatment. Delirium may be experienced by10-30 percent of hospitalized elderly patients.

Dementia manifests in gradually increasing cognitive impairment, memory problems, and difficulty coping with the ordinary functions of daily life.

Evaluation of elderly patients includes their baseline ability to perform the normal activities of daily living (ADLs). "ADLs relate to personal care including bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating."[30] Other functions, called instrumental activities of daily living (IADLs), include preparing food, managing finances, grocery shopping, using a telephone, and doing housework.[21]

Distinguishing between mental illness, depression, or early dementia in elderly patients is critical to ensure referral to the most appropriate agency or provider to get the right care. Prompt assessment is essential to avoid overwhelming departments of behavioral health with individuals who would be better served by other agencies or by medical specialists in dementia-focused care.

The information in the table below is presented to inform patients and families and to help facilitate conversations with professional care providers who have expertise in making these determinations and planning treatment.

Table 8. Characteristics of Depression, Delirium and Dementia[27]

[30] American Medical Association Journal of Ethics, June 2008, Volume 10, Number 6, pages 383-388, downloaded from http://journalofethics.ama-assn.org/2008/06/cpr11-0806.html.

	Depression	**Delirium**	**Dementia**
Onset	Weeks to Months	Hours to Days	Months to Years
Mood	Low/Apathetic	Fluctuates	Fluctuates
Course	Chronic; responds to treatment	Acute: responds to treatment	Chronic, with deterioration over time
Self-Awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of Daily Living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, become impaired as disease progresses
Instrumental Activities of Daily Living (IADLs)	Maybe intact or impaired	May be intact or impaired	May be intact early, but impaired before ADLs as the disease progresses.

As part of their Older Adult System of Care, some county Departments of Behavioral Health have a division (e.g. San Mateo, Orange) or may contract with a provider, (e.g. Gardner in Santa Clara) for outreach and services to older adults with chronic mental illness, some of whom are homebound or have limited mobility for travel to a care provider. These programs may help keep the client out of a mental health facility or hospital. When the time comes, clients who display increasing physical frailty or cognitive impairment may be helped with care coordination or linkages for transition to an assisted care facility more appropriate to their changing needs. Counties may address such problems in a variety of ways.

11. Does your county have a special program(s) to address the needs of older adults with chronic mental illness who also begin to be affected by mild cognitive impairment or early dementia? Yes___ No___

    If yes, please provide one example.

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

Peer counselors are individuals with "lived experience" in the experience of recovery from mental illness and/or substance use disorders. These individuals receive specific training in the scope of their role and how to be effective at helping others who are on the road to recovery. Health navigators are a specific type of peer counselor that helps people navigate the health care system and may provide information about other services which are available, such as food, housing, or medical care. Clients and family members of clients may participate in this type of work, depending on their past experience and personal skills.

12. Does your community train and/or utilize the skills and knowledge of older adults as peer counselors, and/or health navigators? Yes___ No___

    If yes, then please provide one example of how this occurs.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

___ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

___MH Board completed majority of the Data Notebook

___ County staff and/or Director completed majority of the Data Notebook

___ Data Notebook placed on Agenda and discussed at Board meeting

___ MH Board work group or temporary ad hoc committee worked on it

___ MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

___Other; please describe: ____.

(b) Does your Board have designated staff to support your activities?

Yes___ No___

If yes, please provide their job classification ___________________

(c) What is the best method for contacting this staff member or board liaison?

Name and County: ___________________________________

Email____

Phone #____

Signature: ____

Other (optional): _____________________________________

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: ____________________________________

Email: ____

Phone #____

Signature: ____

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.ca.gov .

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413