

Contra Costa County Mental Health Services Act Community Forum

Community Program Planning Process for the
Fiscal Year 2018-19 MHSA Three Year Plan
Update



Mental Health Services Act (MHSA)

- Proposition 63 voted into law in November 2004 by California's citizens.
- Taxed 1% of income over \$1 million.
- Provides additional funding to the County's existing public mental health system of care.
- Services are to be consumer driven, family focused, based in the community, culturally competent, and integrated with other appropriate health and social services.
- Requires that a three year program and expenditure plan be developed with the active participation of local stakeholders in a community program planning process.



Updating the MHSA Three Year Program and Expenditure Plan

- Contra Costa's current Three Year Plan was approved by the Board of Supervisors starting July 2017
- Preceded by a comprehensive community program planning process
- Over 400 consumers, family members, service providers and other interested individuals participated in the planning that identified service needs, and offered strategies for meeting these needs.
- **Today we are asking for your input as we prepare for the FY 18-19 Three Year Plan Update starting July 2018.**

Current MHSA Three Year Plan

For Fiscal Year 2017-18 the Three Year Plan set aside \$51.6 million for over 80 programs and plan elements in the following five components:

- Community Services and Supports – \$37.6 million for children with serious emotional disturbance and adults with serious mental illness
- Prevention and Early Intervention - \$8.7 million for services to prevent mental illness from becoming severe and debilitating
- Innovation - \$2.1 million for new or different patterns of service that can be subsequently added into the system.
- Workforce Education and Training - \$2.5 million to recruit, train and retain CCBHS County employees and contract staff.
- Capital Facilities/Information Technology - \$650,000 toward implementing an electronic mental health record system.

The full Three Year Plan is on the MHSA web page.



What Input do We Need From You Today?

We would like input from you in three areas:

- Discuss current mental health topics in the community, and strategies to address these issues
- Identify new and/or emerging public mental health needs and recommended strategies for meeting these needs.
- Prioritize previously identified service needs

Service Needs (1)

- Finding the right services when you need it
- Getting quality care in my culture, in my language
- Outreach and engagement to underserved populations
- Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care
- How to better connect mental health service providers with the community
- Getting to and from services

Service Needs (2)

- Improved response to crisis and trauma
- More housing and homeless services
- Assistance with meaningful activity
- More support for family members and loved ones of consumers
- Support for peer and family partner providers

Service Needs (3)

- Serve those who are the most compromised by mental health issues
- Children and youth in-patient and residential beds
- Care for the homebound frail and elderly
- Intervening early in psychosis
- Increased psychiatry time

New and/or Emerging Needs

What community mental health service needs have not been mentioned?

How You Can Provide Input

- Participate in today's discussions
- Provide verbal and/or written input to Contra Costa Behavioral Health Service representatives
- Participate in CCBHS sponsored stakeholder committees and workgroups
- Send email to mhsa@hsd.cccounty.us

What Happens After Today

- Community input informs draft Plan Update JAN
- Draft MHSA Plan Update for FY 18-19 developed FEB
- Draft Plan Update posted and circulated for stakeholder and 30 day public comment MAR
- Mental Health Commission hosts a public hearing APR
- Draft Plan summarizes, analyzes and responds to any substantive written recommendations for revisions MAY
- Board of Supervisors reviews and approves the final Plan Update for FY 18-19 JUN

Today's Agenda

2:30 – Registration, meet and greet

3:00 – Welcome, overview of MHSA and the Community Planning Process

3:30 - Introduction to your community's service providers

3:45 - Small group discussions on selected mental health topics

4:45 – Summary and next steps

5:00 – Optional input invited

- Provide public comment
- Apply your dots to prioritize service needs
- Provide written input
- Speak with CCBHS staff
- Evaluate today's event

Reasonable Accommodations: Spanish translation, gift cards available upon request



Today's Mental Health Topics

- 1.
- 2.
- 3.
- 4.
- 5.

Mental Health Service Needs

- Finding the right services when you need it

- Getting quality care in my culture, in my language

- Outreach and engagement to underserved populations

- Better coordination of care between providers of mental health, substance use disorders, homeless services and primary care

- How to better connect mental health service providers with the community

- Getting to and from services

- Improved response to crisis and trauma

- More housing and homeless services

Mental Health Service Needs

- Assistance with meaningful activity

- More support for family members and loved ones of consumers

- Support for peer and family partner providers

- Serve those who are the most compromised by mental health issues

- Children and youth in-patient and residential beds

- Care for the homebound frail and elderly

- Intervening early in psychosis

- Increased psychiatry time

- Other service needs (please list):



Contra Costa County Behavioral Health Services invites you to participate in planning for the:

Mental Health Services Act Three Year Program and Expenditure Plan Update for Fiscal Year 2018-19

Consumers and their family members, providers of mental health services, and all interested community members are most welcome to attend this community event and provide input on improving public mental health services in Contra Costa County.

Date:	Thursday, October 5th
Time:	2:30 P.M. – 5:30 P.M.
Location:	Richmond Memorial Auditorium 403 Civic Center Plaza, Richmond, CA 94804

Please Join Us!

Meeting Objectives:

- ❖ *Meet and dialogue with mental health service providers in your community*
- ❖ *Discuss important mental health issues affecting your community*
- ❖ *Review the Mental Health Services Act Three Year Plan*
- ❖ *Prioritize service needs and propose new and emerging strategies*

Please RSVP to this event by email or telephone:

mhsa@hsd.cccounty.us

925-957-5150

Please let us know if you would like assistance with the following:

- ❖ *Language translation, such as a Spanish speaking interpreter*
- ❖ *Directions and/or how to access public transportation*
- ❖ *Gift card to offset cost of participation*
- ❖ *Any other reasonable accommodation*





Los Servicios de Salud del Comportamiento del Condado de Contra Costa lo invitan a participar en la planificación para la:

Actualización del Plan de Gastos y Programa Trienal conforme a la Ley de Servicios de Salud Mental (MHSA) para el año fiscal 2018-19

Los consumidores y sus familiares, proveedores de servicios de salud mental, y todos los miembros de la comunidad interesados están invitados a asistir a este evento comunitario y a brindar comentarios acerca de las formas de mejorar los servicios públicos de salud mental en el Condado de Contra Costa.

Fecha:	Jueves 5 de Octubre
Hora:	2:30 P. M. – 5:30 P. M.
Ubicación:	Richmond Memorial Auditorium 403 Civic Center Plaza, Richmond, CA 94804

¡Participe!

Objetivos de la reunión:

- ❖ *Conocer y dialogar con prestadores de servicios de salud mental de su comunidad*
- ❖ *Conversar sobre importantes problemas de salud mental que afectan a su comunidad*
- ❖ *Analizar el Plan Trienal conforme a la Ley de Servicios de Salud Mental*
- ❖ *Priorizar las necesidades de servicio y proponer estrategias nuevas y emergentes*

Por favor, confirme su asistencia a este evento por correo electrónico o por teléfono:

**mhsa@hsd.cccounty.us
925-957-5150**

Háganos saber si necesita asistencia para:

- ❖ *Servicios de traducción, como un intérprete de español*
- ❖ *Instrucciones para llegar al lugar y/o para acceder al transporte público*
- ❖ *Tarjeta de regalo para compensar el costo de la participación*
- ❖ *Cualquier otra adaptación razonable*





Contra Costa County Behavioral Health Services invites you to participate in planning for the:

Mental Health Services Act Three Year Program and Expenditure Plan Update for Fiscal Year 2018-19

Consumers and their family members, providers of mental health services, and all interested community members are most welcome to attend this community event and provide input on improving public mental health services in Contra Costa County.

Date:	Wednesday, October 25th
Time:	2:30 P.M. – 5:30 P.M.
Location:	Vicente Martinez High School 925 Susana Street, Martinez, CA 94553

Please Join Us!

Meeting Objectives:

- ❖ *Meet and dialogue with mental health service providers in your community*
- ❖ *Discuss important mental health issues affecting your community*
- ❖ *Review the Mental Health Services Act Three Year Plan*
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Fecha:	Miércoles 25 de Octubre
Hora:	2:30 P. M. – 5:30 P. M.
Ubicación:	Vicente Martinez High School 925 Susana Street, Martinez, CA 94553

¡Participe!

Objetivos de la reunión:

- ❖ *Conocer y dialogar con prestadores de servicios de salud mental de su comunidad*
- ❖ *Conversar sobre importantes problemas de salud mental que afectan a su comunidad*
- ❖ *Analizar el Plan Trienal conforme a la Ley de Servicios de Salud Mental*
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Mental Health Services Act Three Year Program and Expenditure Plan Update for Fiscal Year 2018-19

Consumers and their family members, providers of mental health services, and all interested community members are most welcome to attend this community event and provide input on improving public mental health services in Contra Costa County.

Date:	Thursday, December 7th
Time:	2:30 P.M. – 5:30 P.M.
Location:	Brentwood Community Center 35 Oak Street, Brentwood, CA 94513

Please Join Us!

Meeting Objectives:

- ❖ *Meet and dialogue with mental health service providers in your community*
- ❖ *Discuss important mental health issues affecting your community*
- ❖ *Review the Mental Health Services Act Three Year Plan*
- ❖ *Prioritize service needs and propose new and emerging strategies*

Please RSVP to this event by email or telephone:

mhsa@hsd.cccounty.us

925-957-5150

Please let us know if you would like assistance with the following:

- ❖ *Language translation, such as a Spanish speaking interpreter*
- ❖ *Directions and/or how to access public transportation*
- ❖ *Gift card to offset cost of participation*
- ❖ *Any other reasonable accommodation*





Los Servicios de Salud del Comportamiento del Condado de Contra Costa lo invitan a participar en la planificación para la:

Actualización del Plan de Gastos y Programa Trienal conforme a la Ley de Servicios de Salud Mental (MHSA) para el año fiscal 2018-19

Los consumidores y sus familiares, proveedores de servicios de salud mental, y todos los miembros de la comunidad interesados están invitados a asistir a este evento comunitario y a brindar comentarios acerca de las formas de mejorar los servicios públicos de salud mental en el Condado de Contra Costa.

Fecha:	Jueves 7 de Diciembre
Hora:	2:30 P. M. – 5:30 P. M.
Ubicación:	Brentwood Community Center 35 Oak Street, Brentwood, CA 94513

¡Participe!

Objetivos de la reunión:

- ❖ *Conocer y dialogar con prestadores de servicios de salud mental de su comunidad*
- ❖ *Conversar sobre importantes problemas de salud mental que afectan a su comunidad*
- ❖ *Analizar el Plan Trienal conforme a la Ley de Servicios de Salud Mental*
- ❖ *Priorizar las necesidades de servicio y proponer estrategias nuevas y emergentes*

Por favor, confirme su asistencia a este evento por correo electrónico o por teléfono:

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- ❖ *Cualquier otra adaptación razonable*





Consumer Satisfaction Data Collection Efforts
Ann Isbell, PhD, Planner/Evaluator

Consolidated Planning Advisory Workgroup
August 3, 2017

CURRENT EFFORTS

- State Consumer Perception Surveys
- County Improvement Surveys
- County Focus Groups

CONSUMER PERCEPTION SURVEY

- **WHAT:** Satisfaction rated on 7 domains
 - General Satisfaction, Access, Participation in Treatment, Quality and Appropriateness, Outcomes, Functioning, & Social Connectedness
- **WHO:** Consumers and caregivers of youth consumers accessing outpatient mental health services
 - County-operated clinics, community-based organizations, & contracted providers

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CONSUMER PERCEPTION SURVEY, cont.

- **WHEN:** Twice a year
 - May 15-19, 2017
- **HIGHLIGHTS:** Percentage who strongly agree/agree

Domain	Youth (N=414)	Parents (N=487)	Adults/Older Adults (N=301)
General Satisfaction	78%	87%	83%
Access	83%	94%	72%
Participation in Treatment	72%	91%	69%
Quality & Appropriateness	87%	96%	71%
Outcomes	53%	62%	55%
Functioning	55%	64%	66%
Social Connectedness	79%	88%	63%

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CONSUMER PERCEPTION SURVEY, cont.

- HIGHLIGHTS: Cultural Competence
 - 97% received services in their preferred language
 - 96% received written materials in preferred language
 - 92% agreed their provider was “respectful and supportive of my culture, values, beliefs, life ways, and lifestyle (this includes race, religion, language, gender/gender expression, sexual orientation, or disability)”

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IMPROVEMENT SURVEY

- WHAT: County-designed surveys collect data on current quality improvement efforts
 - 2016 – Appointment Attendance, Transportation, Communication
 - 2017 – Welcome Handbook, Perceptions of Staff, Waiting Room Environment
- WHO: Consumers and caregivers accessing services at County-operated clinics
- WHEN: Consumer Perception Survey Period

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IMPROVEMENT SURVEY, cont.

- HIGHLIGHTS: 2016 (N=601)
 - Barriers to Appointment Attendance: 54% forgot, 32% lack of transportation
 - Most common modes of transportation to appointments – family/caregiver drives, consumers drive themselves, and use bus
 - Satisfaction with Information and Materials: 78% of consumers and 80% of caregivers reported satisfaction

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IMPROVEMENT SURVEY, cont.

- HIGHLIGHTS: 2017 (N=290)
 - Important in a Welcome Handbook
 - Easy to understand language, how to access services, contact information, & description of services
 - Perception of Staff
 - 90%+ of consumers and caregivers agree that staff treat them with respect, talk in terms they understand, show care and concern, & are friendly and polite
 - Waiting Rooms
 - Clean and safe, but could improve on reading materials

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FOCUS GROUPS

- WHAT: Facilitated group discussions
- WHO: Adult consumers and caregivers of youth consumers at County-operated clinics
- WHEN: August – October 2016; TBD 2017
- HIGHLIGHTS: 2016 (N=27 consumers, 21 caregivers)
 - What is Contra Costa Mental Health doing to help you achieve your goals and make progress?
 - Received Needed Services, Individual Therapy / Counseling, Peer Provider Support, Quality Staff

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FOCUS GROUPS, cont.

- HIGHLIGHTS: 2016
 - What else can Contra Costa Mental Health do to help you achieve your goals and make progress?
 - More Social Activities / Groups, Education on Medications, Educate on How to Advocate, Transportation Support, Educate Other Agencies on Mental Health, More Case Management / Therapy
 - How can we better communicate services and programs offered by the mental health system?
 - Written Materials, Staff Provide Information on Services

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USE OF DATA

- Pilot Welcoming Packet materials
- Compiling transportation resources
- Pilot with SPIRIT interns the role of peers in the waiting room

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QUESTIONS



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**May 2017
MHSIP
Consumer
Satisfaction
Report**

Contra Costa
Behavioral Health
Services

Research & Evaluation Unit

May 2017



Executive Summary

From May 15th to May 19th, 2017, consumers who accessed services at Contra Costa County outpatient mental health clinics completed consumer satisfaction surveys. The California Department of Health Care Services selected four different Mental Health Statistics Improvement Project (MHSIP) surveys to assess consumer satisfaction: Adult Survey (consumers 18-59 years); Older Adult Survey (consumers 60+ years); Youth Survey (consumers 13-17 years); and Parent-Caregiver Survey (caregivers of consumers 0-17 years). The survey instruments included closed-ended and open-ended questions; collecting demographic information, service history, health status, and consumer satisfaction across several domains, including:

- General Satisfaction
- Access
- Participation in Treatment
- Quality and Appropriateness
- Outcomes
- Functioning
- Social Connectedness.

Data from the four surveys were aggregated into two groups for analysis: Adults (Adult and Older Adult surveys) and Youth (Youth and Parent-Caregiver surveys). A total of 1,233 surveys (332 Adult and Older Adult Surveys and 901 Youth and Parent-Caregiver Surveys) were completed.¹ The demographic profile of the sample can be summarized in the following way:

- A small majority of the respondents were male (51%), while 48% of the respondents were females and 1% of respondents selected “other” when identifying their gender²;
- Most of the surveys completed (59%) were about children ages 15 and younger receiving mental health services; 22% of surveys were about transitional age youths (16-25 years old); 16% of surveys were about adults ages 26 to 59; and 5% of surveys were about older adults ages 60 and older.
- Approximately two out of every five respondents (41%) identified as Hispanic/Latino; the remaining 59% of respondents included: 21.5% Black/African-American; 17% White/Caucasian; 11% Multi-Racial (non-Hispanic); 6% ‘Other Race;’ 2% Asian-Pacific Islander; and 1.5% Native American/Alaskan Native.
- The majority of surveys were completed in English (85.5%), with 14.5% being completed in Spanish;
- Parents/Caregivers of youth (ages 0-17) completed a majority of surveys (40%); a third of the respondents completed the Youth survey; 23% completed the Adult survey; and just 4% completed the Older Adult survey (ages 60 and older).
- More than half (56%) of all respondents reported that they had been receiving mental services at Contra Costa Behavioral Health Services for one year or less.

¹ This is a convenience sample. The results are not necessarily representative of the entire population of consumers accessing mental health services at Contra Costa County Behavioral Health Services and affiliated clinics.

² MHSIP questionnaires, which are designed by a national consortium and approved by the California Department of Health Care Services, ask respondents: “What is your gender?” and offer three options as responses: “Female,” “Male,” or “Other.” Clients utilizing behavioral health services at Contra Costa County outpatient mental health clinics complete registration paperwork that includes gender, with two response options offered: female and male.

Survey results show high satisfaction scores consistent with results from the past several years. The average domain scores for **all** respondents were 4.3 overall; including 4.5 for *Quality and Appropriateness*, 4.4 for *General Satisfaction*, 4.4 for *Access*, 4.3 for *Participation in Treatment Planning*, 4.2 for *Social Connectedness*, 4.0 for *Functioning*, and 4.0 for *Outcomes*. Comparing average domain scores by the different survey types, children and youth (or their parents/caregivers) ages 17 and younger generally rated satisfaction higher in all domains except for *Participation*, *Outcomes*, and *Functioning* which had equivalent composite scores from adults ages 18 and older. Specifically, average domain scores for children/youth/parents ranged from a high of 4.6 for *Quality and Appropriateness*, to 4.5 for *Access*, to 4.4 for *General Satisfaction*, to 4.3 for both *Social Connectedness* and *Participation in Treatment*, and 4.0 for both *Outcomes* and *Functioning*. Average domain scores for adult clients ages 18 and older went from a high of 4.3 for two different domains: *General Satisfaction* and *Participation in Treatment*, to 4.2 for both *Quality and Appropriateness* and *Access*, to 4.0 for *Functioning* and *Outcomes*, and 3.9 for *Social Connectedness*.

Tests of statistical significance were performed where appropriate. This report also includes an analysis of the open-ended responses (qualitative data).

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Background

Contra Costa Behavioral Health Services (CCBHS) uses the Mental Health Statistics Improvement Project (MHSIP) consumer satisfaction surveys adopted by the California Department of Health Care Services (DHCS) to assess consumer satisfaction with and perceptions about county outpatient mental health services. Administering these surveys to consumers is one way in which Contra Costa County Behavioral Health Services seeks client feedback and suggestions about its services. The results of these surveys are reviewed by a variety of stakeholders to identify service gaps and to inform quality improvement and policy efforts.

Methodology

Surveys

The California Department of Health Care Services selected four MHSIP consumer satisfaction surveys, which are nationally recognized for their reliability and validity:

- Adult Survey (ages 18-59)
- Older Adult Survey (ages 60+)
- Youth Survey (ages 13-17)
- Parent-Caregiver Survey (parents/caregivers of youth, ages 0-17)

All of the surveys collected demographic and service information from respondents.

The Adult and Older Adult Surveys included one open-ended item for consumers to provide feedback about services received. The Adult and Older Adult Surveys also asked about recent arrests and encounters with police. Surveys included 36 items that assessed consumer perceptions of satisfaction across the following seven domains:

- General Satisfaction (services were overall satisfactory and preferable to other choices);
- Access (staff availability, service options, and timeliness and convenience of services);
- Participation in Treatment (consumer participation in treatment planning);
- Quality and Appropriateness (cultural/linguistic access, individual respect and care);
- Outcomes (services led to positive change in treatment goals);
- Functioning (services aided independent community living and decreased symptom distress);
- Social Connectedness (services contributed to improving family and friend support systems).

The Youth and Parent-Caregiver Surveys included three open-ended questions asking consumers about: (1) the most helpful aspects of the services received, (2) how to improve services, and (3) any other feedback about these services. These surveys also asked about recent arrests and encounters with police, and expulsions or suspensions from school. The Youth and Parent-Caregiver Surveys included 26 items that assessed consumer perceptions across the following seven domains:

- General Satisfaction
- Access
- Participation in Treatment
- Quality and Appropriateness
- Outcomes
- Functioning
- Social Connectedness.

In addition, the May 2017 survey included several county specific questions related to:

- Modes of Transportation for mental health appointments;
- Travel time from home to mental health clinic; and
- Cultural competence.

The items for both the Adult and Older Adult Surveys were identical, while the items in the Youth and Parent-Caregiver Surveys were very similar, but the Parent-Caregiver surveys indicated satisfaction with services for their children. High scores on a domain correspond to high levels of consumer satisfaction for that particular category or domain, whereas low scores on a domain represent low levels of consumer satisfaction for that specific domain. See the Appendix for the survey items associated with each domain.

Procedure

In compliance with the mandate from DHCS, CCBHS administered the semi-annual MHSIP surveys for their consumers during the week of May 15th – 19th, 2017.

CCBHS provided paper surveys in English and Spanish to County child and adult mental health clinics, and PDF versions of the surveys to affiliated community-based organizations throughout the county. County parent partners and volunteers provided support for survey completion to consumers in County clinics during the week of survey administration. To encourage consumer participation in the survey, incentives were provided for completing the survey. Respondents at the county mental health clinics were also offered refreshments. Upon completion of the survey, each respondent at a county clinic also had the option to be entered into a raffle contest to win one of two \$10 Safeway gift cards. Contracted providers in community-based organizations were encouraged to provide incentives to their own consumers to encourage survey participation. Drop-boxes were made available at each survey collection site to ensure confidentiality.

Survey data were uploaded, retrieved, summarized and analyzed using Teleform, SQL, Excel, Access, and SPSS statistical software. CCBHS scanned and entered data locally using Teleform software, which captures handwritten survey data and uploads them into a SQL database. Surveys were validated for accuracy and data were submitted to the State. A Microsoft Access database was developed to enter and analyze (together with Excel) qualitative data. All other data were analyzed using Excel and SPSS.

Sample

The survey sample is a convenience (i.e., non-random) sample. As such, the results are not necessarily representative of the entire population of mental health consumers in the county. Some subgroups may have been under sampled or over sampled in the survey.

Results

Data from the four surveys were aggregated into two groups for analysis: Adults (Adult and Older Adult surveys) and Youth (Youth and Parent-Caregiver surveys). Additional analyses were completed comparing youth to parents/caregivers and adults to older adults. Regarding the youth/parent surveys, in some cases, a parent/caregiver may have completed a survey for a youth who also completed a survey.

Surveys Completed

A total of 1,233 surveys were returned by early June, including:

- 332 (27%) Adult and Older Adult Surveys
- 901 (73%) Youth and Parent-Caregiver Surveys

The total number of surveys collected in May 2017 was comparable to the number collected in November 2016 (1,283) and 5% more than the number of surveys collected in May 2016 (1,178).

Table 1: MHSIP Surveys Completed 2016-2017

Age Group	May 2017		November 2016		May 2016	
	Surveys Completed		Surveys Completed		Surveys Completed	
	Count	Percentage	Count	Percentage	Count	Percentage
Adults	332	27%	522	41%	406	34%
Youth	901	73%	761	59%	772	66%
Total	1,233	100%	1,283	100%	1,178	100%

Table 2: MHSIP Adult Surveys May 2017 by Survey Type

Surveys	Adults Ages 18 - 59		Older Adults Ages 60+		Total
	Count	Percent	Count	Percent	
Surveys	278	84%	54	16%	332

Note: This table describes the number of participants who completed an adult or older adult survey. A separate analysis of age by survey type revealed that some older adults completed an adult survey.

Table 3: MHSIP Child & Youth Surveys May 2017 by Survey Type

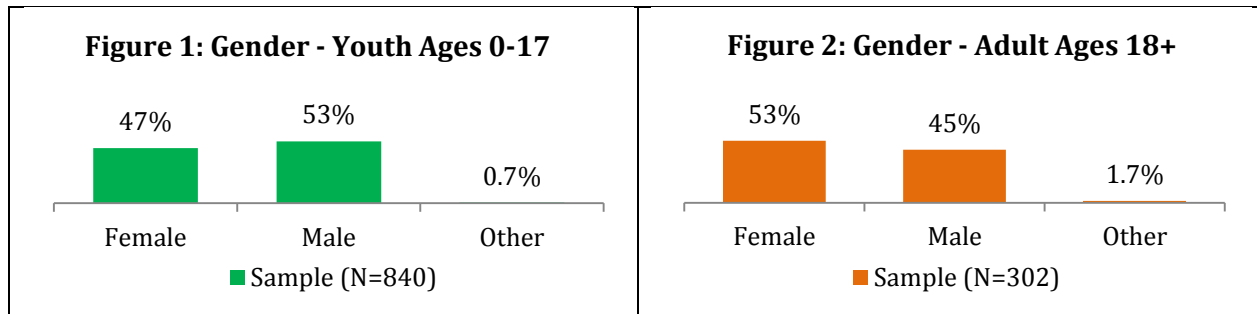
Surveys	Parents of Children & Youth Ages 0-17*		Youth Ages 13 - 17*		Total
	Count	Percent	Count	Percent	
Surveys	487	54%	414	46%	901

Note: This table describes the number of participants who completed a parent/caregiver survey form or a youth survey form. *An analysis of age by survey type revealed that, in some cases, both youth (ages 13-17) and parents of youth completed a survey about the same young person receiving services. Additionally, a total of 21 clients aged 18 - 21 were represented among the youth/parent surveys (although those surveys were meant for clients aged 17 and younger).

Demographics

Gender

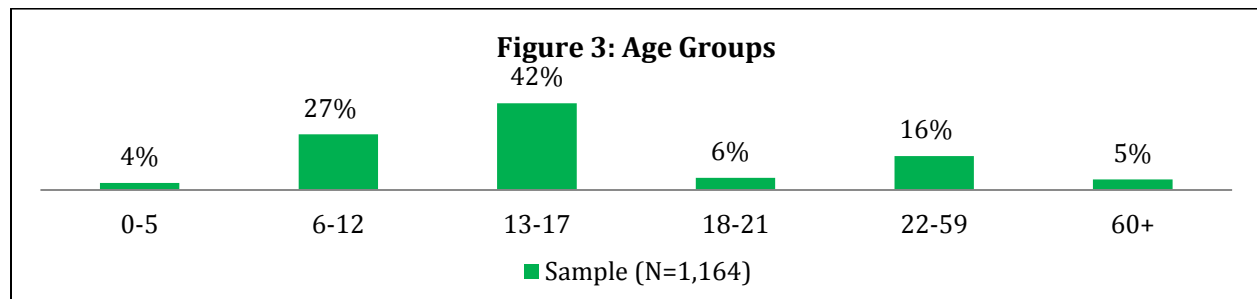
Slightly more youth respondents were Male (53%). Conversely, among adult respondents more were Female (53%). Less than one percent of youth respondents and about two percent of adults selected “Other” as their gender identity.¹



Note. Respondents who chose not to provide their gender were excluded from reported results.

Age

The majority of surveys completed were about respondents aged 13 to 17 (42%), followed by respondents aged 6 to 12 (27%), followed by adult respondents aged 22 to 59 (16%). The remaining sample was distributed as follows: Five and under (4%), ages 18 to 21 (6%), and ages 60 and older (5%).²



Note. Respondents with missing or invalid birthdates were excluded. Age categories were aligned to correspond to the CCBHS demographic reports (of Medi-Cal consumers utilizing County behavioral health services in CY 2016).

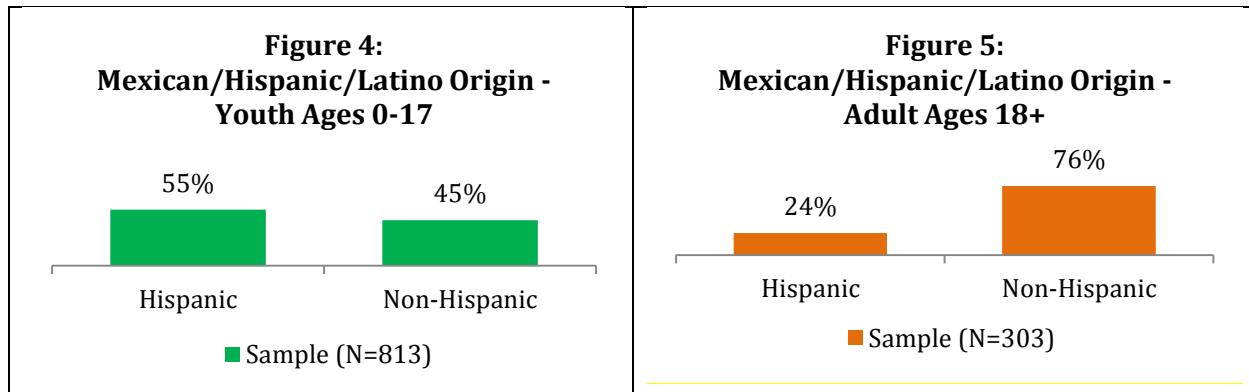
Ethnicity and Race

Hispanic/Latino clients were over represented in the May 2017 MHSIP survey sample. In this sample approximately two out of every five respondents (41%) identified as Hispanic/Latino, whereas 24% of Contra Costa Behavioral Health Services’ Medi-Cal consumers identified as

¹ MHSIP surveys (approved and distributed by the California Department of Health Care Services) ask clients to select one of three options for gender: male, female or other.

² Each respondent’s age (at the time of the survey) was derived using a function in Microsoft Excel that calculates the number of years between the date of birth and the survey date.

Hispanic/Latino based on county penetration data.³ The MHSIP survey sample included 55% of clients aged 0-17 and 24% of clients aged 18 and older who self-identified as being of Hispanic, Latino, Mexican or other Latino nationality.

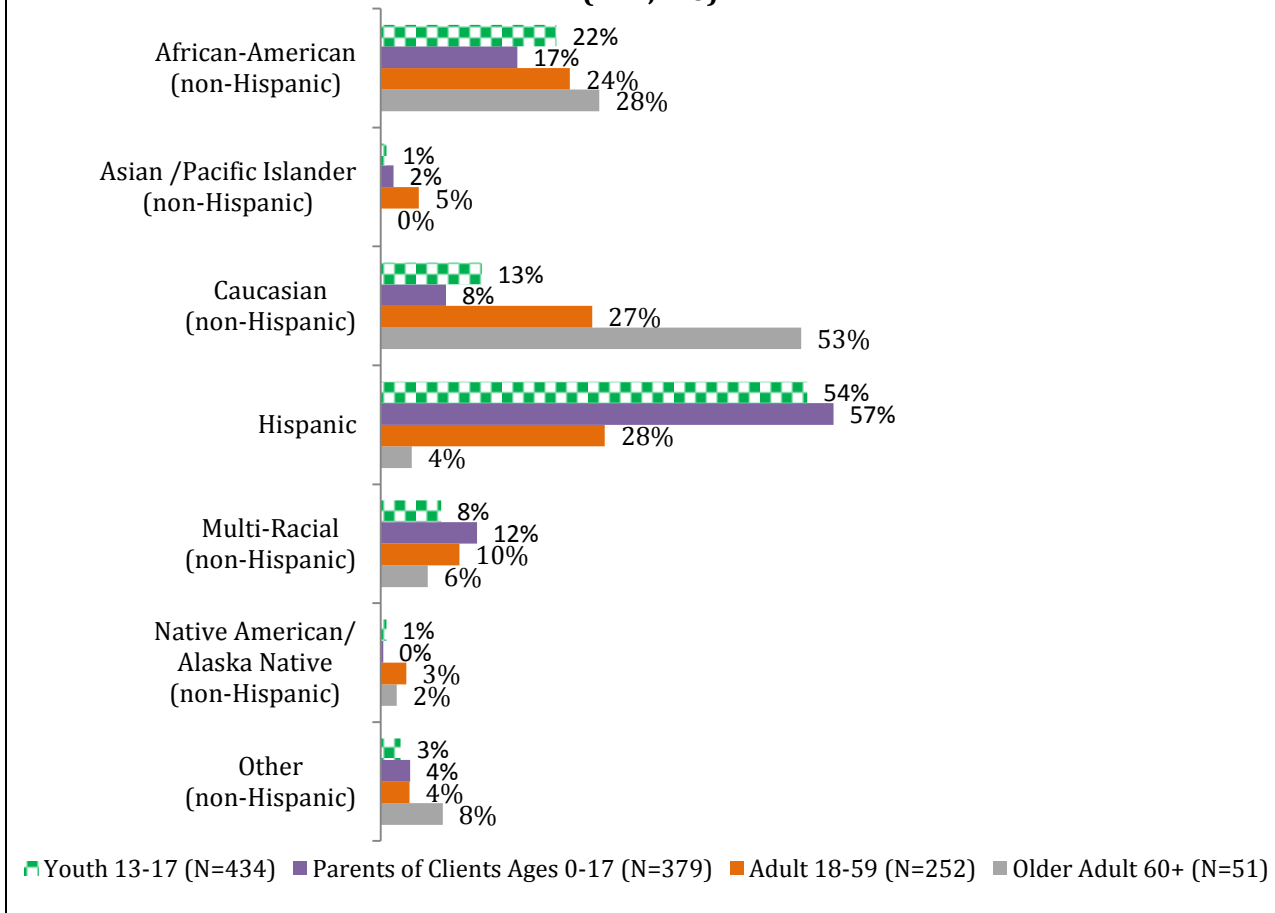


Note: Respondents who did not answer the question about Hispanic ethnicity were excluded.

Ethnicity and Race: Figure 6 on the next page details the distribution of race and ethnicity categories across the four survey populations: 1) Youth ages 13 to 17, 2) Parents of children and youth ages 0-17, 3) Adults ages 18 to 59, and 4) Older Adults ages 60 and older. The graph shows that parents of children/youth had the highest proportion of Hispanic respondents (57%) followed by youth themselves (54%), whereas the highest proportion of non-Hispanic respondents was among Caucasian adult clients ages 60 and older (53%).

³ A total of 24% of consumers with Medi-Cal who utilized Contra Costa Behavior Health Services in CY 2016 identified as Hispanic. (Report titled: PSP3294, MH-EQRO Audit – Penetration Report, accessed using iSite on March 9th, 2017.)

Figure 6: Race/Ethnicity Comparison: Youth and Adults in Survey Sample (N=1,116)

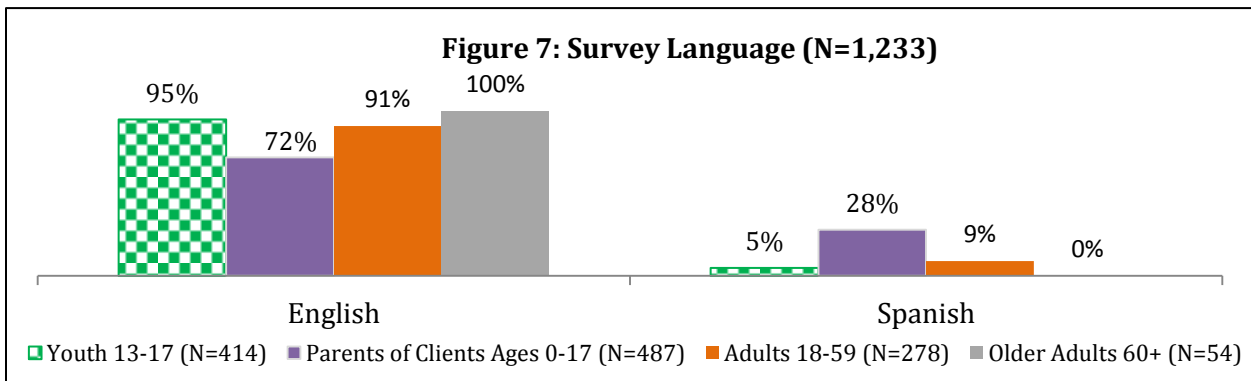


Note: Respondents with missing responses were excluded.

Language

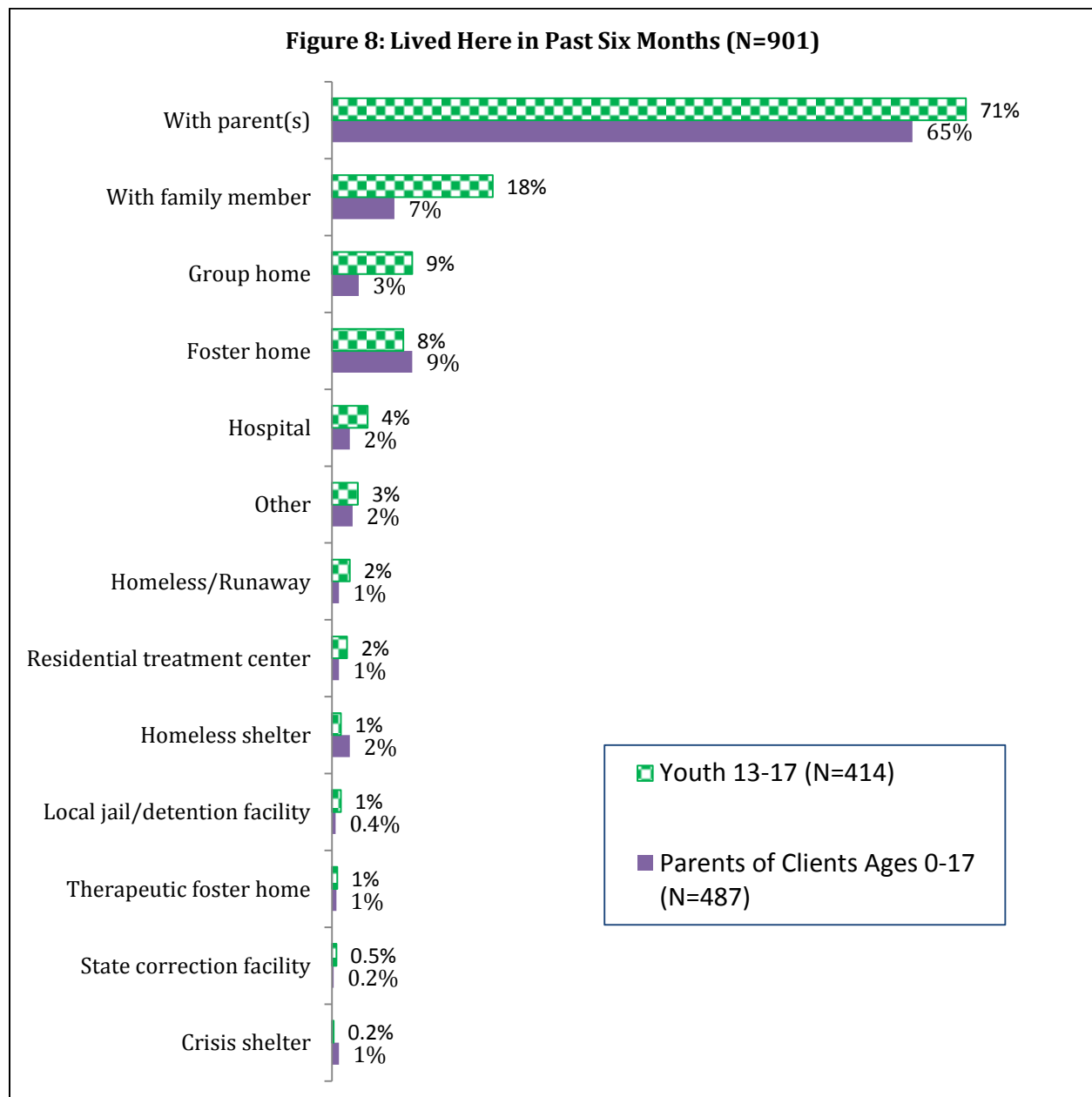
The survey was offered in English and Spanish. The majority of respondents completed the survey in English, with the largest proportion of English speaking respondents being older adults ages 60 and older (100%). Over a quarter (28%) of parents (of clients aged 0-17) completed a survey in Spanish.

Figure 7: Survey Language (N=1,233)



Living Arrangement (children/youth/parents only)

Most parents of children/youth (65%) and youth respondents (71%) reported living with a parent within the past six months, followed by living with another family member (reported by 18% of youth and 7% of parents of children/youth). Residency in a group home (reported by 9% of youth and 3% of parents of children/youth), foster home (reported by 8% of youth and 9% of parents of children/youth), or hospital (reported by 4% of youth and 2% of parents of children/youth) rounded out the top five living arrangements. Three percent of youth reported “other” living arrangements in the past six months, while smaller percentages cited various living arrangements, including: crisis shelter, jail/detention, foster home, residential treatment center, homeless shelter, homeless/runaway, and/or state correctional facility. Multiple responses were possible.

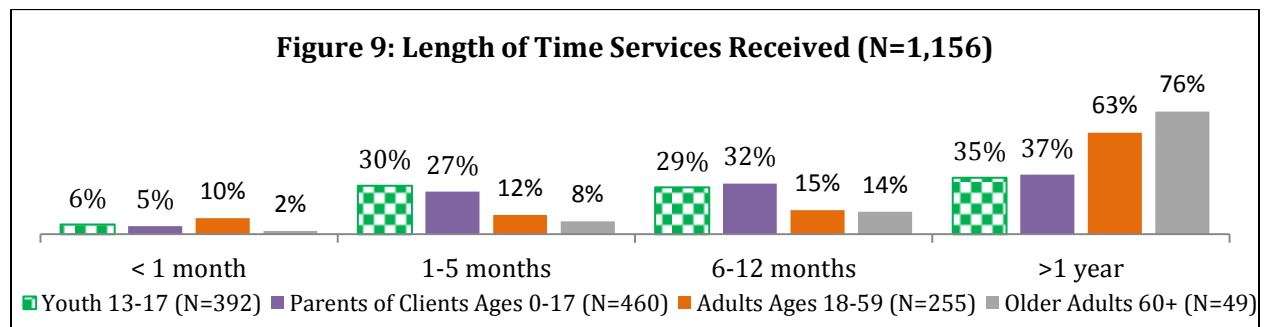


Note: Multiple response question.

Service History

Length of Time Receiving Mental Health Services

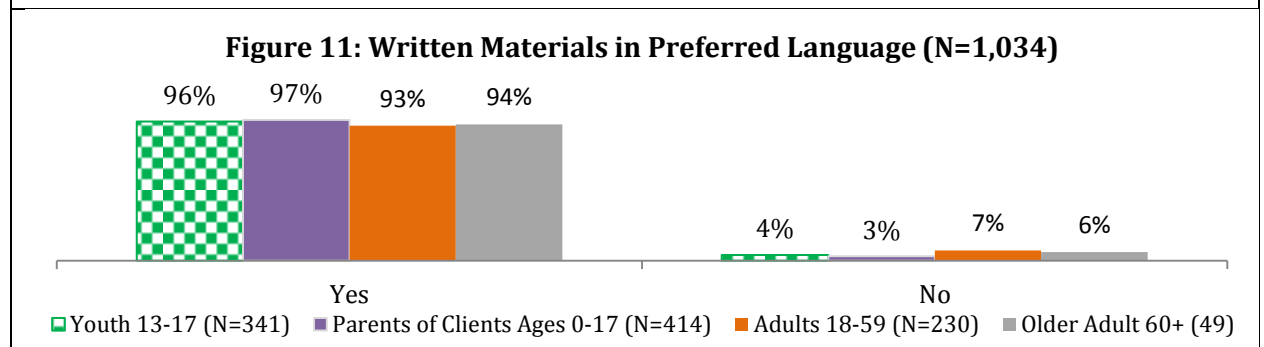
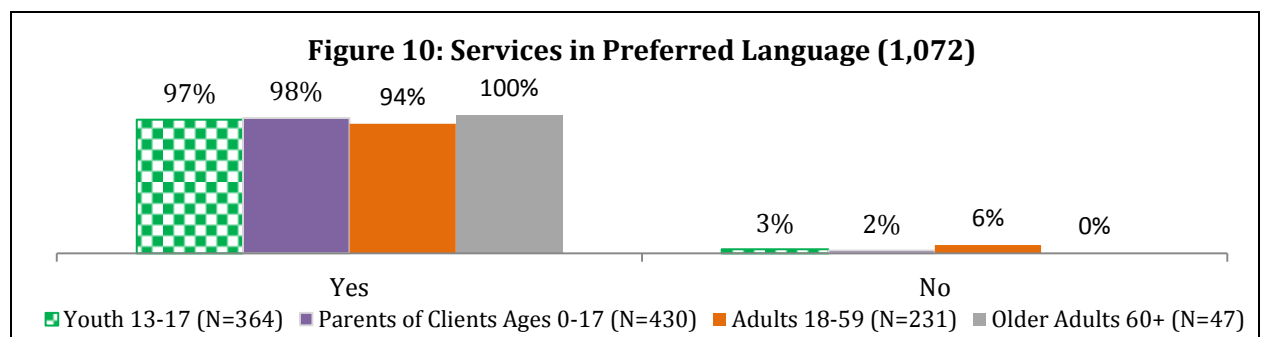
Most respondents (56% overall) reported that they had been receiving mental health services for one year or less. When broken down into smaller time periods and comparing survey populations, the results suggest a different pattern, with the highest relative length of time being more than a year (including 76% of older adults, 63% of adults, 37% of parents, and 35% of youth), followed by respondents who had been receiving services for six months to 1 year (32% of parents, 29% of youth, 15% of adults, and 14% of older adults). Figure 9 below depicts the length of service patterns for each surveyed population.



Note: Respondents with missing responses were excluded.

Cultural Competence

Almost all respondents reported receiving services in their preferred language (100% of older adults, 98% of parents, 97% of youth, and 94% of adults); as well as written information in their preferred language (97% of parents, 96% of youth, 94% of older adults, and 93% of adults). See Figures 10 and 11 below.

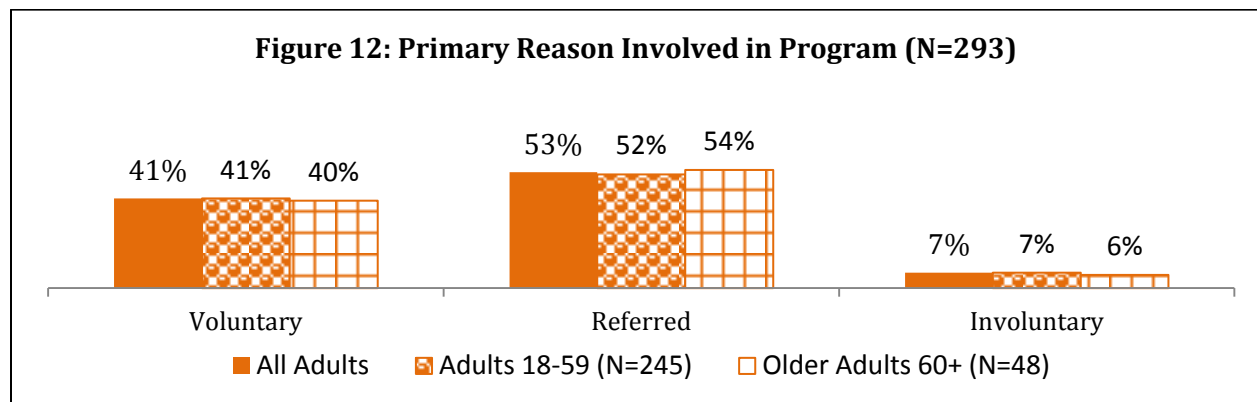


Note: Respondents with missing responses were excluded.

In addition, 92% of survey respondents agreed or strongly agreed that their provider was, as the survey asked: “respectful and supportive of my culture, values, beliefs, life ways and lifestyle (this includes race, religion, language, gender/gender expression, sexual orientation, or disability).”

Reason Services Sought (adults/older adults only)

Two of every five adult respondents age 18 and older (41%) reported that they voluntarily participated in mental health services (“I decided to come in on my own”), with a higher percentage (53%) reporting that they were referred to County mental health services. Only 7% of all adults reported involuntary participation in mental health services (“I came in against my will”). Comparing adult respondents (N=245) to older adult respondents (N=48), both populations were referred at similar rates, 54% for older adults compared to 52% for adults. See Figure 12 below.



Note: Respondents with missing responses were excluded.

Medi-Cal Insurance (children/youth/parents only)

A total of 94% of surveys from children, youth and parents (N=823) indicated that clients had Medicaid coverage (Medi-Cal). Comparing responses by population, parents/caregivers of children and youth ages 17 and younger (N=443) reported somewhat higher rates of Medi-Cal coverage (97%) compared to youth ages 13-17 (91% of 380 youth).

Medical Doctor Visit (children/youth/parents only)

Nearly four out of five surveys (79%) from children, youth and parents (N=857) indicated that clients had seen a physician or nurse for a health check-up or because they were sick in the prior year, either in a clinic/office (66%) or in a hospital/emergency room (13%). The others either did not see a doctor or nurse (13%) or did not remember (8%). Comparing responses by population, parents (N=458) reported somewhat higher rates of medical visits (85%) compared to youth (72% of 399 youth).

Medication (children/youth/parents only)

Over a quarter (27%) of surveys from children, youth and parents (N=809) indicated that clients were taking medications for emotional/behavioral problems. The proportion of yes responses from parents (28% of 429) was slightly higher than the proportion of yes responses from youth (25% of 380). Of those children and youth on medication(s) (N=188), 87% reported that a doctor or nurse had informed them about side effects. The proportion of clients who had been informed about side effects varied by type of survey, with significantly more parents (89% of 104 parents) than youth (83% of 84 youth) reporting that they had been informed about medication side effects.

Transportation Modes and Travel Time

In the May 2017 MHSIP Survey, consumers were asked about their modes of transportation and travel times from home to their mental health clinic for appointments. The most frequent modes of transportation for adults and older adults surveyed (N=332) was to drive to their appointments (“Drive Myself,” 27%), followed by receiving a ride from family members/caregivers (26%). The least frequent modes of transportation were using Taxi, Uber/Lyft, or Paratransit services (3%).

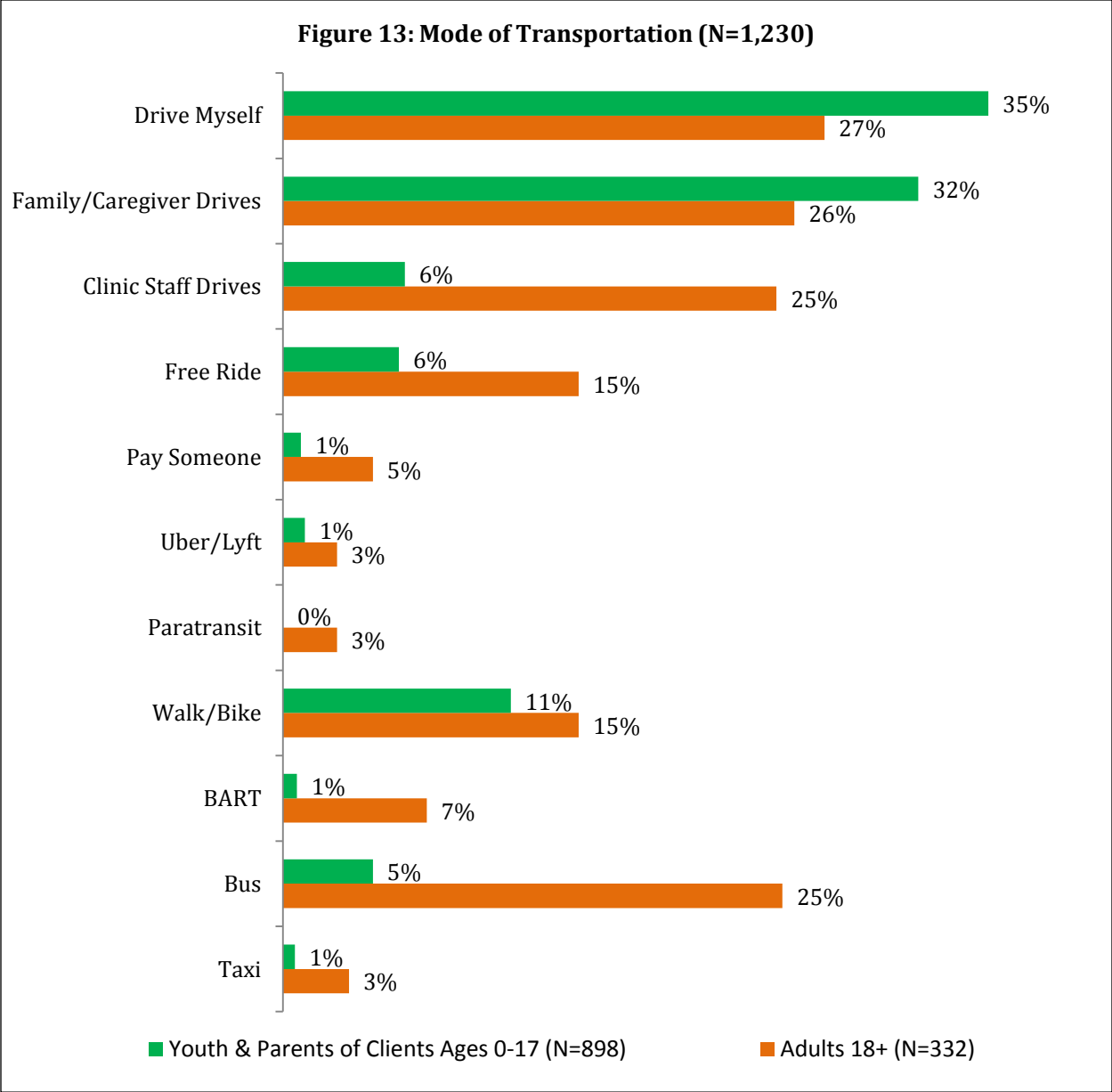
Similar results were recorded among youth and parents of children/youth who participated in the survey when it came to primary modes of transportation. The leading modes of transportation identified were driving myself to appointments (35%) and family member/caregiver drives (32%).⁴ In contrast, youth and parents did not rely on Paratransit services (0%) to get to the mental health clinics and were also less inclined to use BART (1%), Uber/Lyft (1%), or pay someone (1%) for transportation.

Among adult respondents almost three quarters (72%) of those surveyed (N=293) indicated that their travel time for appointments is 30 minutes or less. Of the remaining responses, 19% have travel times of 31 minutes to 1 hour, 6% have travel times of 1 hour to 2 hours, and 3% indicated more than 2 hours to get from home to their mental health appointments.

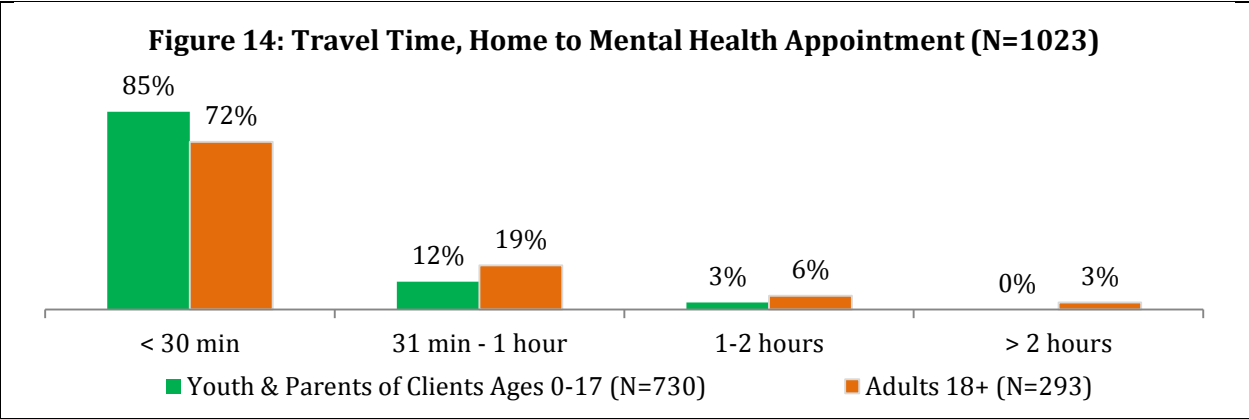
The majority (85%) of youth and parents of children/youth surveyed (N=730) responded that they travel 30 minutes or less to get to their mental health clinic for appointments. 12% have travel times of 31 minutes to 1 hour, 3% take between 1 hour to 2 hours in travel time. Only 1 respondent (0.1%) indicated that it takes more than 2 hours for them to get from home to their mental health clinic for appointments.

See Figures 13 and 14 on the following page.

⁴ When viewed independently, Youth (13-17) were more likely to identify a family member/caregiver as their primary mode of transportation, whereas Parents of Children & Youth 0-17 responded that they “Drive Myself [Child/Youth]” to mental health clinic appointments.



Note: Multiple response question.



Encounters with the Police and School Issues

Police Encounters

Respondents receiving services were asked to indicate any change in the frequency of encounters with police since starting mental health services. **Of adult respondents, age 18 and older, who had been receiving mental health services for one year or less**, three out of every five (60%) of them did not have police encounters. Of the 68 who did have a police encounter, more than half (62%) reported a reduction in those encounters since initiating mental health services, followed by 31% of adult respondents who experienced no change in the number of encounters with the police, and 7% who reported an increase in police encounters.

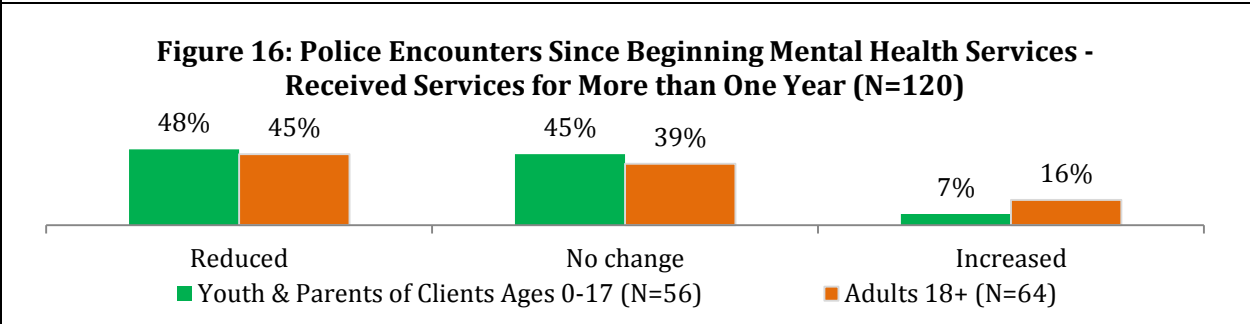
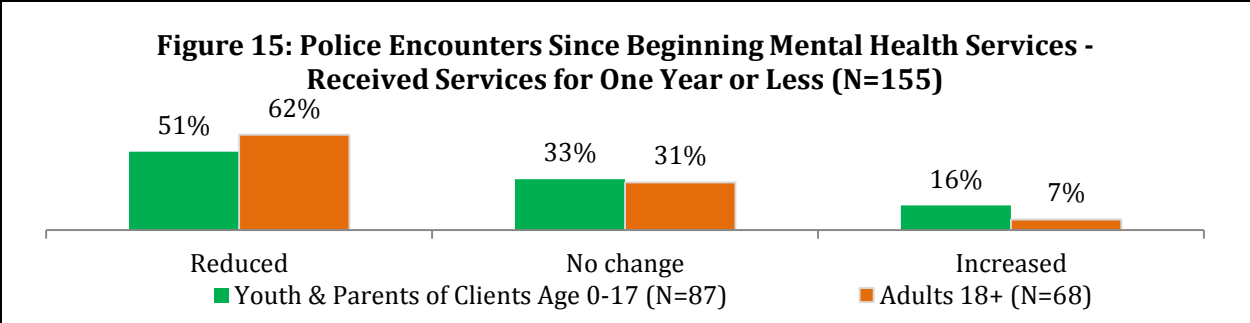
Only 87 (16%) of youth and parents of children/youth who had been receiving mental health services for one year or less reported any encounters with police since initiating mental health services.⁵ Of these, 51% reported reduced numbers of encounters, while 33% reported no change, and 16% reported increased encounters with police.

Findings were similar for respondents who had been receiving mental health services for more than one year, 71% did not report any police encounters. Of the 64 adults who did report police encounters, slightly less than half (45%) reported a reduced number of police encounters, followed by reports of no change (39%). 16% reported an increase in their encounters with the police.

Here again, **the majority (85%) of youth and parents of children/youth receiving mental health services for more than one year reported no police encounters**. Of the 56 individuals who reported encounters with the police since beginning mental health services, 48% reported reduced numbers of encounters, while 45% reported no change, and 7% reported increased encounters.

See Figures 15 and 16 on the following page.

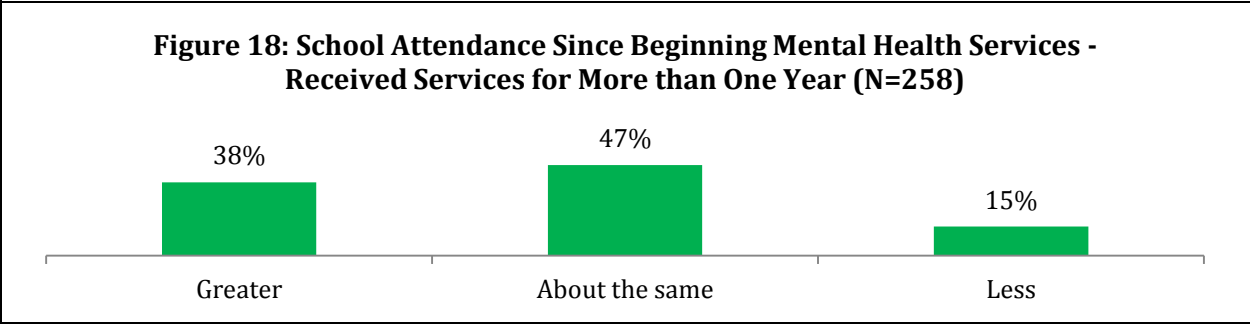
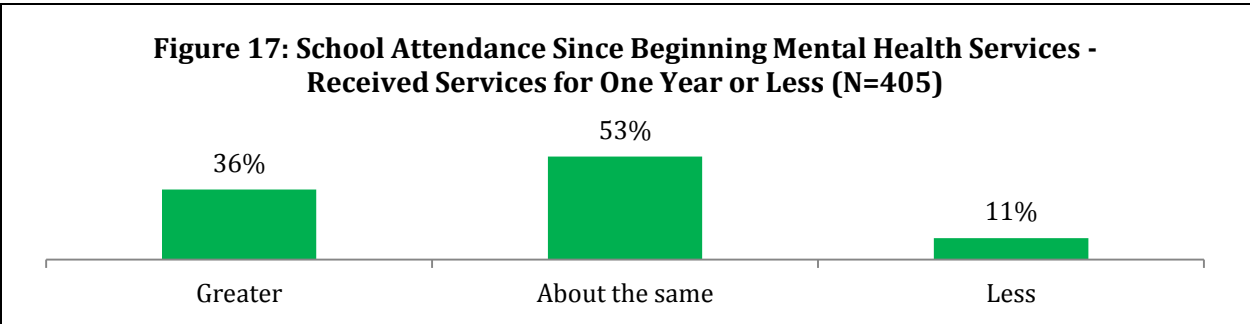
⁵ Youth and parents of children/youth receiving mental health services for one year or less who selected the option “not applicable” selected that option based on this language: “you had no police encounters this year or last year.”



Note: Respondents with missing responses were excluded.

School Attendance (children/youth/parents only)

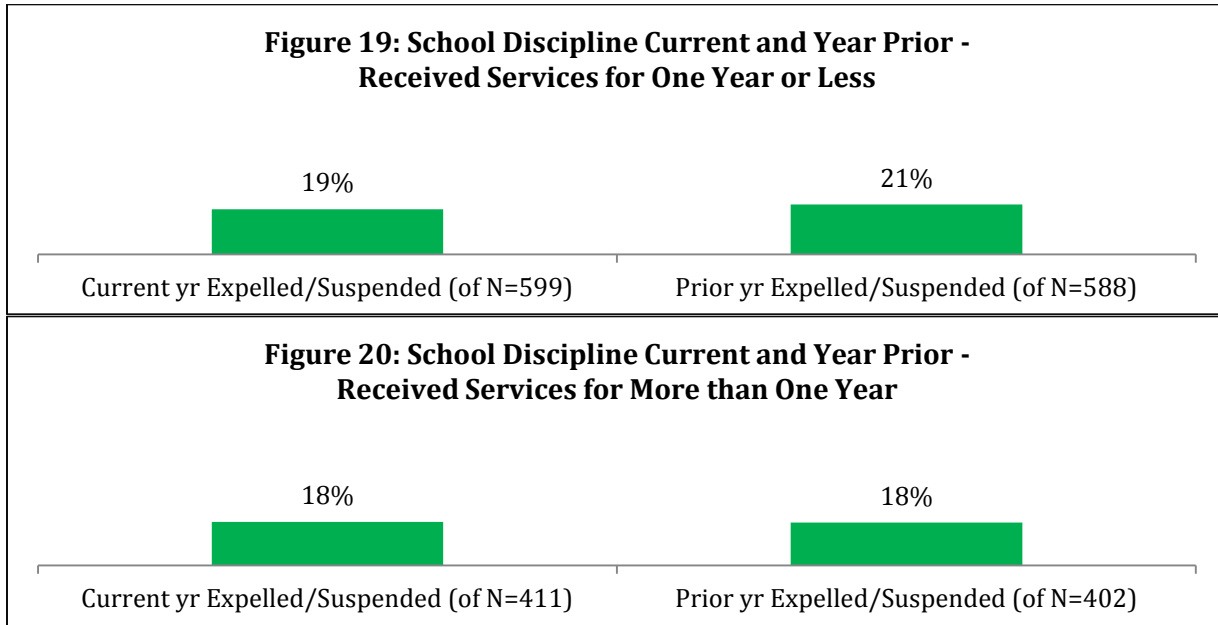
Of those children and youth attending school and receiving mental health services for one year or less (N=405), 36% reported attending more days of school since initiating mental health services; 53% reported about the same attendance; and 11% reported less school attendance since beginning mental health services. Of those youth respondents attending school while receiving services for more than one year (N=258), 38% reported greater attendance; 47% reported that attendance was about the same; and 15% reported less school attendance since beginning mental health services. See Figures 17 and 18 below.



Note: Respondents with missing responses were excluded.

School Discipline (children/youth/parents only)

Youth reported being expelled or suspended from school in fairly consistent proportions, with a slight decrease in reported school disciplinary actions for those who had been receiving services for more than a year. Of youth receiving mental health services for one year or less (N=599), 19% reported being expelled or suspended in the current year and 21% (of 588 responses) reported being expelled or suspended in the prior year. Of youth receiving services for more than a year (N=411), 18% reported being expelled or suspended in the current year, and 18% (of 402 responses) reported being expelled or suspended in the prior year. See Figures 19 and 20 below.



Note: Respondents with missing responses were excluded.

Domain Scores

Calculating Domain Scores

A mean (i.e., average) score for each domain was calculated from all responses. To prevent “Not Applicable” responses from skewing the average, these responses were excluded from the calculation of a mean domain score. In addition, consistent with best practices in MHSIP survey scoring, only respondents who completed at least two-thirds of the questions for any given domain were included in the calculation of the mean score for that domain. Scores were based on responses to a five point Likert scale as follows: (1) Strongly Disagree, (2) Disagree, (3) I am Neutral, (4) Agree, and (5) Strongly Agree.⁶ High mean domain scores indicate high levels of satisfaction with services received.

Domain Scores: Youth & Parents of Children and Youth

As a group, youth and parents of children and youth (age 0-17) generally reported high satisfaction with services received, as evidenced by the overall mean score of 4.3 and the fact that all domain average scores were rated 4.0 or higher. *Quality and Appropriateness* of treatment was the highest ranked domain [$M=4.6$]. The lowest average domain scores among youth and parents were *Outcomes* and *Functioning* [$M=4.0$]. See Table 4 below.

Table 4: Summary MHSIP Domain Scores - Youth/Parents (Combined)

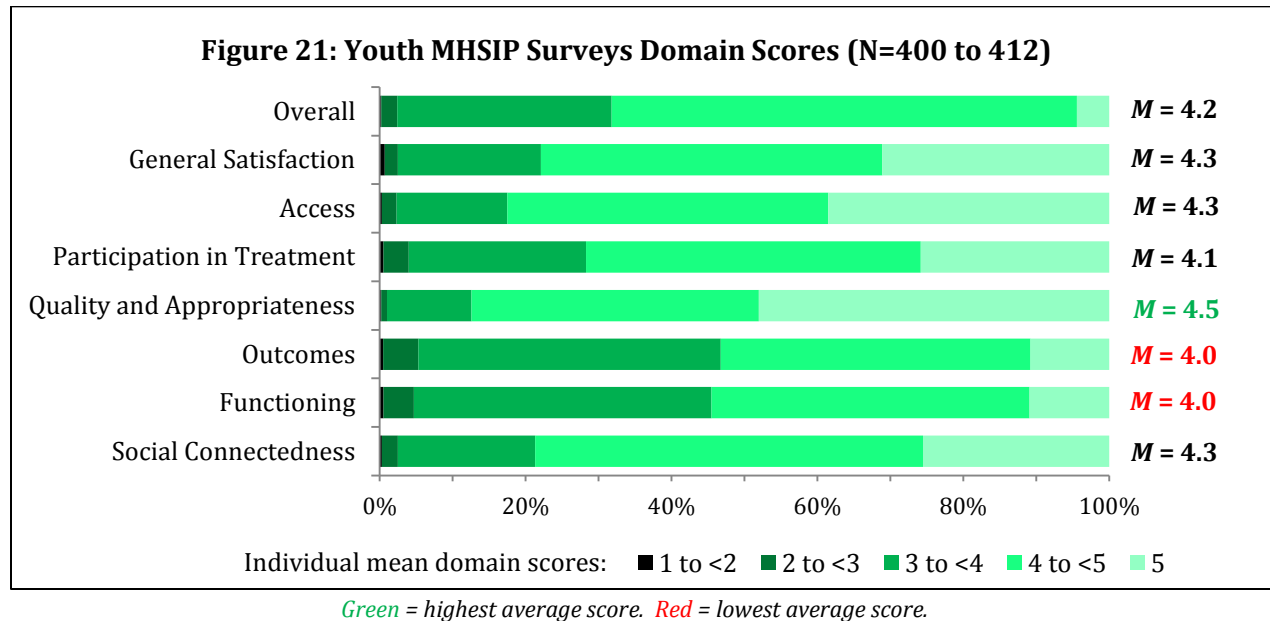
Domain	N	Mean	% 4.0+
Overall	899	4.3	75.0%
General Satisfaction	891	4.4	82.7%
Access	881	4.5	88.8%
Participation in Treatment	879	4.3	81.9%
Quality & Appropriateness	890	4.6	92.0%
Outcomes	874	4.0	58.1%
Functioning	877	4.0	59.7%
Social Connectedness	870	4.3	83.6%

Comparing youth and parents, average domain scores were higher for parents. **The differences in mean scores were statistically significant⁷ for all domains except *Outcomes* and *Functioning*.** See Figure 21 for average domain scores of youth ages 13-17 and Figure 22 (on page 16) for average domain scores of parents of children and youth ages 17 and under.

⁶ One survey instrument – the Parent/Caregiver Survey (for Child/Youth ages 0-17) had one different word in the Likert Scale (“Undecided” instead of “I am Neutral”) for the middle option.

⁷ Differences in mean scores were statistically significant at the $p<.05$ level using the independent samples t -test in SPSS analytical software.

Domain Scores: Youth Ages 13-17⁸



General Satisfaction: A total of **78%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher for the General Satisfaction domain.

Access: A total of **83%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher for the Access domain.

Participation in Treatment: A total of **72%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

Quality and Appropriateness: A total of **87%** of respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

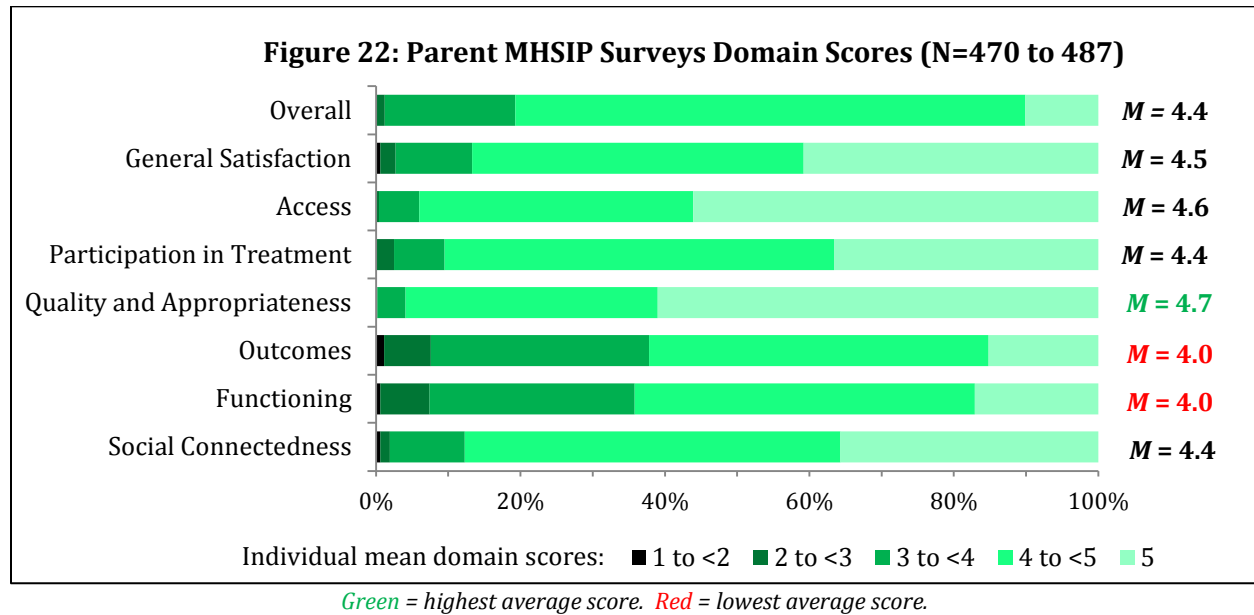
Outcomes: A total of **53%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Functioning: A total of **55%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Functioning domain.

Social Connectedness: A total of **79%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

⁸ Some youth and parents of children/youth ages 18-21 completed surveys that were designed for clients ages 17 and younger. These surveys comprised a small percentage of the total (21 out of 901 or 2%) and are included in the data presented for youth and parents.

Domain Scores: Parents of Children and Youth, Ages 0-17⁹:



General Satisfaction: A total of **87%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher for the General Satisfaction domain.

Access: A total of **94%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher for the Access domain.

Participation in Treatment: A total of **91%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

Quality and Appropriateness: A total of **96%** of respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

Outcomes: A total of **62%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Functioning: A total of **64%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Functioning domain.

Social Connectedness: A total of **88%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

⁹ Some youth and parents of children/youth ages 18-21 completed surveys that were designed for clients ages 17 and younger. These surveys comprised a small percentage of the total (21 out of 901 or 2%) and are included in the data presented for youth and parents.

Comparing Satisfaction Scores: Youth vs. Parent of Children and Youth (Ages 0-17)

Comparing mean domain scores of Youth (ages 13-17) and Parents of Children and Youth (ages 0-17), it is evident that, as a group, parents/caregivers reported higher satisfaction levels than youth. Parents/caregivers had an overall combined satisfaction score of 4.4 compared to the overall combined satisfaction score of 4.2 for youth. Domain satisfaction scores were significantly¹⁰ higher for parents/caregivers compared to youth in all categories except *Outcomes* and *Functioning*. Parents/caregivers scored a high of 4.7 for *Quality & Appropriateness* and a low of 4.0 for *Outcomes and Functioning*, with *Access* [$M=4.6$], *General Satisfaction* [$M=4.5$], *Participation in Treatment* [$M=4.4$] and *Social Connectedness* [$M=4.4$] scores falling in between. Youth satisfaction rankings were similar, but with lower average domain scores compared to parents/caregivers. Specifically, Youth scored a high of 4.5 for *Quality & Appropriateness* and a low of 4.0 for *Outcomes and Functioning*, with *General Satisfaction* [$M=4.3$], *Access* [$M=4.3$], *Social Connectedness* [$M=4.3$] and *Participation in Treatment* [$M=4.1$] scores falling in between. The factors associated with higher satisfaction are listed in Table 5 below. The most common factor associated with higher satisfaction for several domains within each group was Spanish speaking, with other factors listed in Table 5 below.

Table 5: Summary MHSIP Domain Scores – Youth vs Parents: Mean Scores and Statistically Significant Factors Associated with Higher Satisfaction

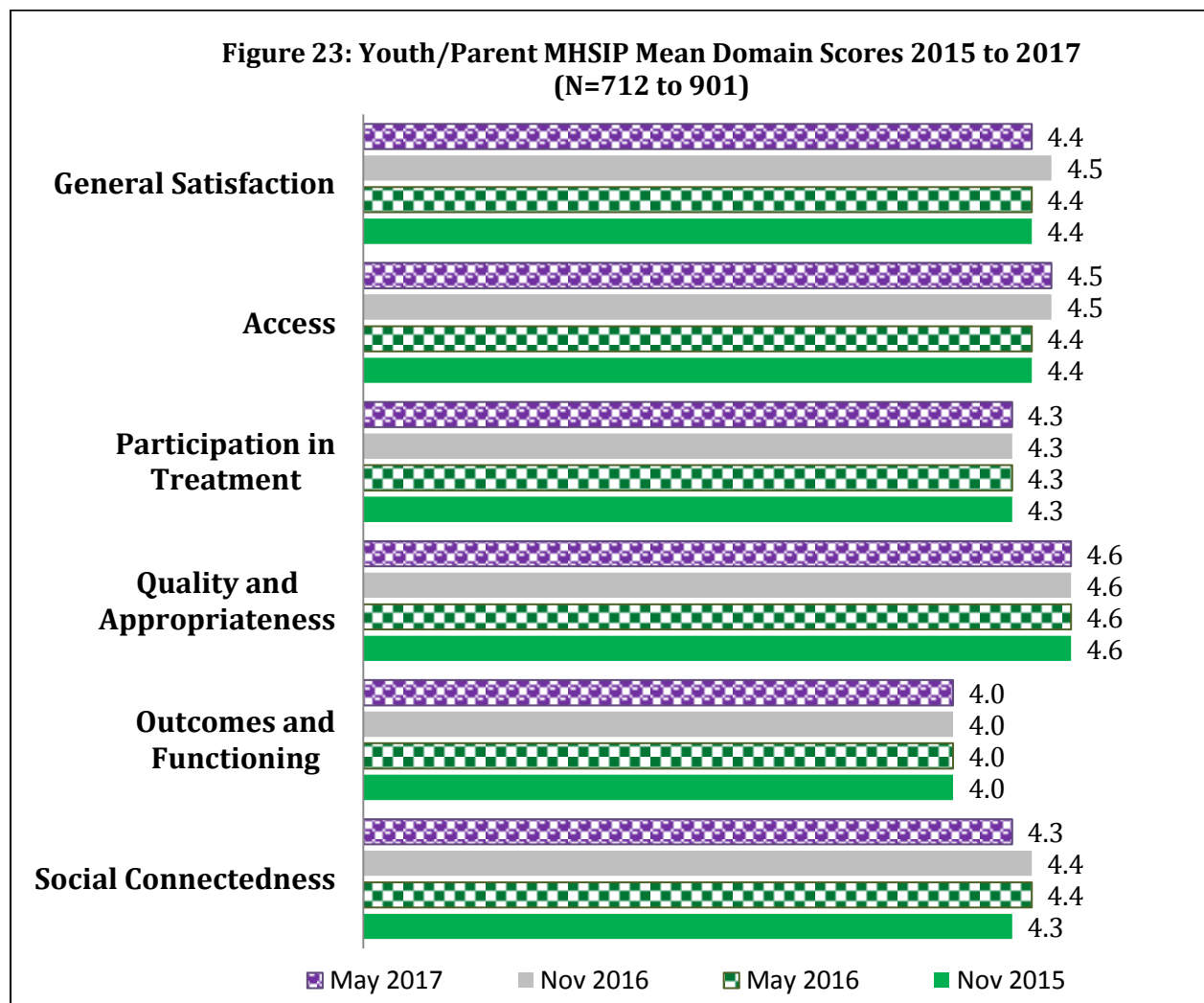
Domain	Youth (N=400-412)		Parents/Caregivers (N=470-487)	
	Mean Domain Score	Reported Factors Associated w/Higher Satisfaction	Mean Domain Score	Reported Factors Associated w/Higher Satisfaction
General Satisfaction	4.3	Female Gender, Hispanic, Spanish Speaking	4.5	Spanish Speaking, Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)
Access	4.3	Female Gender	4.6	Parents with child 0-12 years old
Participation in Treatment	4.1	Female Gender, Spanish Speaking	4.4	Parents with child 0-12 years old
Quality & Appropriateness	4.5	Female Gender, Hispanic, Spanish Speaking, Length of Service <1yr	4.7	Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)
Outcomes	4.0	Spanish Speaking, Greater School Attendance (LOS<1yr), Length of Service <1yr	4.0	Spanish Speaking, Parents with child 0-12 years old
Functioning	4.0	Spanish Speaking, Greater School Attendance (LOS<1yr), Length of Service <1yr	4.0	Spanish Speaking, Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)

¹⁰ Statistically significant differences in mean scores were established at the level $p<.05$ using independent sample *t-tests* in SPSS.

Social Connectedness	4.3	Length of Service <1yr	4.4	Parents with child 0-12 years old, Greater School Attendance
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Comparison to Previous Years: Youth/Parent Surveys (Combined)

Average domain scores for youth/parents have remained consistent or improved in the past four years. Figure 23 compares the mean domain scores for Youth and Parent MHSIP surveys administered from November 2015 to May 2017. Sample sizes for combined youth/parent surveys in the past few years ranged from 712 to 901. Average domain scores are almost identical to those of the past two surveys (administered in November 2016 and May 2016); with the exception of a slight decrease in *General Satisfaction* (from 4.5 to 4.4) and *Social Connectedness* (from 4.4 to 4.3).

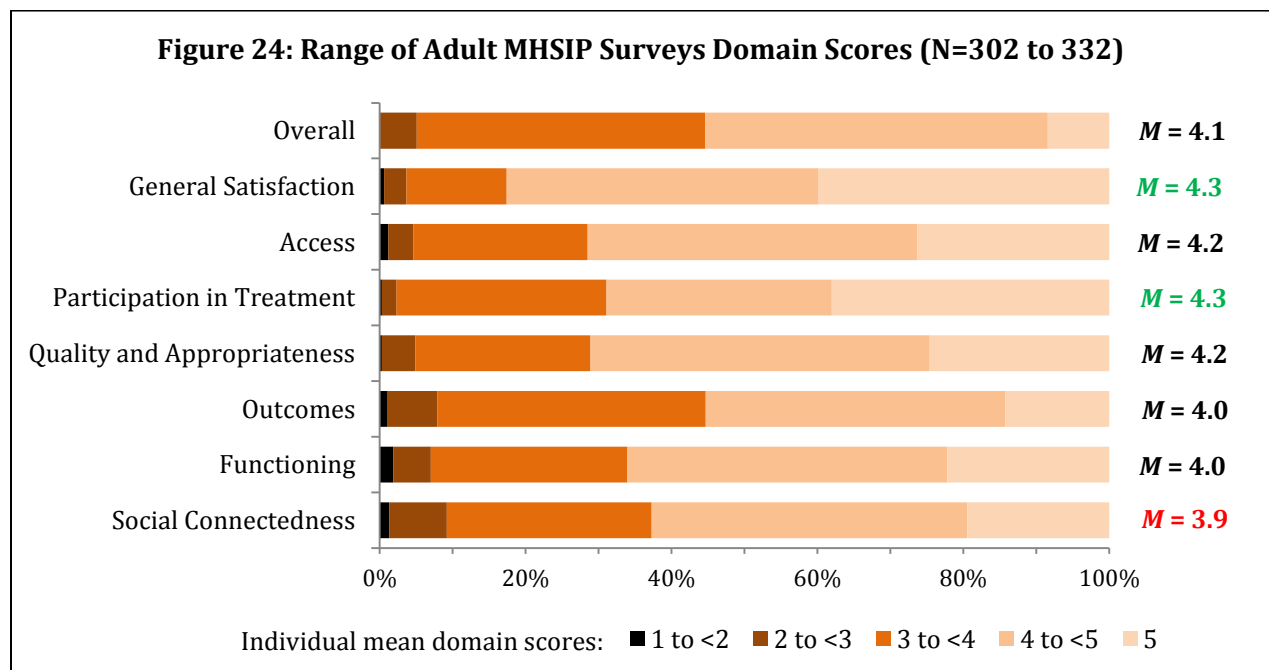


Domain Scores: Adults & Older Adults

Adult respondents (including older adults) were satisfied with services, as demonstrated by the overall average satisfaction rating of 4.1; however, this overall rating is down from 4.3 at the time of last MHSIP administration in November 2016. The highest domain scores for adults were *General Satisfaction* [$M=4.3$] and *Participation in Treatment* [$M=4.3$], while the lowest average domain scores were in *Social Connectedness* [$M=3.9$]. See Table 6 and Figure 24 below.

Table 6: Summary MHSIP Domain Scores – Adult/Older Adults (Combined)

Domain	N	Mean	% 4.0+
Overall	332	4.1	60.8%
General Satisfaction	328	4.3	82.6%
Access	323	4.2	71.5%
Participation in Treatment	308	4.3	78.9%
Quality & Appropriateness	325	4.2	71.1%
Outcomes	302	4.0	55.3%
Functioning	316	4.0	66.1%
Social Connectedness	314	3.9	62.7%



Green = highest average score. Red = lowest average score.

General Satisfaction: A total of 83% of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the General Satisfaction domain.

Access: A total of 72% of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Access domain.

Participation in Treatment: A total of 69% of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

Quality and Appropriateness: A total of **71%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

Outcomes: A total of **55%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Functioning: A total of **66%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Social Connectedness: A total of **63%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

Comparing Satisfaction Scores: Adults vs. Older Adults

Comparing mean domain scores of adults (ages 18-59) and older adults (ages 60+), it is evident that, as a group, older adults reported higher satisfaction levels than adults. While both populations had overall combined satisfaction scores of 4.1, domain satisfaction scores were higher for older adults compared to adults in all categories except for *Access* and *Participation in Treatment*. Older adults scored a high of 4.4 for *General Satisfaction*, and a low of 4.0 for *Social Connectedness*, with *Participation in Treatment* [$M=4.2$], *Quality & Appropriateness* [$M=4.2$], *Access* [$M=4.1$], *Outcomes* [$M=4.1$] and *Functioning* [$M=4.1$] scores falling in between. Adult satisfaction rankings were similar, with slightly lower average domain scores compared to older adults. Specifically, adults scored a high of 4.3 for both *General Satisfaction* and *Participation in Treatment* and a low of 3.9 for both *Outcomes* and *Social Connectedness*; with *Access* [$M=4.2$], *Quality & Appropriateness* [$M=4.2$], and *Functioning* [$M=4.0$] scores falling in between. The most common factor associated with higher satisfaction for several domains within each group was Spanish speaking, with other factors listed in Table 7 below.¹¹

Table 7: Summary MHSIP Domain Scores – Adults vs Older Adults: Mean Scores and Statistically Significant Factors Associated with Higher Satisfaction

Domain	Adults (N=256-278)		Older Adults (N=44-54)	
	Mean Domain Score	Reported Factors Associated w/Higher Satisfaction	Mean Domain Score	Reported Factors Associated w/Higher Satisfaction
General Satisfaction	4.3	Spanish Speaking	4.4	No Statistically Significant Factors among those analyzed
Access	4.2	Hispanic, Spanish Speaking	4.1	No Statistically Significant Factors among those analyzed
Participation in Treatment	4.3	Spanish Speaking	4.2	No Statistically Significant Factors among those analyzed

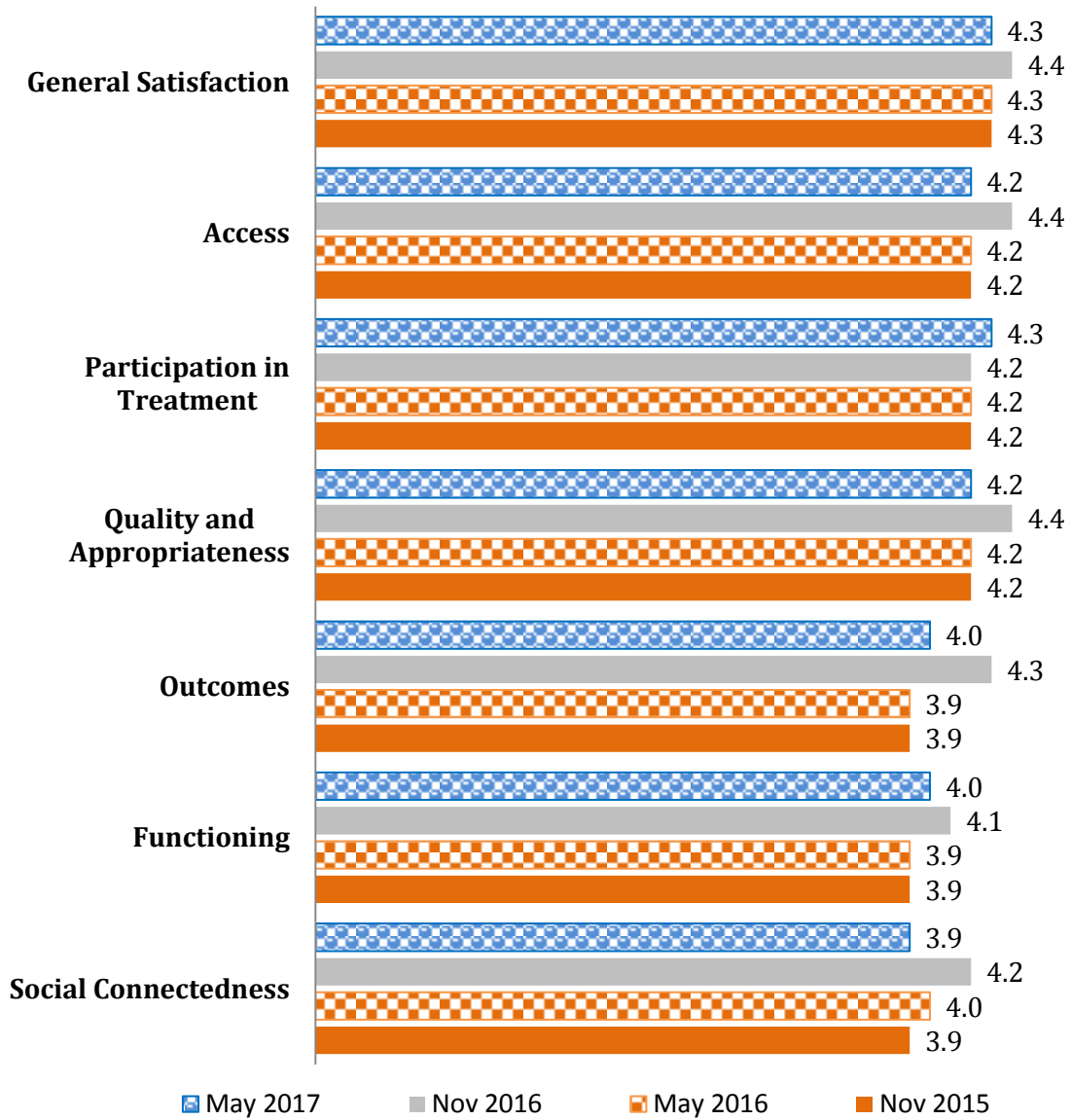
¹¹ Due to the small size of the Older Adult population (N=54) analyses for statistical significance were based on a limited set of grouping variables (gender and Hispanic ethnicity).

Quality & Appropriateness	4.2	Hispanic, Spanish Speaking, Reduced Interactions with Police (LOS<1yr)	4.2	No Statistically Significant Factors among those analyzed
Outcomes	3.9	Older Adults (compared to 16-25 year olds)	4.1	No Statistically Significant Factors among those analyzed
Functioning	4.0	Older Adults (compared to 16-25 year olds)	4.1	No Statistically Significant Factors among those analyzed
Social Connectedness	3.9	Hispanic	4.0	Female Gender

Comparison to Previous Years: Adult (including Older Adult) Surveys

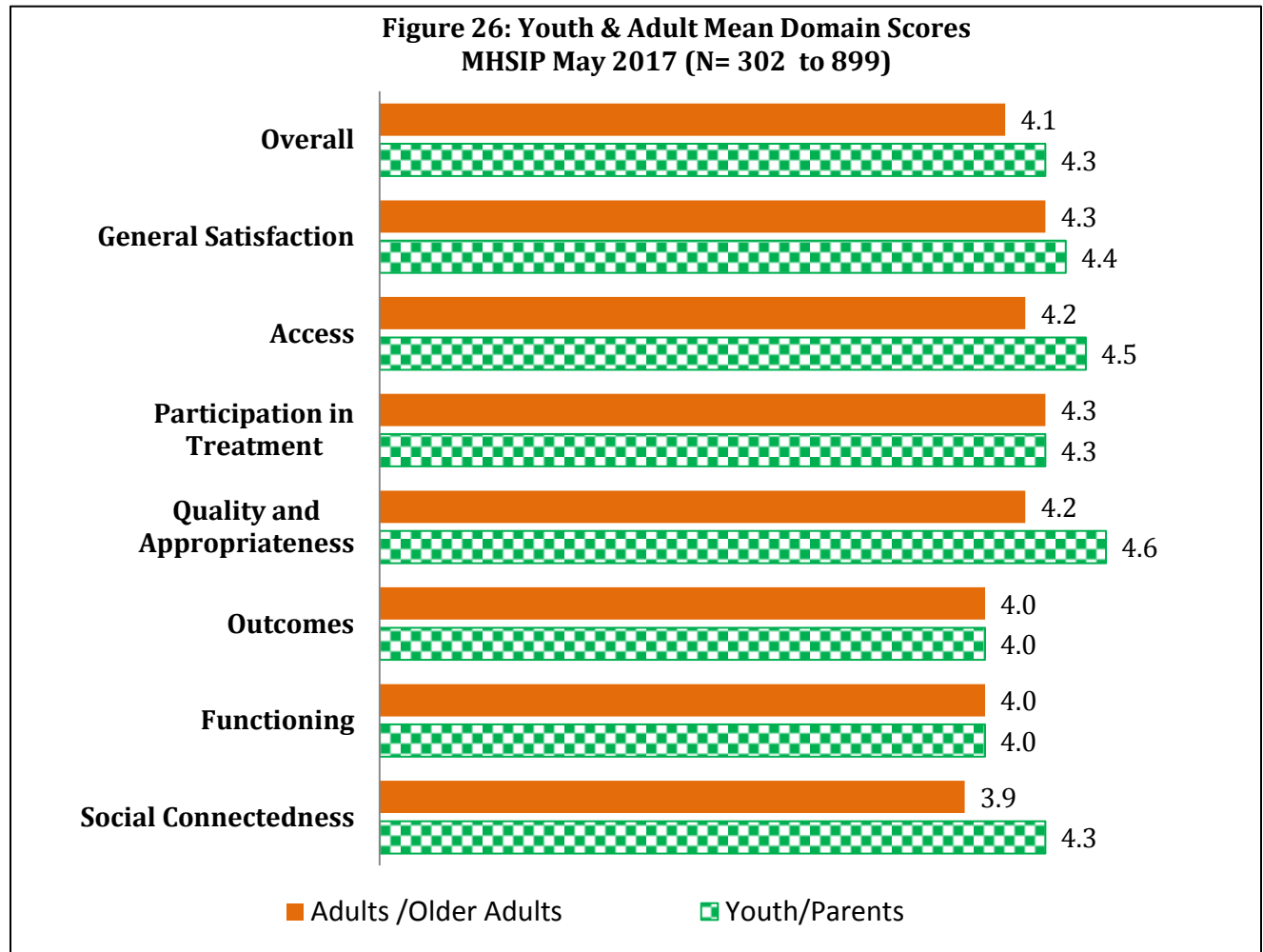
Mean domain scores for adults have remained fairly consistent with slight fluctuations in the past few years. Figure 25 on the following page shows the mean domain scores for adult (including older adult) MHSIP surveys administered between November 2015 and May 2017, with survey sample sizes that ranged from 332 to 522. The May 2017 results show increases in the mean composite score for *Participation in Treatment* (4.2 to 4.3), while all other domains show mean composite score decreases ranging from .10 to .30 compared to November 2016 results. The largest declines in mean composite score were in the domains of *Social Connectedness* (3.9 from 4.2) and *Outcomes* (4.0 from 4.3).

**Figure 25: Adult Average MHSIP Surveys Domain Scores 2015 to 2017
(N= 332 to 522)**



Comparing Adult and Youth/Parent Domain Scores

In five of the seven domains the average scores for Youth/Parents were higher than those for all Adults. The highest satisfaction category for Youth/Parents was *Quality and Appropriateness* [$M=4.6$] whereas for adults both *General Satisfaction* and *Participation in Treatment* [$M=4.3$] were equally rated. The lowest categories of satisfaction were *Outcomes* and *Functioning* for youth/parents [$M=4.0$] and *Social Connectedness* [$M=3.9$] for adults. See Figure 26 below.



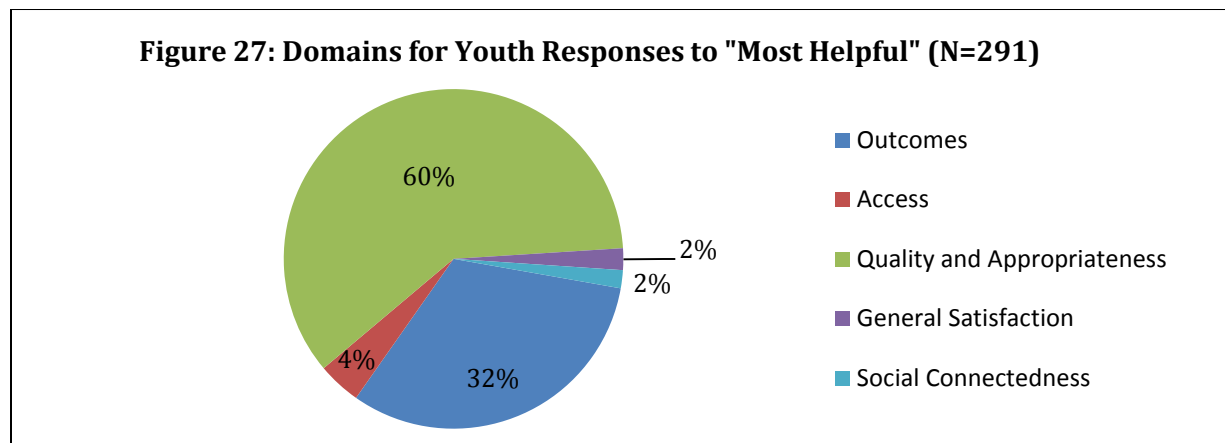
Open-Ended Survey Comments

Methodology for Analyzing Comments

Each open-ended response was reviewed and coded according to emerging themes, particularly themes aligned with survey domains.¹⁴ The comments were coded by two different evaluators to increase the reliability and objectivity of the coding. Only valid responses to the open-ended items are included in the results, such that responses that were missing, incomprehensible, or unrelated to the question were considered invalid and thus were excluded from the analysis. Responses that did not seem to pertain to any particular domain were also excluded from this analysis.

Youth

Most helpful: The first open-ended item on the youth survey asked respondents to describe “*What has been the most helpful thing about the services received over the last six months?*” A total of 314 youth respondents completed this open-ended item, of which 291 responses (representing 89% of all surveyed youth) were deemed valid and thematically relevant to the pre-determined domains. The majority (60%) of comments pertained to the domain *Quality and Appropriateness*, while 32% of responses were related to the *Outcomes* domain.



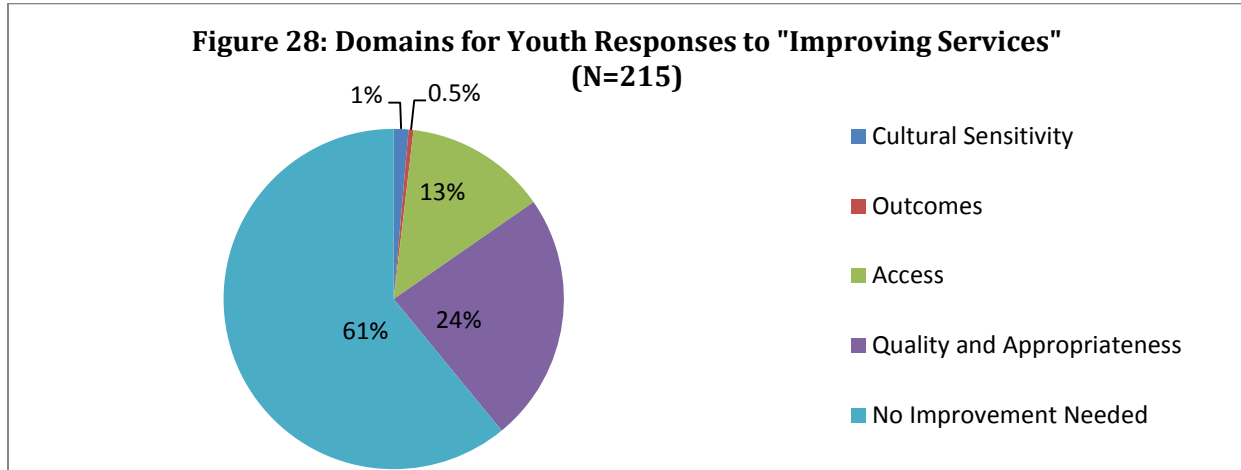
Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

Among the 175 comments related to *Quality and Appropriateness*, 57% of responses mentioned the value of being able to talk and/or have someone to listen. Many youth responded that the most helpful thing about services were being able to “talk to someone without being judged,” “being heard,” and “having someone who will listen.”

Youth also mentioned specific aspects of the services they were receiving, including groups, one-on-one therapy, and some activities such as art and games. Many youth highlighted getting advice and coping skills, such as “breathing techniques,” “ways to calm down,” and “communication skill building.”

¹⁴ Open-Ended responses include the analysis of comments that centered around “Cultural Sensitivity” as a theme; this theme corresponded to the *Quality and Appropriateness* domain outlined in the quantitative analysis section. Additionally, comments identified as relating to the “Functioning” theme have been incorporated into the *Outcomes* domain in this section.

Improving services: The second open-ended item on the youth survey asked “*What would improve services?*” A total of 246 youth respondents completed this open-ended item and 215 responses (representing 66% of all surveyed youth) were deemed relevant to the pre-determined domains. The majority of responses (61%) – which represented 40% of all surveyed youth – indicated that no improvements were needed. A majority of comments fell within the domains of *Quality and Appropriateness* (24%) and/or *Access* (13%).

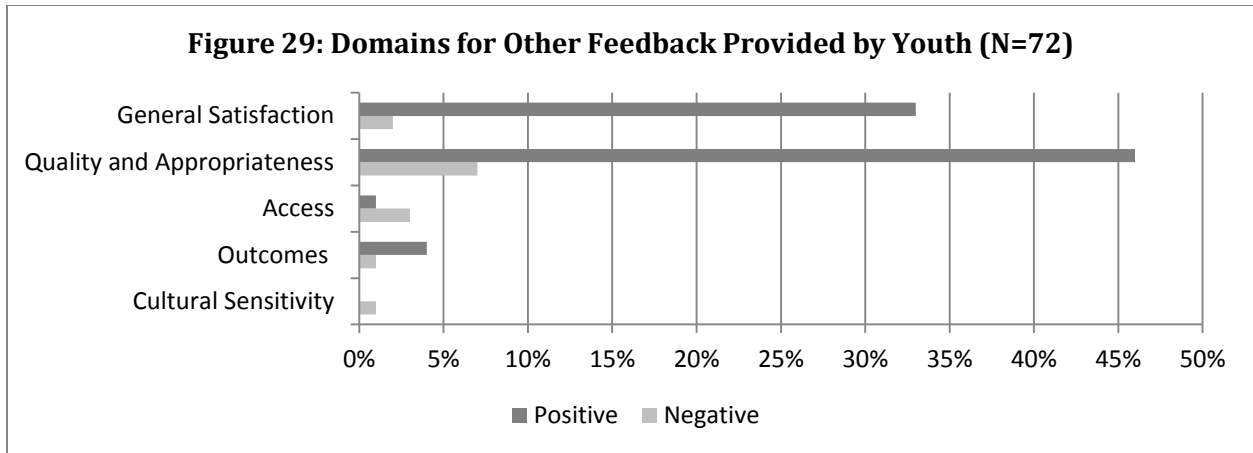


Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

A total of 84 respondents provided comments within the predetermined domains that indicated that improvement was needed. These comments primarily centered around the following themes:

- **Activities:** About 27% of the comments in coded as pertaining to the topic Quality and Appropriateness related to improved or increased activities. This included specific therapeutic support such as more strategies and skills, daily check-ins and requests for more active activities, games, field trips, etc. One youth wanted “more independent activities” and “help with jobs.”
- **Staff:** About 35% of comments related to staff. Some youth respondents had complaints about the staff or suggestions for staff behavior change (“Staff to stop using bad language” and “better support and less mean staff.”) Youth also wanted more sensitivity from staff such as “more understanding comments” and “being left alone more often.” A couple youth expressed gratitude or satisfaction with their counselors.
- **Other:** Several youth wanted amenities such as food, better rooms, relaxing music and less paperwork.

Other feedback: The third open-ended item on the youth survey asked respondents to provide “*both positive and negative feedback.*” A total of 97 respondents completed this open-ended item, and 72 of these responses (representing 22% of all surveyed youth) were considered valid and related to the domains. Of these valid responses, 85% contained positive feedback.

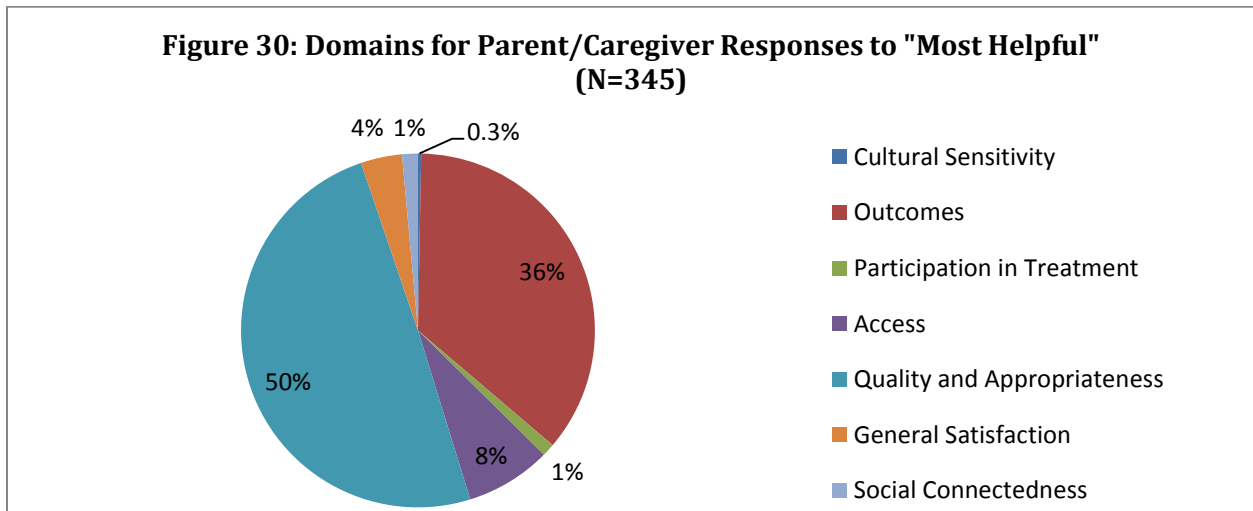


Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

The 61 positive responses were predominantly related to two domains: *General Satisfaction* and *Quality and Appropriateness*. Respondents expressed contentment with the services and people at the clinics, especially service providers. Respondents expressed appreciation for the services and for the positive impact the services had on their lives. In general, comments and themes were similar to the responses to the first two questions.

Parents and Caregivers

Most helpful: Parents and caregivers received a survey with the same open-ended questions as the youth surveys. The first open-ended item on the parent and caregiver survey asked respondents to describe “*What has been the most helpful thing about the services you and your child received over the last six months?*” Of the 368 responses received for this question, 345 responses (comprising 89% of all surveyed parents and caregivers) were deemed valid and relevant to the identified thematic domains. The majority of the responses (50%) were related to the domain *Quality and Appropriateness*, while 36% related to *Outcomes*.



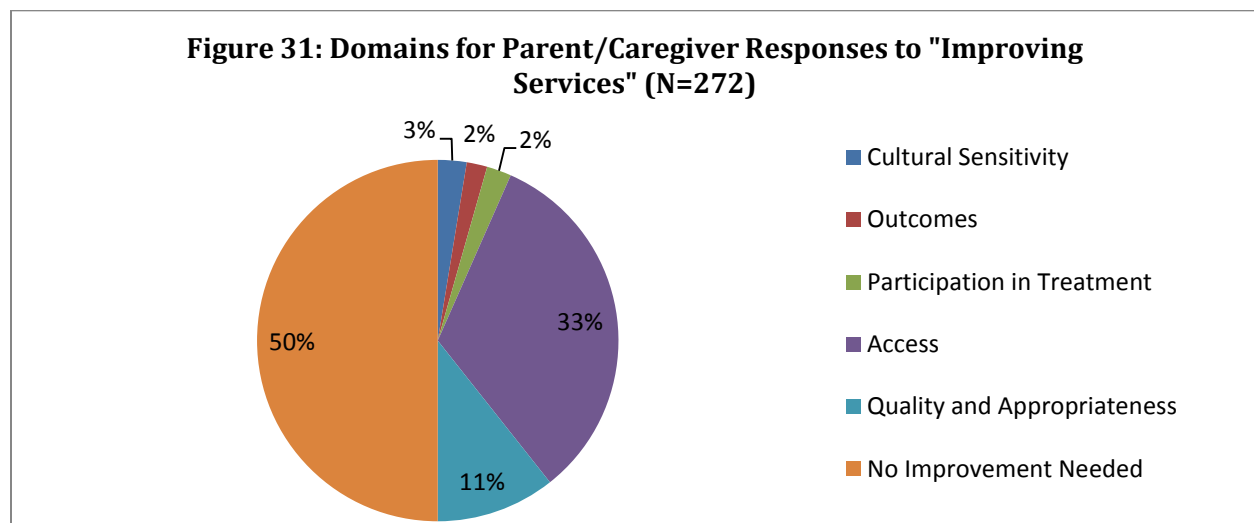
Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

Among the comments related to the domain *Quality and Appropriateness*, respondents were most likely to mention one of two topics: Support and Talking/Listening. Parents/caregivers spoke about

the support that they and their families have received. One wrote, “I like the support that they gave from the first day my service started. They came in being concerned of my child's needs and mine.” Respondents praised the ability of staff to communicate well with both youth consumers and their parents/caregivers. One person wrote, “Counselor helped me navigate and open up conversation with my son at home and gave him someone to talk to at school.” One wrote that the most helpful thing about services was, “Being able to confide in staff without judgement, having my child feel they're being protected and heard.”

Among the 124 comments related to *Outcomes*, parents/caregivers were most likely to speak about improvements in the individual youth’s communication, as well as behavioral improvements. One respondent wrote, “That my son now talks with the other people who come to my house and expresses what he feels and talks better with everyone.”

Improving Services: The second open-ended item on the parent/caregiver survey asked, “*What would improve the services here?*” Of the 293 parents/caregivers who responded to this question, 272 responses were deemed valid and related to the predetermined domains. Of the valid responses, half (50%) indicated that no improvement was needed. Of the 136 individuals (representing 35% of all surveyed parents/caregivers) who indicated that improvement was needed, most mentioned *Access* (33%) and/or *Quality and Appropriateness* (11%).

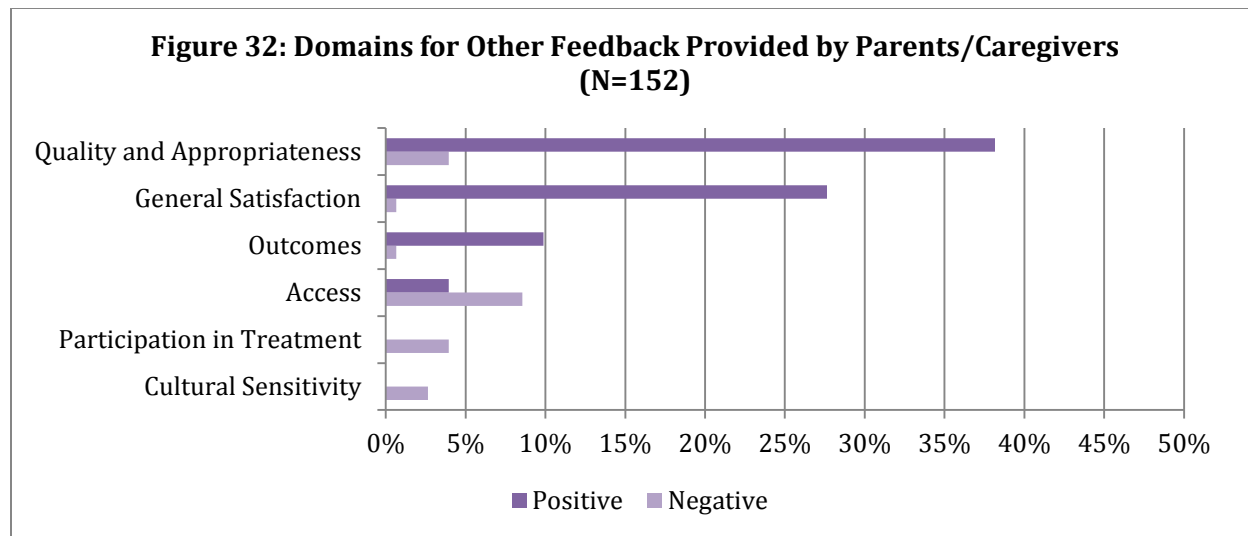


Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

Among the 89 responses that were categorized in the *Access* domain, the most common theme was wanting more frequent sessions and desiring expanded clinic hours (weekends and evenings). One parent/caregiver wrote, “If there were more available days and not only one session per week...” Multiple respondents also mentioned the need for more resources, such as more staff (“More counselors, one is not enough for a student body of 700+”), and for an improved referral system. Other respondents wished for expanded services at school, in the classroom or with the entire family.

Other Feedback: The third open-ended item on the parent/caregiver survey asked respondents to provide “*both positive and negative feedback.*” A total of 180 respondents completed this open-ended item, and 152 of these responses (representing 39% of all surveyed parents/caregivers)

were considered valid and related to the domains. Of these valid responses, 80% contained positive feedback.



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

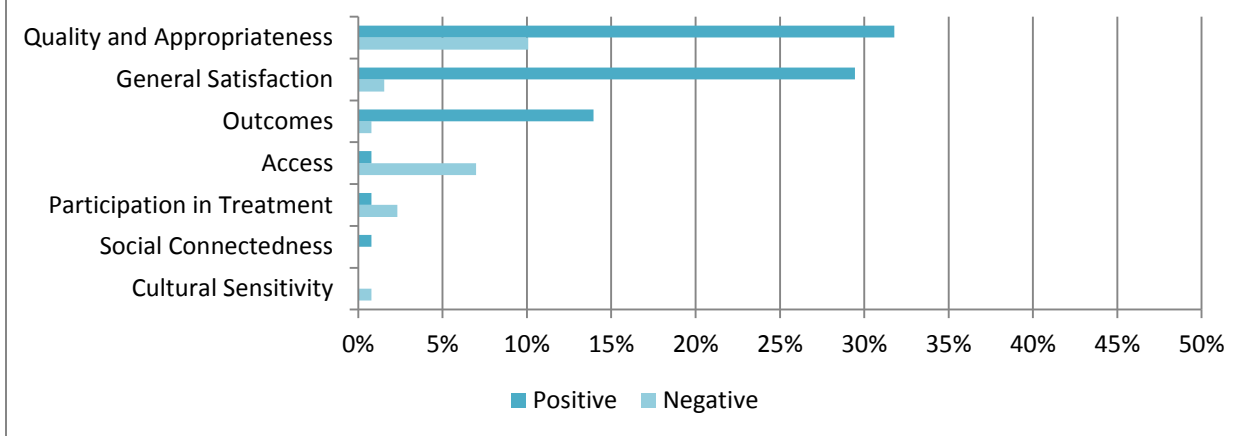
Among the valid comments, 38% were related to the domain *Quality and Appropriateness* (positive). Within this domain, most responses commented on the helpfulness and pleasantness of program staff. One parent/caregiver wrote, “Staff is very friendly, available, ready to listen and offers support whenever needed.” The positive comments in categorized in the domain *General Satisfaction* were similar, frequently commenting on their gratitude for services and specific staff members.

The 31 negative comments mentioned desiring extended or additional services. One person wrote, “We feel so attached to our clinician, and it will be difficult to adjust to someone else.” Some respondents commented on their need for more consistency in staff and in appointments, as well as the need for better communication from staff about updates.

Adults and Older Adults

The one open-ended item on the adult survey asked respondents to provide “*both positive and negative feedback.*” A total of 108 older adult and adult respondents completed this open-ended item. A total of 129 distinct comments (from 88 unique individuals, or 27% of all surveyed adults and older adults) were deemed valid and pertaining to the identified domains. Some individuals contributed more than one comment. The majority of the domain comments were considered positive (78%) while the remainder (22%) were classified as negative. Of the positive comments, most fell into two domains: *Quality and Appropriateness* and *General Satisfaction*. The negative comments were predominantly related to *Quality and Appropriateness* and *Access*.

Figure 33: Themes on Feedback Provided on Adult MHSIP (N=129)



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

The negative comments were likely to mention barriers to issues pertaining to service quality and accessing services. Several felt staff needed more training, experience, or cultural sensitivity, with a few stating that they disliked their doctors or thought they were rude. Some talked about staff having communication issues or not being able to access needed services due to scheduling issues, providers turning them away, or lack of response from staff. A couple wanted more services such as grief counseling, support for hearing voices, and food.

The positive responses related to the domain of *General Satisfaction* (30%) generally expressed satisfaction with the services received and gratitude for the programs. The positive responses in *Quality and Appropriateness* (32%) were more specific about the positive aspects of services. Several mentioned specific staff members by name or by roles (therapists, doctors, peer providers, receptionists, etc.) or specific organizations. One older adult consumer wrote, “I like my psychiatrist. He understands me. Explains things very well, i.e. my treatment...the who, what, when, where, why, etc. He's respectful, patient, professional, caring. The first time I saw with him, felt like the biggest weights were lifted off my shoulders within the first 5 minutes. I need the help this facility provides and I'm blessed it's available for those who need it.” Comments described the services received as life-changing and even life-saving.

Discussion

MHSIP surveys that were administered for a week during May 2017 showed continued high levels of satisfaction with outpatient mental health services at Contra Costa County Behavioral Health Services (CCBHS). As has been the pattern for the past several years, ratings by youth/parents of children were higher than ratings by adults in most domains (except for *Outcomes* and *Functioning*). The highest satisfaction category was *Quality and Appropriateness* for youth and parents [$M=4.6$] followed by *Access* [$M=4.5$] and *General Satisfaction* [$M=4.4$] for youth and parents. The lowest categories of satisfaction were *Outcomes* and *Functioning* for both adults and youth/parents [$M=4.0$]. Due to the large sample sizes more than to big differences in the mean domain scores, most differences in mean composite scores were statistically significant (except for *Outcomes* and *Functioning*).

The relationships between demographic traits/service histories, health status and satisfaction domains were analyzed¹⁵ to answer the following questions:

Is consumer age associated with consumer satisfaction?

Age was significantly associated with mean scores for parents of children/youth in all domains, except for *Outcomes* and *Functioning*. Alternatively for adults, age was not a discernably significant factor between higher satisfaction for older adults (aged 60 and older) versus adults (ages 18-59).

Is consumer gender identity associated with consumer satisfaction?

Gender identity was significantly correlated with higher satisfaction in only a few domains among youth respondents. Female youth had higher satisfaction with *General Satisfaction*, *Access*, *Participation in Treatment*, and *Quality and Appropriateness* compared to male youth. There were no other statistically significant findings related gender among the other surveyed populations (parents/caregivers, adults, or older adults).

Is Mexican/Latino/Hispanic origin associated with consumer satisfaction?

Mexican/Latino/Hispanic origin (here referred to as Hispanic) was significantly correlated with satisfaction scores among youth in two domains – *General Satisfaction* and *Quality and Appropriateness*. Among adults, ethnicity was significantly correlated with *Access*, *Quality and Appropriateness*, and *Social Connectedness*. There were no significant differences in mean satisfaction scores among parents/caregivers who identified as Hispanic compared to those who did not.

Is consumer race associated with consumer satisfaction?

Race was not associated with significant differences in satisfaction for any domains among adults, youth or parents.

¹⁵ Statistically significant differences in mean scores by grouping variables (e.g. demographic or service variables) were tested in these survey populations: youth (ages 13-17), parents/caregivers (of clients ages 0-17), adults/older adults (ages 18+) and adults ages 18-59, and older adults (ages 60+). Statistically significant differences in mean scores were also tested (without associated factors) in youth/parents combined compared to adults/older adults.

Is survey language associated with consumer satisfaction?

In many domains, respondents who completed the MHSIP surveys in Spanish were more satisfied than individuals who completed surveys in English.¹⁶ Among youth, Spanish language respondents had higher levels of satisfaction compared to English language respondents in all domains excluding *Access* and *Social Connectedness*. Among parents, Spanish language speakers had higher mean domain scores in *General Satisfaction*, *Outcomes*, and *Functioning* compared to English speakers. Adult Spanish language respondents also had higher levels of satisfaction compared to English language respondents in *General Satisfaction*, *Access*, *Participation in Treatment*, and *Quality and Appropriateness*.

Is the length of time receiving mental health services associated with consumer satisfaction?

The length of time that respondents had been receiving mental health services was significantly correlated with four domains among youth (ages 13-17): *Quality and Appropriateness*, *Outcomes*, *Functioning*, and *Social Connectedness*. Youth receiving services for less than one year were more satisfied than youth receiving services for a year or more.

Is a change in school attendance associated with youth consumer satisfaction?

Better school attendance was significantly associated with greater satisfaction among youth and parents of child/youth clients who have been receiving services for less than one year. Specifically, youth who reported higher school attendance since starting mental health services were more satisfied in the following domains: *Outcomes* and *Functioning*. Parents who reported higher school attendance among their children reported higher satisfaction in three domains: *General Satisfaction*, *Quality and Appropriateness*, and *Functioning*.

Additionally, qualitative findings revealed high response rates among youth, significant proportions of positive comments, and some suggestions for improvement related to access and quality of services. The majority (70%) of surveyed youth described services that had been helpful; most of which had to do with quality of services and improved functioning. A total of 20% of surveyed youth had suggestions for improvements that focused mainly on *Quality and Appropriateness* and *Access*. A total of 17% of youth provided additional feedback, the vast majority (85%) of it positive. Response rates among parents/caregivers were also quite high. The majority (71%) of parents/caregivers described services that had been helpful to their children, particularly in the areas of *Quality and Appropriateness* and *Outcomes*. A total of 28% of parents/caregivers had suggestions for improvements, which pertained mainly to *Quality and Appropriateness* and *Access*. Roughly a third (31%) of parents/guardians offered additional feedback, 79% of it positive. In contrast, only about a third (33%) of surveyed adults and older adults completed the open-ended question on the survey. Just over three-quarters of their comments were positive, with most comments relating to *General Satisfaction* and *Quality and Appropriateness*. The negative comments related primarily to *Quality and Appropriateness as well as Access*.

The primary limitation of the surveys is that they only represent the perspectives of active clients who agreed to complete a survey. As a result, input is not included from consumers who:

- Chose not to participate;
- Are active consumers but did not have an appointment during the week the survey was administered;

¹⁶ When comparing this finding to differences related to reported Hispanic ethnicity, one would expect to find more significant differences for Hispanic ethnicity reported above. The discrepancy may be due to a number of respondents in each survey group who did not report race or ethnicity.

- Discontinued services or were unable to access services;
- Are not active clients/successfully completed services.
- Children and their parents both filled out surveys for the same service, thus doublecounting one service experience. In addition, some parents filled out multiple surveys for different children while others only filled out a single survey. Therefore, some families perspectives may have been weighed heavier than others.

Although the MHSIP surveys have some limitations, they provide feedback from a diverse spectrum of mental health consumers regarding satisfaction with services.

Recommendations

The MHSIP survey results from May 2017 provided a wealth of information allowing Contra Costa County Behavioral Health Services to better understand the strengths of its programs and to identify areas for improvement. Overall, the results demonstrate continued high levels of consumer satisfaction. Findings suggest some opportunities for improvement, particularly regarding service quality, access, outcomes/functioning and participation in treatment planning. Recommendations are summarized below:

Survey Administration:

- To achieve a more representative sample with respect to race and ethnicity, promote greater survey participation by Community-Based Organizations that do not have large numbers of Spanish-speaking clients.
- To ensure more support for Spanish speaking survey participants at County clinics, arrange for Spanish-speaking volunteers to assist in the administration of surveys.
- Provide ongoing training to volunteers who administer the surveys regarding the different survey forms and who should fill out which form.

Service Quality and Appropriateness and Access to Services:

- Continue to provide culturally competent services. Higher levels of satisfaction displayed by Hispanic and Spanish-language responders, coupled with high levels of agreement that providers are respectful and supportive of consumer culture, values, etc., indicate that services are perceived as culturally appropriate for Hispanic consumers. At the same time, some Spanish-speaking consumers have expressed the desire for more services in Spanish. This may indicate a need to explore staffing and competencies locally and regionally to ensure the best fit with consumer needs.

Outcomes, Functioning, Participation in Treatment Planning, and Social Connectedness:

- *Outcomes and Functioning:* These continue to be the categories with the lowest consumer satisfaction. Implementing more Evidence-based practices in the adult system of care may help to improve these scores. For Participation in Treatment Planning, consider how expectations are set and communicated regarding service access, treatment, and follow-up as well as other factors related to participation in treatment, adherence and support for recovery.
- Further explore opportunities to enhance experiences of social connectedness, mainly among adult consumers.

Involving Consumers, Family Members, Staff and Providers in Using MHSIP Survey Data for Improvements:

- Encourage provider/clinician as well as management participation in reviewing the survey reports and addressing weak areas/opportunities for improvement in their clinical sites. Identify meaningful forums where issues identified in the MHSIP surveys can be shared, action plans or projects developed, and progress celebrated.
- Involve the Office of Consumer Empowerment in exploring ways to involve consumers and family members as volunteers in survey administration but also in sharing results and working on improvement efforts related to the results.

Appendix: Domain Items

Youth and Parent/Caregiver Surveys

General Satisfaction

Overall, I am satisfied with the services I [my child] received.
The people helping me [my child] stuck with me [us] no matter what.
I felt I [my child] had someone to talk to when I [he / she] was troubled.
I received services that [The services my child and / or family received] were right for me [us].
I [My family] got the help I [we] wanted [for my child].
I [My family] got as much help as I [we] needed [for my child].

Access

The location of services was convenient for me [us].
Services were available at times that were convenient for me [us].

Quality & Appropriateness

Staff treated me with respect.
Staff respected my [family's] religious / spiritual beliefs.
Staff spoke with me in a way that I understood.
Staff were sensitive to my cultural / ethnic background.

Participation in Treatment

I helped choose my [child's] services.
I helped to choose my [child's] treatment goals.
I participated in my own [child's] treatment.

Outcomes & Functioning

I am [My child is] better at handling daily life.
I [My child] get along better with family members.
I [My child] get along better with friends and other people.
I am [My child is] doing better in school and / or work.
I am [My child is] better able to cope when things go wrong.
I am satisfied with my family life right now.
I am [My child is] better able to do things I [he or she] want to do.

Social Connectedness

I know people who will listen and understand me when I need to talk.
I have people that I am comfortable talking with about my [my child's] problem(s).
In a crisis, I would have the support I need from family or friends.
I have people with whom I can do enjoyable things.

Adult and Older Adult Surveys

General Satisfaction

I like the services that I received here.

If I had other choices, I would still get services from this agency.

I would recommend this agency to a friend or family member.

Access

The location of services was convenient (parking, public transportation, distance, etc.).

Staff were willing to see me as often as I felt it was necessary.

Staff returned my calls within 24 hours.

Services were available at times that were good for me.

I was able to get all the services I thought I needed.

I was able to see a psychiatrist when I wanted to.

Quality & Appropriateness

Staff here believe that I can grow, change, and recover.

I felt free to complain.

I was given information about my rights.

Staff encouraged me to take responsibility for how I live my life.

Staff told me what side effects to watch out for.

Staff respected my wishes about who is, and who is not to be given information about my treatment.

Staff were sensitive to my cultural background (race, religion, language, etc.).

Staff helped me obtain the information I needed so that I could take charge of managing my illness.

I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).

Participation in Treatment

I felt comfortable asking questions about my treatment and medication.

I, not staff, decided my treatment goals.

Outcomes

I deal more effectively with daily problems.

I am better able to control my life.

I am better able to deal with crisis.

I am getting along better with my family.

I do better in social situations.

I do better in school and / or work.

My housing situation has improved.

My symptoms are not bothering me as much.

Functioning

I do things that are more meaningful to me.

I am better able to take care of my needs.

I am better able to handle things when go wrong.

I am better able to do things that I want to do.

Social Connectedness

I am happy with the friendships I have.

I have people with whom I can do enjoyable things.

I feel I belong in my community.

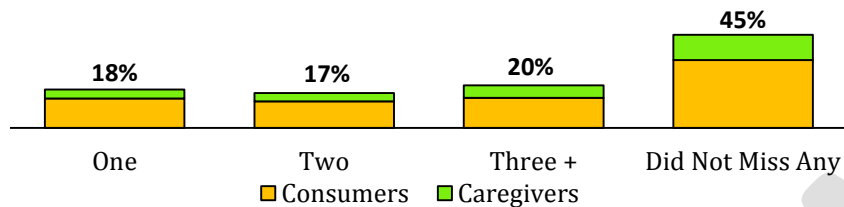
In a crisis, I would have the support I need from family or friends.

2016 Service Improvement Survey

Individuals receiving services at a County mental health clinic and their caregivers had the opportunity to complete a Service Improvement Survey between November 14 and December 15, 2016. Surveys were available at 6 County-operated clinics during this timeframe. In addition, the survey was available for a limited time at several consumer-centered venues. The purpose of the survey is to inform efforts to improve appointment adherence. There were 448 (421 English, 27 Spanish) consumer and 153 (128 English, 25 Spanish) caregiver surveys submitted resulting in a **total of 601 surveys**.ⁱ

APPOINTMENT ADHERENCE

More than half of consumers missed at least one appointment



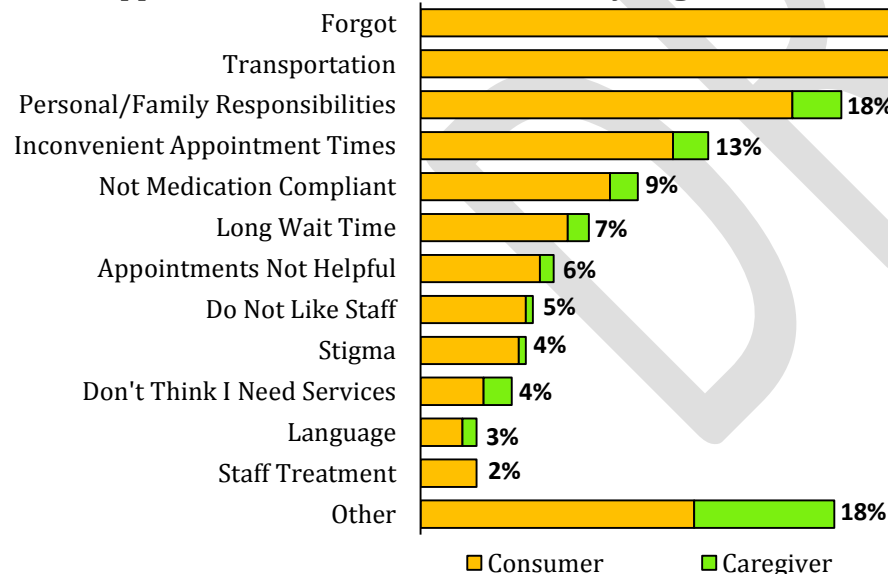
Appointments Missed (n=560)

When asked how many times an appointment was missed at a mental health clinic over the past year, 45% of individuals reported not missing any of their mental health appointments in the past year, 18% missed one appointment, 17% missed two appointments, and 20% missed three or more appointments. **Adult clinic respondents were more likely than children's clinic respondents to report that they missed an appointment.**

Barriers to Appointment Adherence (n=330)

A total of 54% of respondents "forgot I had an appointment." Appointments were also often missed because of a lack of transportation (32%), conflicting personal or family responsibilities (18%), and inconvenient appointment time (13%). Respondents had the option to list other barriers, which 18% of respondents did. These responses included: Illness, conflicting appointments, arrived late, did not want to come, and hospitalized.

Half of appointments are missed because they forgot



**multiple response option

Statistically significant differences in reported barriers included:

- Regionally, fewer Central County respondents marked transportation as a barrier to attending appointments compared to other regions.
- Adult clinic respondents were more likely to report they missed an appointment because they forgot or were not medication compliant than children's clinic respondents.
- Consumers were more likely than parents/caregivers to report missing an appointment because of forgetting, transportation, not medication compliant, inconvenient appointment time, stigma, do not like staff, and personal/family responsibilities.
- English survey respondents were more likely than Spanish survey respondents to report they missed an appointment because they forgot, not medication compliant, stigma, do not find appointments helpful, and do not think services are needed.
- Those who reported missing multiple appointments were more likely to marked transportation, medication compliance, and language as issues.

Appointment Adherence Support (n=222)

Asked what can be done differently to help individuals attend their appointments, responses included:

- Phone Reminder, including multiple phone reminders and a reminder one day before appointment
- Text Reminder
- Email Reminder
- Reminders in General
- Transportation Support
- Provide Bus Tickets/Fare
- Improve Rapport with Consumers
- Greater Appointment Availability
- Better Scheduling System
- Improve Wait Time
- Decrease Lobby Wait
- Have More Types of Services

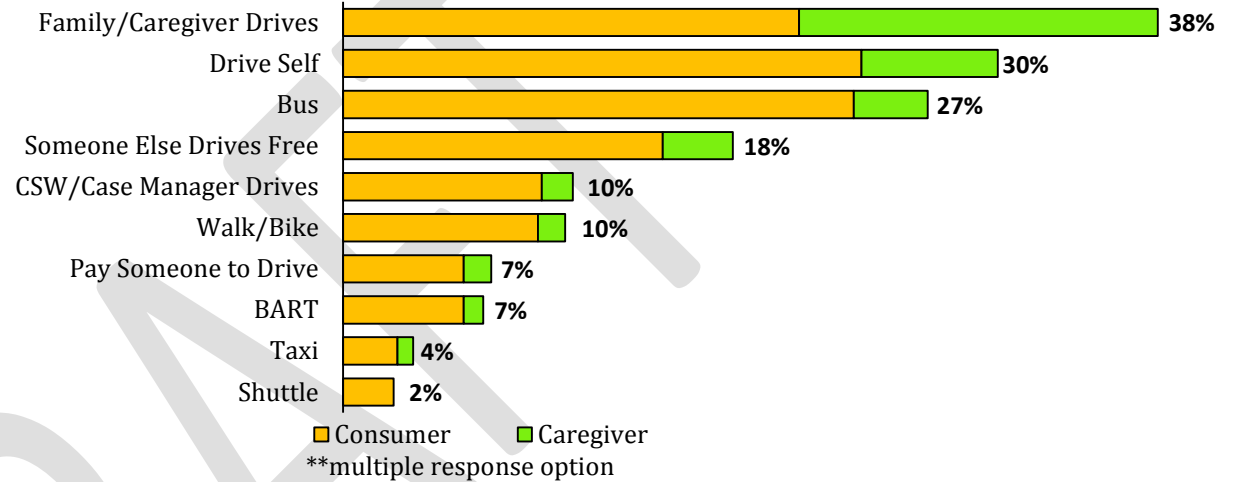
Transportation Modes (n=577)

When asked how consumers get to their mental health appointments, the most common modes were: **family/caregiver drives (38%), consumers drive themselves (30%), and use bus (27%)**. More than one-fifth (22%) of consumers rely on multiple modes of transportation to make it to their appointments.

There were several statistically significant group differences found.

- Compared to other regions, fewer respondents from West County reported that family/ caregivers drive or someone was paid to drive them to appointments. **Fewer East County respondents reported that staff transport them.**
- Caregivers were more likely to report that a family/ caregiver drives consumers to appointments, while consumers were more likely to report that someone drives them for free, they walk, and take the shuttle or bus.
- **Adult clinic respondents were more likely to use the bus to get to their appointments,** while children's clinic respondents were more likely to have family/caregivers drive consumers to appointments.
- English survey respondents were more likely than Spanish survey respondents to report a staff member drives them, someone else drives them for free, they walk/bike, or use BART or bus to get to appointments. Spanish survey respondents were more likely to drive themselves to appointments.

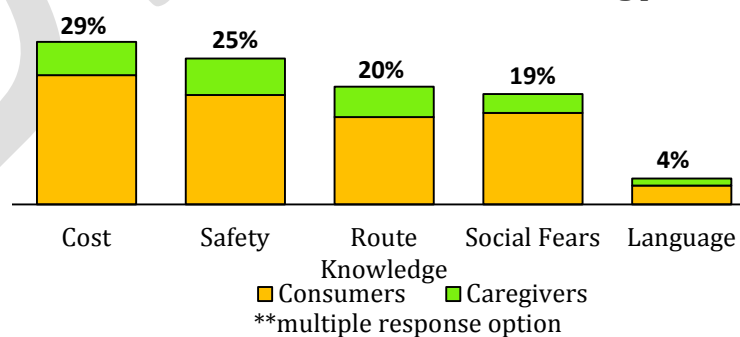
Individuals use multiple modes of transportation to get to their appointments



Public Transportation Concerns (n=547)

In an effort to support greater transportation independence, the survey asked about concerns using public transportation. **Cost (29%), safety (25%), lack of knowledge on routes (20%), and social fears (19%) are each experienced by approximately one in five consumers.** A quarter each of respondents said they have no concerns or they do not use public transportation.

Individuals have several concerns about using public transportation

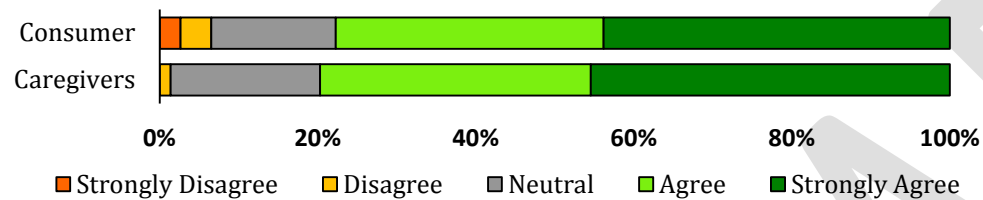


Group differences in public transportation concerns:

- Consumers were more likely than caregivers to report social fears as a concern, while caregivers were more likely to report not using public transportation.
- **Adult clinic respondents were more likely than children’s clinic respondents to report that cost is a concern** to using public transportation. Children’s clinic respondents were more likely to report not using public transportation
- English survey respondents were more likely to report that cost, safety, and social fears are concerns than were Spanish survey respondents.

COMMUNICATION

Satisfaction with information and materials provided explaining the mental health systems and services was high



Satisfaction with Information and Materials (n=556)

When asked about satisfaction with information and materials provided, 78% of consumers and 80% of caregivers reported satisfaction.

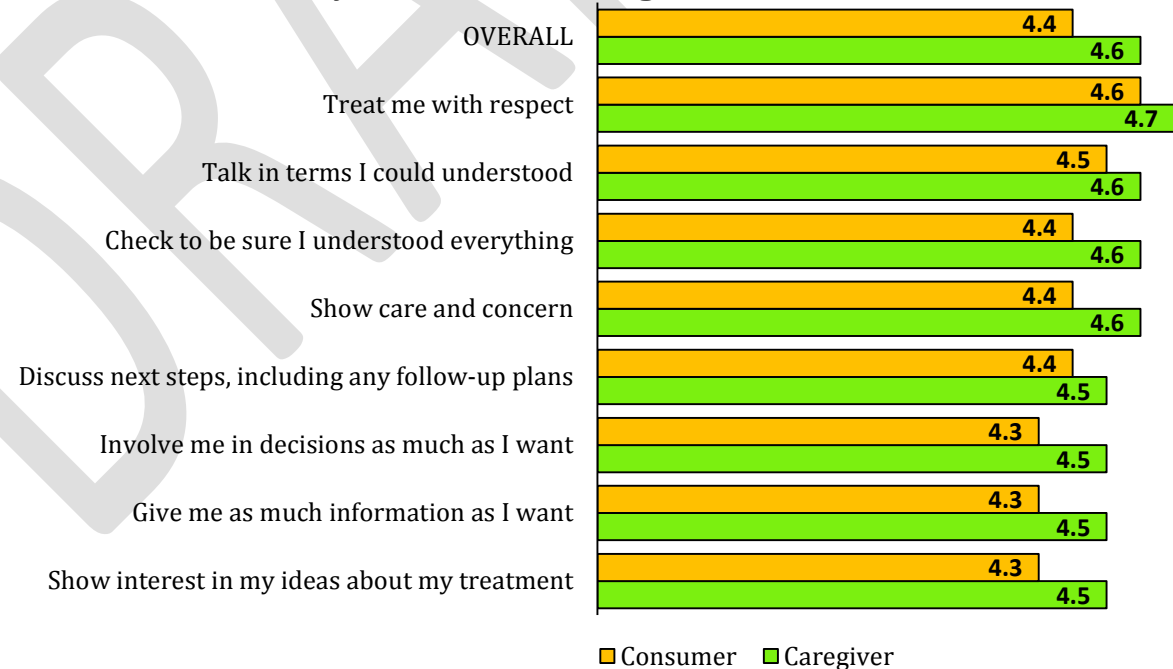
Communication with Staff

On a 5-point scale from *1-Strongly Disagree* to *5-Strongly Agree*, individuals were asked to provide feedback on their communication with different staff roles. Overall, respondents were highly satisfied across staff roles.

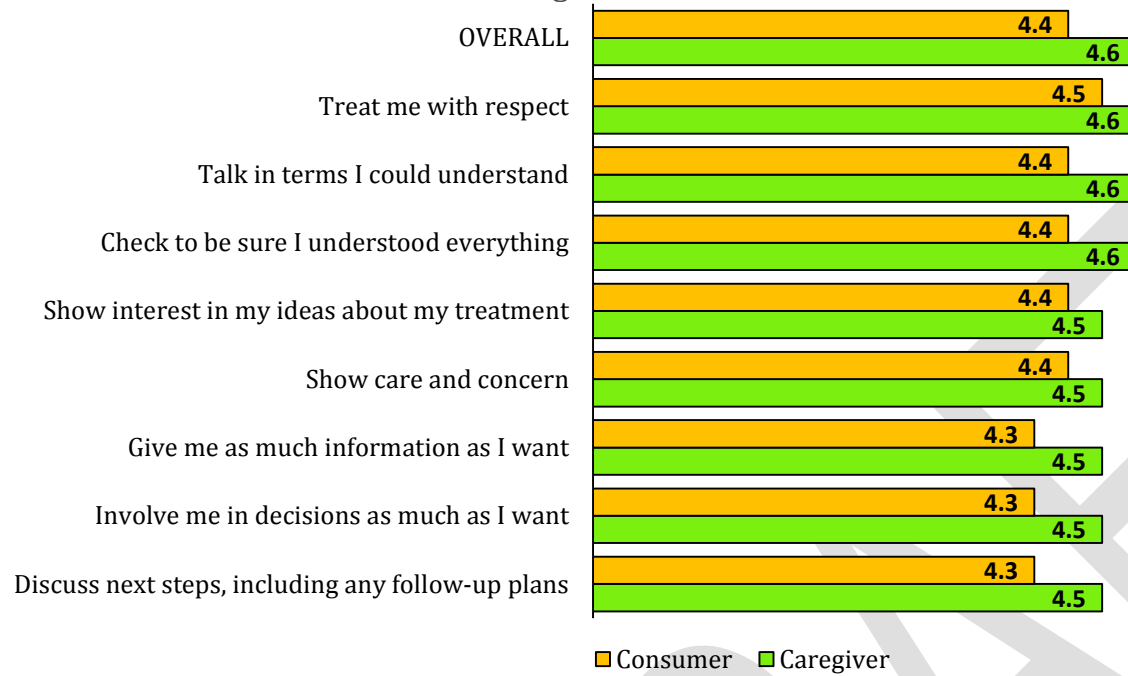
As for group differences:

- Compared to caregivers, **consumers were less satisfied with communication with psychiatrists and nurses.**
- Spanish survey respondents, overall, were more satisfied with communication than English survey respondents.

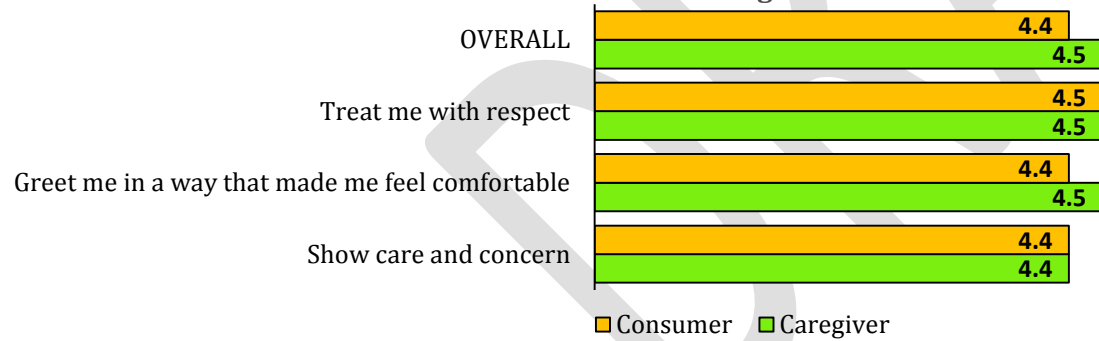
Communication with Psychiatrists: Mean ratings



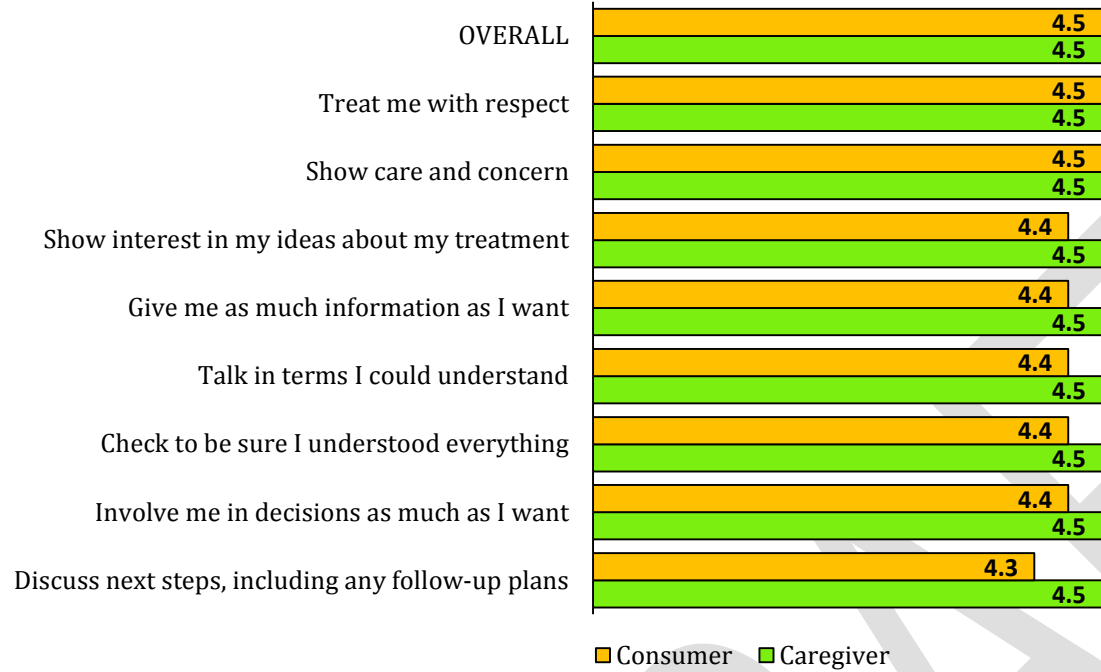
Communication with Nurses: Mean ratings



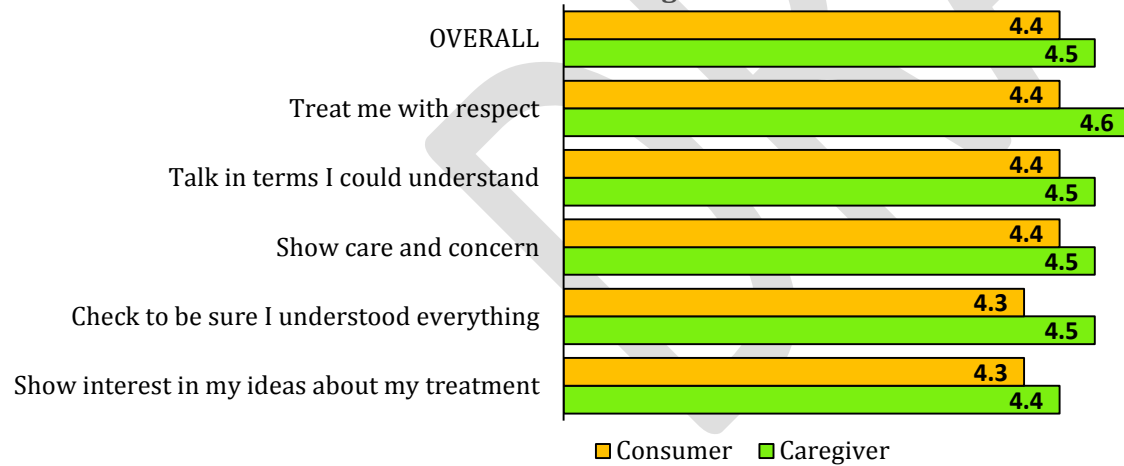
Communication with Clerks and Front Desk: Mean ratings



Communication with Case Managers/Therapists/Clinicians: Mean ratings



Communication with Peer Providers: Mean ratings

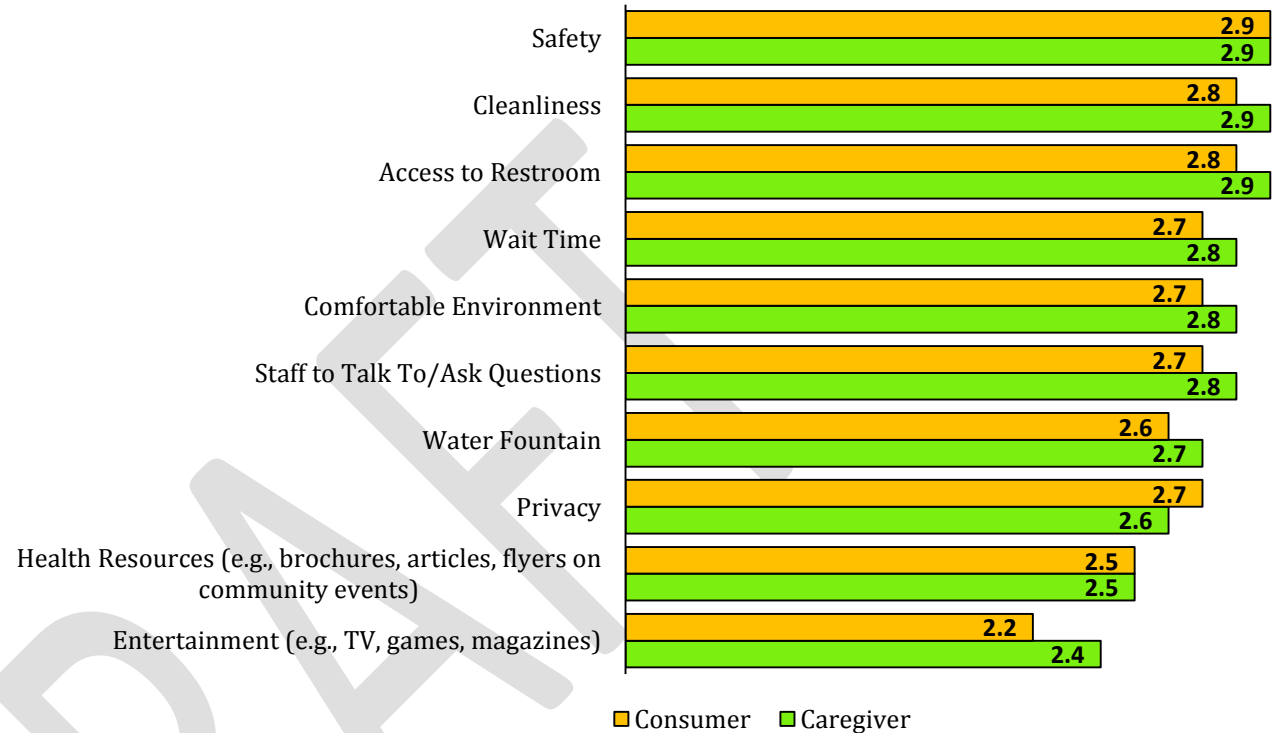


WAITING ROOM ENVIRONMENT

On a 3-point scale from 1-Not Important to 3-Very Important, individuals were asked how important different waiting room features were to them. Respondents valued most of the listed features, with safety being the most important.

Statistically significant differences included:

- Compared to other regions, respondents from **West County rated privacy higher and having entertainment available lower**. Those from **East County rated higher a comfortable waiting room and having staff available** to communicate with them.
- Compared to consumers, caregivers rated higher entertainment, staff available to communicate with, safety, and cleanliness.
- **Spanish survey respondents rated privacy and entertainment higher** than English survey respondents.



RECOMMENDATIONSⁱⁱ

- **Appointment Adherence:** Ensure that we have the correct phone numbers of consumers so that appointment calls are useful; inquire if text or email reminders are feasible; follow up with individuals who chronically miss appointments to investigate support needed to attend appointments; and pilot a transportation education program.
- **Communication:** Survey consumers and their family on experiences with institutional stigma to follow up on separate focus group findings.
- **Waiting Room Environment:** Ensure they are well maintained through regular painting and carpet replacement; consider designating a peer provider to the waiting room to interact with individuals; ensure information resources are in the lobby and assign staff to monitor; and investigate how the television can be used to provide health education.

ⁱ The consumer survey was offered to consumers 13 years and older; the caregiver survey was offered to caregivers of youth and adult consumers. A greater number of caregiver surveys were submitted from Central County clinics and fewer Spanish language surveys were submitted from the West County clinics compared to other regions.

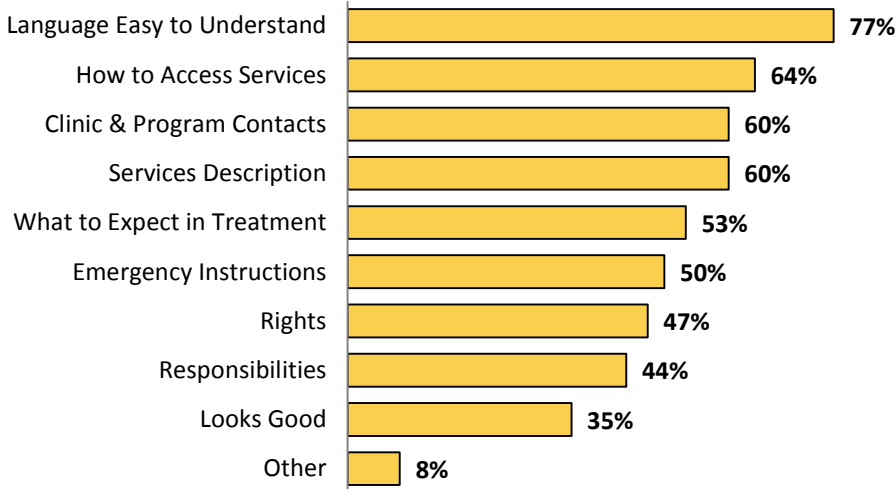
ⁱⁱ The survey ended with a space for other comments or suggestions. Most individuals left this blank or expressed thankfulness for services with some requesting specific resources such as housing or transportation support.

2017 Service Improvement Survey

Individuals receiving services at County-operated mental health clinics and programs and their caregivers had the opportunity to complete a Service Improvement Survey between May 15 and May 19, 2017. The purpose of the survey is to inform efforts to improve consumer experience through ensuring welcoming environments at the clinics. There were 290 (266 English, 24 Spanish) surveys submitted.

WELCOME HANDBOOK

Easy to Understand Language is Important in a Welcome Handbook



Contra Costa Behavioral Health Services is currently piloting a Welcome Handbook. Consumers were asked to identify what was important to them in a Welcome Handbook. The majority of respondents indicated they want easy to understand language, information on how to access services, contact information for clinics and programs, and a description of services. Half of consumers felt information on what to expect in treatment and instructions on what to do in an emergency was important to include.

18 respondents commented on additional things that would be helpful in a Welcome Handbook. Responses included information on: staff directory, collecting Social Security Disability, programs to prevent hospital visits, stigma reduction and peer run services, and procedures for filing complaints.

PERCEPTIONS OF STAFF

On a 5-point scale from *Strongly Disagree* to *Strongly Agree*, respondents were asked to rate their agreement with various statements about staff at their mental health clinic (see graph on following page). Overall, staff were rated highly, indicating consumer and caregiver satisfaction with communication. In particular, over 90% of consumers and caregivers agree that staff treat them with respect, talk in terms they understand, show care and concern, and are friendly and polite. On the other hand, consumers and caregivers had slightly lower agreement on items related to consumer-driven care.

Respondents who disagreed were asked for an explanation. Several respondents noted that they have never been greeted upon arrival, and staff sit “behind a glass window”, are not at the desk, or are rude. Others talked about staff running late, rescheduling or cancelling appointments. A couple stated their providers do not respect their desires for treatment.

There were some statistically significant regional differences. Specifically, West and Central County staff, compared to East County staff, were rated higher on 9 of 12 items (see * items on graph).

Consumers and Caregivers Agree that Staff Have Good Communication



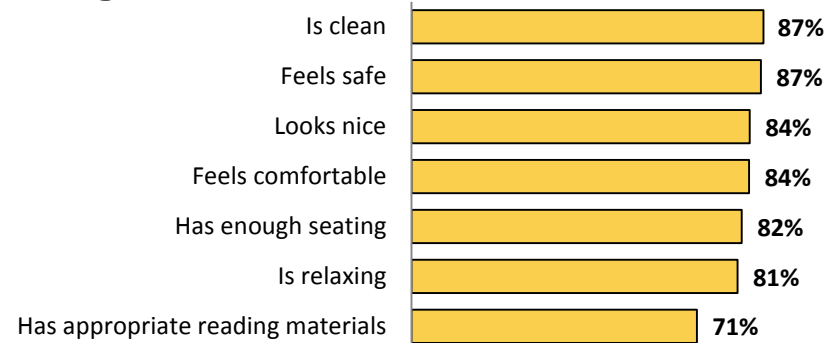
WAITING ROOM ENVIRONMENT

Consumers and caregivers were asked to rate the extent to which they agreed with various statements about their clinic's waiting room. The lowest rated item concerned reading material with 71% agreeing that their waiting room has appropriate reading materials. Waiting rooms were rated positively overall with 87% of consumers reporting that they feel safe in the waiting room and that the room is clean. Note that approximately 1 in 10 respondents do not feel safe and are not comfortable in the waiting room.

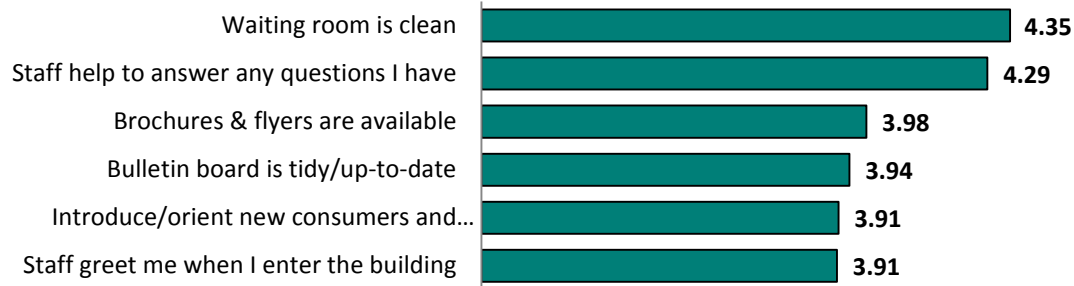
Statistically significant group differences included:

- Children's clinics were rated slightly higher in looking nice and having appropriate reading materials and enough seating than adult clinics.
- East and West County respondents were more likely to feel safe and relaxed in waiting rooms than Central County respondents.
- East County clinic waiting rooms were rated higher in looking nice compared to other regions.
- Central County clinic waiting rooms were least likely to be reported as having enough seating and appropriate reading materials.

Waiting Rooms Are Generally Clean and Safe But Could Improve on Reading Materials



Cleanliness and Staff Answering Questions are Essential to Have in Waiting Rooms



On a 5-point scale from 1=*Not Important* to 5=*Absolutely Essential*, individuals were asked how important different waiting room and clinic features were to them. Respondents valued most of the listed features, with cleanliness of the waiting room and having staff available to answer questions being the most important.

Statistically significant group differences included:

- Children's clinic respondents rated waiting room cleanliness as more important than those at the adult clinics.
- Central County clinic respondents were least likely to rate staff greeting them as an important feature.

The survey concluded by asking how else we could improve the waiting room experience. Responses discussed:

- More seating and space
- More comfortable seating
- Better lighting
- Happy decorations
- Tidiness
- Low volume music
- More reading materials such as magazines, guides on mental illness, health brochures, and information on community resources
- Snacks or beverages such as water
- Television or different television entertainment including G-rated movies, Recovery TV, and other shows besides cartoons
- Shorter wait times
- Better treatment from doctors and front desk staff

RECOMMENDATIONS

- **Welcome Handbook:** Pilot Welcome Handbook and during revision ensure Welcome Handbook has language that is accessible (e.g., at a 6th grade reading level) and provides sufficient information on services, how to access services, and current contact information for programs and clinics.
- **Staff:** Attend to clinic scheduling issues to better value consumers' time. Consider trainings to address how to involve consumers in decision-making and seek their feedback and ideas about treatment.
- **Waiting Room Environment:** Identify, develop, and stock appropriate reading materials (e.g., up to date flyers, health booklets, information on mental illness) in clinics and ensure there is sufficient seating and clean spaces (e.g., clean carpets). Have staff visible and accessible to answer questions and make sure waiting rooms are clean. Develop procedures on television use and appropriate content, such as identifying an menu of content and investigate the feasibility of using similar content used at the Regional Medical Center.

2016 Consumer and Family Member Focus Groups Summary

Background

Consumer and family member/caregiver satisfaction is an important factor when considering the quality of our mental health services. There are two main ways that Contra Costa Behavioral Health assesses satisfaction. Twice a year for a one week period, consumers and parents/caregivers of youth consumers receiving services at an outpatient mental health clinic are given the opportunity to complete a consumer perception survey of closed-ended and open-ended questions that collects demographic information, service history, and consumer satisfaction across several domains. Another means to gather satisfaction data is through focus groups. A focus group is a facilitated group discussion that allows for in-depth input on a select number of issues. In 2016, a focus group was held at each of 7 County-operated clinics. At our 4 Adult or Older Adult clinics, the focus groups were conducted with consumer participants. At our 3 Children's clinics, focus groups were held with parents and caregivers of consumers. Two focus groups were conducted in Spanish, one each at an Adult and Children's clinic. In addition, one of the Adult clinic focus groups was held specifically for transition aged youth (TAY) consumers ages 18-25.

Methodology

Facilitator Guide Development

To develop the Facilitator Guide, the Research and Evaluation Team began by reviewing the domain findings from recent consumer perception surveys and considered current quality improvement efforts. A list of potential questions was compiled and presented to the Quality Management Committee. The questions were narrowed down and reviewed by the Children's Chief and Adult and Children's Family Services Coordinators before being vetted again by the Quality Management Committee. The Guide is comprised of the following sections:

- Welcoming Participants
- Getting Consent
- Introductions

- Questions
- Closing and Distribution of Incentives

About the Participants

Adult consumer participants ($n = 27$) ranged in age from 20 to 76 years old ($mean = 43$ years old). The majority of adult participants was female (59%) and was White (52%) or Hispanic (37%). Youth ($n = 24$) of parent/caregiver participants ($n = 21$) ranged in age from 8 to 19 years old ($mean = 13$ years old). The majority of youth was male (58%) and was White (45%) or Hispanic (25%).

Themes

Question 1: What is Contra Costa Mental Health currently doing to help you [your family] achieve your goals and make progress?

Common Themes¹

- In General Received Needed Services
- Individual Therapy / Counseling
- Peer Provider Support
- Quality Staff

Question 2: What else can Contra Costa Mental Health do to help you achieve your [their] goals and make progress?

Common Themes

- More Social Activities / Groups
- Provide Education on Medications
- Educate on How to Advocate
- Transportation Support
- Educate Other Agencies on Mental Health
- More Case Management / Therapy

Question 3: How can we better communicate services and programs offered by the mental health system?

Common Themes

Note that at all focus groups, participants shared information on resources with each other. It was also noted that participants tended to hear about services through word of mouth.

- Provide Written Materials on Services
- Staff Provide Information on Services

¹ Common Themes are themes that emerged in at least 4 or the 7 focus groups.

Question 4: What has the Contra Costa staff done to show you that they are aware and sensitive to you and your [child's] background? Are you included in decisions?

Common Theme

- See Them as a Person, Not Just a Case

Question 5: What have [has] you [your family] done to better connect to your [their] families or community?

Common Themes

- Family Is Supportive
- Need Family / Relationship Counseling

Recommendations

The focus groups are intended to lead to improvements in the services that individuals receive. Based on the results of the focus groups, it is recommended that the following areas be addressed.

- Welcoming Environments
 - Pilot Welcoming Packet materials
 - Ensure that informational materials like brochures on diagnoses are available in waiting rooms
- Overcoming Transportation Barriers
 - Compile transportation resources
 - Assess consumer readiness to use public transit and set up necessary supports for use
- Groups
 - Communicate groups to both staff and consumers (e.g., consider distributing monthly calendar)

- Attain consumer and caregiver feedback on what group topics they are interested in
- Staff Training
 - Mandatory orientation for all staff emphasizing division structure and trauma-informed care
 - Consider trainings on active listening techniques, non-judgmental language, rapport building, and available resources for consumers
- County and Community Education
 - Coordinate with other agencies to educate non-behavioral health staff on mental health issues
 - Attend community events to distribute materials and convey services
 - Convene a Community Communication Workgroup to plan how to raise public awareness of behavioral health and increase community involvement
- Peer Expansion
 - Consider how peers can initiate new consumers to the mental health system
 - Pair consumers / families with peer(s) so they are a part of the treatment team from the start of treatment
- Family Connection
 - Consider modes to educate families on mental health issues such as producing written materials or hosting seminars similar to EES
 - Grow Family Support Workers positions

In closing, individuals are appreciative of services received but are looking for ways to better engage in treatment.



ALCOHOL AND OTHER DRUG SERVICES (AOD)

STAFF REPORT

ALCOHOL AND OTHER DRUGS ADVISORY BOARD MONTHLY BOARD July 2017 MEETING

July 26, 2017

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver

Last July 3, Contra Costa went live with the Drug Medi-Cal Waiver. Specifically, effective the first week in July, the Behavioral Health Access Line became the entry point to all alcohol and other drug treatment in Contra Costa. To ensure a gradual transition, during the first week, only Residential-related calls were transferred. The following week, Outpatient treatment calls continued. During the week of July 10-14, AOD Administration received all of the waitlists from providers, and we contacted all of the individuals interested in treatment. We were not able to reach all of them, but those we did were connected immediately to treatment. The first week Access made 35 total referrals excluding those individuals referred by Administration from the waitlist. Our biggest challenge has been with criminal justice involved clients who are either court mandated to a substantial number of days in residential treatment or who are in custody and are unable to contact the BH Access Line. The AOD Administration has met already with the Public Defender (PD) to discuss potential solutions in a cooperative way with the goal of supporting the needs of the clients. Through the PD we hope to reach the court system to provide an update on the Drug Medi-Cal Waiver. Additional challenges involve engaging special populations into treatment for example: pregnant and parenting women, Spanish speakers, youth, etc.

Naloxone Grant Program in Contra Costa County

Senate Bill (SB) 833 (Chapter 30, Statutes of 2016) established a new Naloxone Grant Program within the California Department of Public Health (CDPH) with the goal of reducing the number of fatal overdoses in California from opioid drugs, including prescription opioids and heroin, by increasing access to the life-saving drug naloxone. A total of \$3 million was allocated on a one-time basis to support this program. Drug overdose (poisoning) is the leading cause of unintentional injury death in the United States, causing more deaths than motor vehicle crashes. Opioids – both prescription painkillers and heroin – are responsible for most of those deaths. Naloxone is a medication that works almost immediately to reverse opiate overdose. Naloxone is currently a prescription drug, but is not a controlled substance. It has few known adverse effects, no potential for abuse, and can be rapidly administered through intramuscular injection or nasal spray. CC Public Health Department received one of the awards which includes 1,642 (provided in kits of 2 doses) total for a two-year grant award period. The first allotment of the Naloxone kits should be arriving in the next few weeks. There are two providers that will be responsible for providing the education and distribution. As part of the grant, Alcohol and Other Drug (AOD) treatment providers will be trained on overdose prevention techniques, how to recognize an opioid overdose (signs and symptoms), how to respond by calling 911, provide rescue breathing, and naloxone storage. Due to regulations, AOD providers will not be able to administer naloxone. For more information **please visit:** <https://www.cdph.ca.gov/Programs/CCDPHP/DCCID/SACB/Pages/NaloxoneGrantProgram.aspx>

Community Connect Update & Sobering Center

The new Restoration Center [Sobering Center] Program Manager started early June. Steve McNutt, previously with Healthcare for the Homeless, has started to attend all of the Community Connect Steering Committee meetings. Community Connect has currently enrolled 7181 patients within 2 different tiers. Patient outreach and engagement is in progress with positive responses to letter mailings and mycclink messaging. There is potential for a new site with a location in Pacheco previously occupied by a bar; however, this is work in progress.

State Grant for Opioid Treatment Received by BayMark previously BAART

BayMark just received a recent award from the Department of Health Care Services (DHCS) to implement the Vermont's Hub and Spoke model. The grant will expand services for opioid disorders and it will expand availability of other medications such as: Suboxone, Vivitrol and Disulfiram. The proposal will use the Antioch BAART clinic as the Hub. More planning and information will follow.

JOIN THE VOICES FOR RECOVERY STRENGTHEN FAMILIES AND COMMUNITIES



National
Recovery Month
Prevention Works • Treatment is Effective • People Recover
SEPTEMBER 2017

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MEDIA OUTREACH



MEDIA OUTREACH

PROMOTE **RECOVERY MONTH** WITH EVENTS

Every September, the Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://samhsa.gov/>), within the U.S. Department of Health and Human Services (HHS) (<https://www.hhs.gov/>), sponsors **National Recovery Month (Recovery Month)** to increase awareness of behavioral health conditions. This observance promotes the belief that behavioral health is essential to overall health, prevention works, treatment is effective, and people can and do recover from mental and substance use disorders.

Organizing an event for **Recovery Month** is an ideal way to celebrate the achievements of the recovery community. It is also a great way to support the 2017 theme, “*Join the Voices for Recovery: Strengthen Families and Communities.*” Events bring people together to share real-life experiences that demonstrate the power of recovery from mental and substance use disorders.

This document will help guide your event planning process and provide tips and instructions on how to publicize events to maximize attendance.

DEFINE GOALS...

Before planning your event, consider the criteria that will make it a success. Setting goals will help determine the type of event you host and inform the choice of messages you use to resonate with attendees. Possible goals include:

- Spread knowledge and awareness about mental and substance use disorders and prevention, treatment, and recovery.
- Promote the availability of prevention, treatment, and recovery support programs in your community.
- Inspire others to champion recovery as possible and attainable.
- Secure coverage in the media, blogs, or social media platforms to reach those who cannot attend an event or to continue the conversation.

CHOOSE THE EVENT TYPE...

Events can come in all forms and sizes. The following are types of events that may be of interest:

- **Proclamation signing:** A proclamation is an official announcement by a public official, usually a political figure. The signing gathers people together to generate enthusiasm and awareness for a common cause. By declaring September **Recovery Month**, public officials can alert members of the community that prevention, treatment, and recovery support services are available and that mental and substance use disorders are significant needs affecting communities nationwide.
- **Walk, run, or rally:** A walk, run, or rally can draw large crowds of all ages and backgrounds, fostering a celebratory community atmosphere. These events can be sponsored by local businesses and organizations dedicated to mental and substance use disorders. Walks or runs often consist of pre-determined lengths and routes, with social opportunities intermingled, while rallies may identify speakers and opportunities to interact with members of the recovery community.

- **Cookout, dinner, or picnic:** Cookouts, dinners, or picnics are easy ways to unite friends, family, and neighbors in a positive environment. These events can be tailored to encourage treatment, celebrate recovery, or support a person’s reintegration into society.
- **Public garden, artwork, or memorial dedication:** These types of events gather community members to dedicate a public landmark or item to serve as a lasting reminder of recovery. At the dedication, a local government official can speak about the community’s commitment to invest in prevention, treatment, and recovery support services. Other community members with personal recovery experiences can share their inspiring stories.
- **Twitter chat, webinar, or Google Hangout:** Technology allows people to participate in the online discussion surrounding recovery. These types of events are convenient when you are discussing the role of online services in recovery, such as e-therapy and support chat rooms.
- **Forums or discussion groups:** Forums and discussion groups are cost-effective and informal ways to bring members of the community together to address local interests. When planning these events, consider engaging civic leaders and elected officials to participate. These events can take place in a variety of settings—for example, a provider’s office or treatment center, a community center, or a place of worship. Attendees should be prepared to take part in a two-way conversation about local issues centered on prevention, treatment, and recovery.
- **Other types of events:** No event is too small to celebrate the accomplishments of individuals in recovery and those who serve them. Be sure to have information on how to get help for mental and substance use disorders readily available for event attendees.

PLAN THE EVENT...

When planning a **Recovery Month** event, consider the following checklist.

- **Form a planning committee:** The first step for a successful event involves forming a planning committee. It ensures that the workload is divided evenly among volunteers, staff, and partner organizations. It also encourages the exchange of ideas. The number of committee members depends on the size and scope of the event. A committee leader should convene the committee regularly to create a timeline and develop goals for the event.
- **Determine a budget:** Adhering to a budget is crucial. Deciding on a budget early will inform critical decision making about the size, shape, scope, and promotion of the event. Other items involved in the budget include fundraising costs, food and entertainment, venue and equipment rentals, permits and licenses, invitations, and speaker fees.
- **Plan logistics:** Select the event date, time, and venue as soon as possible after budget approval. When choosing a location, remember to select a venue that is accessible and appropriate for the type of event and size of the audience. Ask the venue contacts if permits or licenses are required. If the event is in a public location, contact local authorities to confirm the steps that are needed to meet local requirements. When selecting a date and time, consider other events occurring in the community to minimize schedule conflicts and increase participation. Use the following tools to help streamline the search process:
 - + Search for already scheduled local **Recovery Month** events on <https://recoverymonth.gov/events> by typing in a ZIP Code in the “Community Events” page. When a date is finalized, post the event on the **Recovery Month** website.
 - + Check event postings in the local newspaper’s community calendar, which is often housed on its website.

- **Find a sponsor or partner:** Partnering with local organizations, television networks, or small businesses can help distribute the workloads, share costs and enhance publicity and outreach efforts. Support from partners or sponsors may come in the form of money, broadcast coverage, marketing, catering, printing, giveaways, or other significant resources. In addition, local mental health and addiction treatment, and recovery centers can provide volunteers from the recovery community to staff an event. Check out **Recovery Month** events at <https://recoverymonth.gov/events> held in prior years in your community to find local partners and sponsors. The **Recovery Month** Planning Partners are local organizations an event planner can potentially collaborate with to garner support, attendees, and/or speakers for an event. The **Recovery Month** Planning Partners are instrumental in spreading the message that behavioral health is essential to health, prevention works, treatment is effective, and people recover. For more information about the **Recovery Month** Planning Partners, visit <https://recoverymonth.gov/planning-partners>.
- **Implement a publicity plan:** Some necessary outreach may involve developing flyers, banners (print and online), and advertisements, as well as using social media to start a dialogue about an event. Print or broadcast journalists, as well as bloggers, can help increase the credibility of an event. Refer to the “Work with the Media” section in this toolkit for more information on garnering publicity for an event and speaking with the media. Be sure to brand your event as a **Recovery Month** event by placing the official **Recovery Month** logo on your printed materials. Such logos can be accessed and downloaded from <https://recoverymonth.gov/promote/banners-logos-flyers>.
- **Post your event on the Recovery Month website:** Promote your event by posting it on <https://recoverymonth.gov/events> under the events section. By doing this, you can let others know the date, time, location, and other details about your event. You can also use this posting as a publicity tool by sharing your event on social media platforms and posting the promotional materials for your event in your event listing on the **Recovery Month** website at <https://recoverymonth.gov/events>.

- **Remember last-minute details:** Hold a final planning meeting in the days leading up to the event. Call vendors and speakers to confirm reservations and attendance. If possible, set up any booths or multimedia equipment the day before, and plan to arrive early the day of the event in case of any unexpected issues.
- **Develop a back-up plan:** Successful events have contingency plans in place. If the event location is outdoors, always plan a back-up indoor space, or a well-publicized rain date.

EVALUATE...

Once the event concludes, take time to review lessons learned from the event. A questionnaire is helpful to record feedback from attendees, and follow-up messages by email or social media may elicit audience response following the event. Staff insights are also critical to inform successes and areas to improve on for future events.

After the event, take the opportunity to thank event staff, volunteers, and community leaders for participating by handwriting thank-you letters or posting a thank-you letter to a blog or website.

SHARE...

SAMHSA wants to hear about all of the events held in honor of **Recovery Month** this year. Once an event takes place, visit <https://recoverymonth.gov> to post details, photos, or materials from the event. Also, if you would like your event highlighted in the *2017 Road to Recovery: A Showcase of Events*, send information about your event, the promotional pieces, and any photos for use to recoverymonth@samhsa.hhs.gov. The **Recovery Month** Facebook page (<https://facebook.com/RecoveryMonth>), YouTube channel (<https://youtube.com/RecoveryMonth>), and Twitter account (<https://twitter.com/RecoveryMonth>) also serve as platforms on which event planners or attendees can post details about their experiences. More information about these online tools can be found by visiting the “Social Media Tools” section in the **Recovery Month** website for details.

Inclusion of websites and resources in this document and on the Recovery Month website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

WORK WITH THE MEDIA

Building relationships with members of the media is essential to the success of **Recovery Month**. Media outreach and the resulting coverage will increase awareness of events and highlight community efforts focused on mental and substance use disorders. The term “media” refers to the mass means of communication that reach many people through different channels, including broadcast, print, web, and other social media platforms.

This document includes the basics of media outreach, including tips on speaking with the media and creating long-term relationships.

DETERMINE A FOCUS...

To begin, it is important to differentiate your **Recovery Month** event from other activities in the area, since members of the media receive many requests to attend and cover events.

When determining the focus of your media outreach, use the following factors to increase your chances of coverage:

- **Hot topics:** In the crowded news space, a fresh, timely, and relevant angle will ensure that an event is considered. Check out health care trends, such as new research or policies, which may be driving the conversation in the news or on blogs.
- **Local impact:** Research compelling and current statistics that illustrate the prevalence of mental and substance use disorders, both locally and nationally. You can use this information to create and supplement a localized fact sheet, outlining the effects of mental and substance use disorders in your area.
- **Proximity:** Media outlets have less money to spend on staffing and travel, so make sure you are contacting the most appropriate outlet and person. When reaching out to the media, emphasize the direct connection of the event to the local community, such as the appearance of a local official.
- **Timeliness:** When contacting reporters, take into account how frequently their publications are distributed. Many reporters may request an advance lead time to write about an event before their publications go to print. Other reporters, such as those for broadcast outlets, may only cover “breaking news” live at the event site.

RESEARCH...

After establishing the key, newsworthy aspects of your event, identify the appropriate outlets and reporters to contact. To find out who has covered topics related to mental and substance use disorders, set up Google Alerts (<https://www.google.com/alerts>) online, which notify you when news on the topic you select is published.

ORGANIZE...

It is helpful to keep your media contacts’ information organized and accessible. Media lists are best created in a spreadsheet database program. Once you have identified a potential contact, include the following information in your spreadsheet:

- Contact name and title
- Contact outlet
- Email
- Phone number
- Facebook page and Twitter handle
- Pertinent notes (e.g., preferred time and method of contact, previous articles on recovery topics, and remarks from your interactions with this person)

CONNECT...

Once the list is complete, reach out to reporters via phone or email, depending on each contact’s individual preferences. Reporters often have time limitations, so keep the message short when “pitching” the event. Refer to the end of this document for sample pitches and phone scripts.

Bloggers tend to respond to people they have engaged with previously, so it may be beneficial to send an introductory email to the blogger to break the ice and start developing a relationship. Once a relationship is established, follow up with details of your **Recovery Month** event.

Likewise, when “pitching” reporters, start with an introduction and then ask about their availability. Don’t be discouraged if a journalist is short with you or in a hurry. Instead, offer to call back at a different time or connect with a colleague who may be interested in talking about the event.

After the conversation, thank each media contact for his or her time, exchange contact information, and set expectations for potential follow-up. Also, offer to send event materials (such as a promotional flyer) for further details. Confirm by email or phone whether they will be attending.

INTERVIEW...

Reporters who cover an event may request an interview with the host, a speaker, or a key member of the host organization. If your team is presented with an opportunity to be interviewed by a member of the media, prepare for the discussion in advance. Research the interested media contact and anticipate the types of questions that may be asked. To best answer the questions, familiarize yourself with the event and all supplementary materials. Finally, practice answering questions with a friend or colleague.

The day before the interview, confirm the logistics and anticipated length of the interview. Whether your interview will be in-person or on the phone, always be professional and polite. Keep in mind that the goal of the interview is to communicate **Recovery Month** key messages, event details, and to describe the importance of prevention, treatment, and recovery support services in the local area.

The following tips may also be useful in an interview:

- **Bridging:** This technique allows you to stay on message and avoid answering questions that may steer the conversation to unanticipated areas. Instead of answering the question head on, find a component of the question that can be tied back to one of the main points. For example, you might say, “That’s a great example of the power of recovery...” and then give a main talking point about recovery.
- **Bundling:** This technique allows a person to state a key point and then explain their justification for making the point. For example, a key message may include the phrase, “[**City Name, Organization or Coalition**] has a series of initiatives that improve prevention, treatment, and recovery support services.” This would be followed by important follow-up points that back up the key message, such as: “**Recovery Month** supports these initiatives by...”
- **Blocking:** If a reporter asks you a question that you are uncomfortable answering, avoid saying “no comment,” as it may appear you are hiding something. Instead, offer to put the reporter in contact with someone who can accurately answer the question. For example, “I am not the best person to answer that question; however, I can put you in contact with a local organization who can provide the information.”

For a successful in-person interview, remember to maintain eye contact, sit up straight, control hand movements, demonstrate enthusiasm and genuine feelings in your voice, and dress professionally. For a successful phone interview, be sure to prepare by rehearsing and drafting notes. Find a quiet place to hold the call, convey a friendly tone in your voice, and ask follow-up questions if needed.

PRACTICE...

When speaking with the media, it may be helpful to use the following talking points about **Recovery Month**, which can be specific to an event.

For a specific event: On **[Date]** at **[Time]**, **[Organization]** is hosting **[Event or Activity]** at **[Location]** to celebrate recovery and encourage individuals with a mental and/or substance use disorder to seek treatment and achieve a healthy, happy life. Mental and substance use disorders can affect anyone, including people in **[City]**, where **[Number]** people have a mental health and/or substance use disorder. Our community must remain vigilant and dedicated to the recovery process by helping people address these preventable and treatable conditions, and support individuals in recovery, as well as their family members.

To promote Recovery Month: **[Organization]’s** activities are part of **National Recovery Month (Recovery Month)**, which is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS). This year, **[Organization]** will be observing **Recovery Month** by **[Include the Name and Brief Description of your Recovery Month Activities]**.

Inclusion of websites and resources in this document and on the Recovery Month website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

The following templates should not quote any SAMHSA official directly or add any content that could be potentially misconstrued as an official SAMHSA pronouncement.

SAMPLE PITCH EMAIL

Subject Line of Email: Main topic of your email

Hello **[Name]**,

I recently noticed your article on **[Behavioral Health Topic]**, and I thought you might be interested in an upcoming event celebrating people in recovery from mental and/or substance use disorders. In our community, behavioral health conditions affect many people: **[Insert Statistic on Local Prevalence of Mental and/or Substance Use Disorders]**. On **[Event Date]**, **[Name of Host Organization and any Noteworthy Attendees]** will host **[Type of Event]** in the **[City/Town Name]** area as part of **National Recovery Month (Recovery Month)**, a large national observance. This event increases awareness and understanding of mental and substance use disorders, and promotes the message that behavioral health is essential to health, prevention works, treatment is effective, and people recover.

Recovery Month is an annual celebration sponsored each September by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is a part of the U.S. Department of Health and Human Services (HHS).

Included in this message is a media advisory that provides additional details about the event. Please feel free to contact me if you need further information or would like to schedule an interview with **[Name and Title of Person Being Offered for Interviews]**. I will follow up with you prior to the **[Event]** to see if you or someone from your organization will be attending.

Thank you for your time and consideration.

Best regards,

[Your Name and Contact Information]

SAMPLE PITCH CALL SCRIPT

Hi **[Name]**,

My name is **[Insert Name]**, and I am calling on behalf of **[Name of Organization]**. An upcoming event in our community will emphasize the seriousness of mental and substance use disorders. Do you still cover **[Reporter's Beat – Health Care, Community Events, etc.]** and have a moment to chat?

As you may know, mental and substance use disorders are common, and not everyone receives the support they need to get better. **[Insert Local Prevalence Statistics to Support the Local Community Impact]**. Despite the prevalence of these conditions, recovery from mental and substance use disorders is possible.

We are hosting an event on **[Date]** in **[City]** as part of **National Recovery Month**, an annual observance sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS). The goals of the event are to increase awareness and understanding of mental and substance use disorders, and promote the message that behavioral health is essential to health, prevention works, treatment is effective, and people recover.

If you are interested in learning more about the event, or are interested in speaking with **[Spokesperson Name and Role]**, I have additional information I can send you. Is your email address **[Email Address]**?

Please let me know if you have any additional questions. My contact information will be included in the email, and I will follow up prior to the **[Event]** to see if you or someone from your organization will be attending.

Thank you for your time, and I hope to speak with you again soon.

USE OP-EDS AND ONLINE ARTICLES

People's opinions are often shaped by what they read in the media, whether in newspapers or online. The media is a powerful mechanism for spreading information, and placing an op-ed or bylined piece in a print or online media outlet can help raise awareness about **Recovery Month**. An op-ed, short for “opposite the editorial pages” of a newspaper, is a way to express opinions and perspectives on a certain subject or initiative. Writing about **Recovery Month** in any publication can promote understanding of mental and substance use disorders in your community, town, city, territory, or state.

This document includes helpful tips on how to write an op-ed or online article and how to submit it for publication.

GET STARTED...

The 2017 **Recovery Month** theme, “*Join the Voices for Recovery: Strengthen Families and Communities*,” highlights the value of peer support by educating, mentoring, and helping others. It invites individuals in recovery and their support systems to be change agents in communities and in civic and advocacy engagements.

Think about this theme when you brainstorm ideas for your op-ed or online article. Also consider the purpose of **Recovery Month**—to spread the message that behavioral health is essential to overall health, prevention works, treatment is effective, and people recover.

Plan appropriately and start writing early to place your op-ed or opinion piece—either in print or online—during **Recovery Month**. Refer to the list below to stay on track:

- **Determine a clear and concise message:** A strong op-ed or online article persuasively makes a single point or argument in the beginning of the piece. Explain topics through simple messaging, allowing readers to stay focused and walk away with the main point.
- **Think relevance:** Make the subject of an op-ed or article timely and relevant to the general public. Consider tying your piece to a recent event or news story.
- **Personalize it:** Include a personal story to help readers easily connect with the message. Be sure to ask for permission before sharing someone's personal story.

- **Locate statistics and facts:** Validate all statements or opinions with hard facts. For example, if you want to note that mental and substance use disorders are common and more prevalent than one might think, include statistics on the prevalence.
- **Think local:** Give the article a local angle to increase chances that a print or online outlet will publish the piece. Feature local residents in your op-ed or article—if they have granted you permission beforehand. You can also address recent local events and include statistics that are specific to your city or state.
- **Keep it brief:** Op-ed or online articles should be between 400 and 750 words. Check with publications to determine specific limitations on word count or other requirements, such as deadlines and how they prefer to receive submissions.
- **Identify the appropriate publication(s):** Assess which publication is the best fit for a particular op-ed. A local newspaper might be ideal if the article focuses on community issues. If the article focuses on a broader, national issue, try a newspaper with a higher circulation rate. Remember that most publications will not publish op-eds that were already published in another outlet. For this reason, prioritize each outlet and select your top choices, followed by back-up options. Read examples of past op-eds to get a sense of what formats and topics appear to capture the publication's interest.
- **Create a relationship:** The best way to have your thoughts published or posted is to develop a relationship with the editor in advance. Always plan out what you want to say before contacting the publication. Provide background information about yourself, your organization, and **Recovery Month**, in addition to any local and state recovery issues.
- **Refer to the template:** Consult the sample op-ed at the end of this document to help initiate the writing process.

To gain additional attention for your op-ed, contact well-known organizations in the community and offer to co-write an op-ed or online article with them. An established partner might catch the eye of an editor and increase the chances that your op-ed is published. Refer to the “Resources” section of this toolkit to identify organizations you can collaborate with in your area.

WRITE...

Select a topic and statistics with a local angle to support your information about **Recovery Month** and its mission, along with this year's theme. Avoid controversial statements or imposing beliefs on others, but do take a clear position. Also, consider the publication's readers when writing an op-ed or online article, and think about what would catch their attention and create interest in **Recovery Month**. If you feature or mention any prevention, treatment, and/or recovery programs in your community, make sure you have their permission first.

Refer to the following tips when writing an op-ed or online article.

- Include an eye-catching title that emphasizes central messaging.
- Make it personal and include real stories to connect with readers.
- Restate your main points at the end of the op-ed and issue a call to action.
- Avoid technical jargon and acronyms—most newspapers are written at a fifth-grade level.
- Include your name, contact information, and a description of who you are and your qualifications at the end of the piece.

PERSONALIZE...

Refer to the resources below for facts to make an op-ed or online article more compelling.

- **SAMHSA's Recovery Statement** (<https://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated>)
- **SAMHSA's National Survey on Drug Use and Health** (<https://samhsa.gov/data/population-data-nsduh>)
- **SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS)** (<https://samhsa.gov/data/substance-abuse-facilities-data-nssats>)
- **SAMHSA's Treatment Episode Data Set** (<https://samhsa.gov/data/client-level-data-teds>)
- **SAMHSA'S Drug Abuse Warning Network** (<https://samhsa.gov/data/emergency-department-data-dawn>)
- **Mental Health Facilities Data (NMHSS)** (<https://samhsa.gov/data/mental-health-facilities-data-nmhss>)
- **SAMHSA's Publications Store** (<https://store.samhsa.gov/>)
- **SAMHSA's Recovery and Recovery Support Webpage** (<https://samhsa.gov/recovery>)

PUBLISH...

When submitting an op-ed or online article, include a brief cover letter to establish why you are qualified to write the piece and why it is timely, along with a simple explanation of why recovery from mental and substance use disorders is important to readers. When trying to place your piece in a publication or online, be sure to:

- **Place a follow-up call:** Follow up with the editor 1 week after submitting the op-ed or article. If he or she has not had time to look at it, follow up again 1 week later. Remember to be polite and state that publishing your piece will help others who may not be aware of the seriousness of mental and substance use disorders and the possibility of recovery.
- **Set a time limit:** Since most publications will not send notification if an op-ed is rejected, set a deadline for your piece to be published. If the deadline passes, move on to the next outlet and gauge their interest in publishing the piece. Don't give up!

If your op-ed is rejected from your desired publications, consider alternatives to the traditional printed op-ed. Ask the publication's website editor if op-eds can be posted on the online version of the newspaper. Online opinion pieces can be much easier to share with others through social media outlets, such as Twitter (<https://twitter.com/RecoveryMonth>) and Facebook (<https://facebook.com>).

Also consider that many newspapers have online bloggers who cover local philanthropic events, and some may accept guest post contributions to discuss mental and substance use disorders or a **Recovery Month** event in your area. Use the sample op-ed at the end of this document as a guide for a guest post, but remember to write in a more casual, personal manner when blogging. If a blogger does not agree to a guest post, offer information about **Recovery Month** and prevention, treatment, and recovery of mental and substance use disorders, and encourage the blogger to write his or her own post on the topic or link to a local **Recovery Month** event's website.

Keep in mind that **Recovery Month** celebrates individuals in long-term recovery; acknowledges those who provide prevention, treatment, and recovery support services; and empowers those in need of help to seek treatment throughout the year. Even if your op-ed or online piece does not get published in September, keep trying throughout the rest of the year to help spread these crucial messages.

SHARE...

SAMHSA is interested in receiving copies of published op-eds and hearing about any successes in promoting **Recovery Month**. Be sure to check news sites such as Google News (<https://news.google.com>) or Yahoo News (<https://news.yahoo.com/>) to see if an op-ed is published or whether other outlets have picked it up. Posting on personal social media accounts is also a great way to share an op-ed. In particular, you can do the following:

- Post a published op-ed on the **Recovery Month** website (<https://recoverymonth.gov/planning-partners>), Facebook page (<https://facebook.com/RecoveryMonth>), and Twitter account (<https://twitter.com/recoverymonth>).
- Visit the “Social Media Tools” section on the **Recovery Month** website (<https://recoverymonth.gov/events/plan-events/social-media-tools>) for assistance on how to use these online tools.
- Distribute event details, materials, and pictures to the social media channels above.

Send a copy of your published op-ed and placement information electronically to recoverymonth@samhsa.hhs.gov or by mail to:

Substance Abuse and Mental
Health Services Administration
ATTN: Consumer Affairs/**Recovery Month**
Center for Substance Abuse Treatment
5600 Fishers Lane
13E33B
Rockville, MD 20857

Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

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Families and Communities Can Make a Difference

Oftentimes, individuals who experience a mental and/or substance use disorder feel isolated and alone. Yet, every year millions of Americans experience these conditions. It's important that we offer support to individuals facing mental and/or substance use disorders. In fact, we need to create environments and relationships that promote acceptance. Support from families is essential to recovery, so it's important that family members have the tools to start conversations about prevention, treatment, and recovery. Too many people are still unaware that prevention works and that mental and substance use disorders can be treated, just like other health problems.

Having **[Been in Long-term Recovery for XX Years / Worked in the Recovery Field for XX years / Other Statement of Personal Experience]**, I have witnessed the positive reality of recovery. Individuals who embrace recovery achieve improved mental and physical health and form stronger relationships with their neighbors, family members, and peers. We need to make more people feel as though recovery is possible.

Mental and/or substance use disorders affect people of all ethnicities, ages, genders, geographic regions, and socioeconomic levels. They need to know that help is available. These individuals can get better, both physically and emotionally, with the support of a welcoming community.

Families and communities can find hope and spread the message that recovery works by celebrating the annual **National Recovery Month (Recovery Month)**, an initiative sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services (HHS).

[Name of Organization] is celebrating **Recovery Month** by holding a variety of educational and entertaining events **[Or Name Specific Event]** to honor individuals and families who are in long-term recovery. Your attendance will demonstrate the support of the recovery community, including those who provide prevention, treatment, and recovery support services.

I urge all community members to join the celebration and help stem the incidence of mental and substance use disorders. Let people know that free, confidential help is available 24 hours a day through SAMHSA's National Helpline, **1-800-662-HELP (4357)** or **1-800-487-4889 (TDD)**. Additionally, you can provide information about local treatment and recovery resources on your website and link to additional information available at <https://recoverymonth.gov/events/plan-events/social-media-tools>.

Offering support to those experiencing mental and/or substance use disorders can make a huge difference. Together we can help others realize the promise of recovery and give families the right support to help their loved ones.

[Include Author Name, Title, and Brief Summary of Qualifications that Make Him or Her an Expert on this Topic.]

PRESS MATERIALS FOR YOUR **RECOVERY MONTH** EVENT

To assist with the effort and generate positive publicity for **Recovery Month** activities, create and distribute press materials to spread the recovery message. These materials should garner media coverage by highlighting the fact that behavioral health is essential to health, prevention works, treatment is effective, and people recover from mental and/or substance use disorders.

The 2017 **Recovery Month** theme, “*Join the Voices for Recovery: Strengthen Families and Communities*,” highlights the importance of families, communities, and individuals sharing stories of recovery to encourage others to make a personal connection with the recovery movement. Use this document to guide the development and distribution of publicity materials to promote **Recovery Month** events this September and throughout the year.

CHOOSE A FORMAT...

There are several types of materials you or your organization can share with the media to publicize your **Recovery Month** event and highlight messages that will resonate with your intended audiences and the media.

The following tools will build awareness for a **Recovery Month** event. Examples of most of these tools can be found at the end of this document and can be modified to distribute to media outlets.

- **Media advisories**, or media alerts, are brief one-page documents that notify the media of an upcoming event and provide essential information about the event’s date, time, and location. They are brief and entice reporters to attend the event to learn more. Advisories should be sent to the calendar editor of a local newspaper and also the health care reporter or editor that covers local news or events. They should also include the organization’s contact information, as well as information on scheduling interviews and taking photos.
- **Press releases**, or news releases, are one- or two-page announcements sent to the media so they will cover a story or event. A release is similar to a condensed news story, which sometimes is repurposed as a stand-alone article in a newspaper. Refer to the “Work with the Media” section in this toolkit for factors that reporters use to determine if a story is newsworthy. Press releases should:
 - + Be approximately 500 words, formatted in short paragraphs;
 - + Contain the most important information at the top, followed by supporting details later in the article; and
 - + Include a quote from an event’s spokesperson or key figure.
- **Backgrounders** are succinct, supplementary documents that often accompany a media advisory or news release. A backgrounder may also be distributed at **Recovery Month** events, or sent to reporters separately. They can be written in paragraph form or have bulleted information. Create a backgrounder, such as the one at the end of this document, that highlights SAMHSA and **Recovery Month**; your organization; the specific event; recent behavioral health data; relevant prevention, treatment, and recovery support services; and local individuals in recovery.
- **Op-eds**, or “opposite of the editorials,” provide an opinion on a specific topic or event, and are published opposite a publication’s editorial page. An op-ed’s purpose is to influence public opinion by taking a strong position and creating a dialogue about issues affecting a community, such as mental and substance use disorders.
- **Letters to the editor** are brief letters (no more than 150 to 175 words) written to express an individual’s or organization’s point of view on a particular, yet timely, subject that was recently covered in the news. Letters should be written as a response to another news story (within a couple of days of the story’s appearance) and should highlight a timely issue, such as how the rate of mental and substance use disorders in a local community factors into other stories in the news. Letters to the editor tend to be published in newspapers and news magazines.
- **Public service announcements** (PSAs) are non-paid informational commercials, distributed to local radio or television outlets. PSAs create awareness of **Recovery Month** in communities and help inform audiences about the realities of mental and substance use disorders. Refer to the “**Recovery Month** Public Service Announcements” section in this toolkit for more information.

DRAFT...

When drafting press materials for a **Recovery Month** event, explain why behavioral health conditions are important to address and why your event is beneficial to the community. Remember to share these messages with all members of your event-planning committee, in order for them to offer a relevant quote if asked by the media. It may be helpful to review the “Work with the Media” section for more advice on interacting with reporters.

When developing press materials, keep in mind the following tips.

- Avoid using slang terms, which may offend people in recovery, or technical jargon that the general public may not understand.
- Double-check the names, titles, and contact information in press materials, and verify that all statistics and spelling are correct.

PERSONALIZE...

Use the following resources to customize your press materials with local data when possible.

- **SAMHSA’s National Survey on Drug Use and Health** (<https://samhsa.gov/data/population-data-nsduh>)
- **SAMHSA’s National Survey of Substance Abuse Treatment Services (N-SSATS)** (<https://samhsa.gov/data/substance-abuse-facilities-data-nssats>)
- **SAMHSA’s Treatment Episode Data Set** (<https://samhsa.gov/data/client-level-data-teds>)
- **SAMHSA’s Drug Abuse Warning Network** (<https://samhsa.gov/data/emergency-department-data-dawn>)
- **SAMHSA’s Mental Health Facilities Data (NMHSS)** (<https://samhsa.gov/data/mental-health-facilities-data-nmhss>)
- **SAMHSA’s Behavioral Health Treatments and Services Webpage** (<https://samhsa.gov/treatment>)
- **SAMHSA’s Recovery and Recovery Support Webpage** (<https://samhsa.gov/recovery>)

DISSEMINATE...

Before distributing the media materials you have developed, make sure your materials adequately highlight the importance of **Recovery Month**, have a specific call to action, and provide community-specific information.

Press materials are most commonly distributed electronically. To ensure that a reporter views the press materials, copy and paste the information into the body of an email. Make sure the headline and first paragraph are readable to prevent unnecessary scrolling. Also, personalize each email so the reporter knows it is not a mass message.

To learn where to send materials and how to build a comprehensive media list, refer to the “Work with the Media” section in this toolkit.

COORDINATE TIMING...

Media advisories are typically sent to reporters about a week in advance of an event. Remember, these alerts serve as an invitation or “save-the-date” for the event. Press releases are distributed either immediately before or at the event, or can be given to reporters under an “embargo” agreement until the event or announcement becomes official.

To distribute materials to a large number of recipients, you can send them to a news wire service organization, such as the Associated Press or Reuters, which may choose to run them for free. You can also choose to use an online fee-based distribution service, such as:

- 24/7 Press Release (<https://www.24-7pressrelease.com/>)
- Business Wire (<https://www.businesswire.com/portal/site/home>)
- PR Log (<https://www.prlog.org/>)
- PR Newswire (<https://www.prnewswire.com/>)

Once materials have been distributed, remember to post them on the **Recovery Month** website at <https://recoverymonth.gov/events/plan-events/social-media-tools> and link to the materials on appropriate web-based platforms. It is also important to follow up with the reporters who received the materials to ensure that they received them and to gauge their interest in attending the event or to schedule an interview with a spokesperson or speaker. Refer to the “Work with the Media” section in this toolkit for tips on pitching and advice on communicating with journalists.

SHARE...

As discussed in the “Promote **Recovery Month** with Events” section in this toolkit, it is important to evaluate an event after it has taken place. The planning committee can use key lessons learned from an event to improve future events.

Post press materials on the **Recovery Month** website (<https://recoverymonth.gov/events/plan-events/social-media-tools>) to accompany the event listing.

Share event information through **Recovery Month** social media outlets, such as the Facebook page (<https://facebook.com/RecoveryMonth>), YouTube channel (<https://youtube.com/recoverymonth>), and Twitter account (<https://twitter.com/RecoveryMonth>). Share the event’s outreach efforts and talk about the materials that were useful during **Recovery Month** by completing the “Customer Satisfaction Form.”

Send promotional materials electronically to recoverymonth@samhsa.hhs.gov or by mail to:

Substance Abuse and Mental
Health Services Administration
ATTN: Consumer Affairs/**Recovery Month**
Center for Substance Abuse Treatment
5600 Fishers Lane
13E33B
Rockville, MD 20857

CONSULT RESOURCES...

For more information on **Recovery Month** and services available to people in need, please refer to the “Treatment and Recovery Support Services” section of this toolkit.

Inclusion of websites and event examples in this document and on the *Recovery Month* website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

SAMPLE MEDIA ADVISORY

[Adapt as needed for event by modifying the type of event, date, etc.]

The following templates should not quote any SAMHSA official directly or add any content that could potentially be misconstrued as an official SAMHSA announcement.

[Name of Official] to Issue Proclamation and Lead Recovery Event to Raise Awareness of Mental and Substance Use Disorders

Mental and substance use disorders are prevalent in our community, and it’s imperative that individuals in [City or State] understand how to seek help. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2015, an estimated XX [Thousand/Million] people in [City or State] were affected by mental illness. In addition, an estimated XX [Thousand/Million] people in [City or State] were affected by substance use disorders.

To address this significant problem, [Name of Official] will issue a proclamation for **National Recovery Month** this September, raising awareness about prevention, treatment, and recovery support services in the area. Additionally, [Name of Expert] will discuss local mental and substance use disorder programs and highlight individuals in recovery, detailing the journey they took to get where they are today.

Last year, 32 proclamations were issued nationwide, including one by the President of the United States. After the signing of the proclamation, attendees and all citizens of [City or State] are encouraged to join a recovery event around the community to highlight the significance of helping people in need of prevention, treatment, and recovery support services, while also celebrating the accomplishments of individuals in recovery.

WHO: [Participants]

WHEN: [Date and Time]

WHERE: [Address of Event]

CONTACT: [Name and Phone Number of Primary Contact for Event]

SAMPLE PRESS RELEASE

[Adapt as needed for the event by modifying the type of event, date, and local statistics as available.]

For Immediate Release

Contact: [Name of Person Who is Available to Answer Questions from the Media]

[Phone Number of Contact Person – Include Office and Cell Numbers]

[Email Address of Contact Person]

[Name of Official] Hosts Recovery Event to Raise Awareness of Mental and Substance Use Disorders Support Services in [City or State]

[City, State], [Date] – Mental and substance use disorders and the societal benefits of recovery for [City or State] must be addressed immediately, according to [Name of Local Official], who today recognized September as **National Recovery Month (Recovery Month)**. To promote the widespread national observance, [Name of Official] led a recovery event, which featured opening speakers and was intended to support people in recovery and draw attention to critical prevention, treatment, and recovery support services.

In addition, a walk, attended by more than [Number of People Who Attended the Walk] people, celebrated real-life examples of people in recovery.

- “Today’s event emphasized that individuals in recovery and their support systems can be change agents in our communities,” stated [Name of Official]. “It is critical that people experiencing mental and/or substance use disorders receive the support they need. The reality is that behavioral health is essential to health, prevention works, treatment is effective, and people recover.”

[Replace the Following Paragraph with Local Statistics, if Available.] In 2015, 43.4 million people aged 18 or older (17.9 percent of adults) had any mental illness according to the *2015 National Survey on Drug Use and Health*, an annual survey released by the Substance Abuse and Mental Health Services Administration (SAMHSA). For the same time frame, 20.8 million people aged 12 or older (7.8 percent) had a substance use disorder. And, 8.1 million adults, aged 18 or older, had both a substance use disorder and a mental illness.

Opening speakers at the event described the impact of mental and substance use disorders on the community, and joined the crowd on the walk in downtown [City]. The event also featured the support of local businesses and organizations that recognize the value of seeking treatment and overcoming mental and substance use disorders.

“It is important that the momentum we’ve established at this event is carried over to tomorrow, and the next day, week, and year,” said [Name of Person]. “We all have the potential to make a difference and be visible, vocal, and valuable to help spread the message that recovery is possible.”

Today’s event was part of **Recovery Month**, a national observance sponsored by SAMHSA, within the U.S. Department of Health and Human Services. The observance raises awareness of mental and substance use disorders, celebrates individuals in long-term recovery, and acknowledges the work of prevention, treatment, and recovery support services.

SAMPLE BACKGROUND

[Adapt as needed by including additional organization-specific information or information on the event]

National Recovery Month Media Fact Sheet

What is National Recovery Month?

National Recovery Month (Recovery Month) is an annual observance celebrated every September since 1989. In September, and throughout the year, **Recovery Month** spreads the message that –

- Behavioral health is essential to health.
- Treatment is effective.
- Prevention works.
- People recover.

Refer to the **Recovery Month** website, <https://recoverymonth.gov/about>, for additional information on the initiative.

Who sponsors Recovery Month?

Recovery Month is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services. SAMHSA collaborates with nearly 250 **Recovery Month** Planning Partner organizations who represent local, state, and national organizations dedicated to prevention, treatment, and recovery.

What is this year's Recovery Month theme?

This year's theme, "*Join the Voices for Recovery: Strengthen Families and Communities*," encourages communities to be socially inclusive, offering those in need of recovery support the chance to seek help, lend a hand, and contribute to their community as citizens, parents, employees, students, volunteers, and leaders. Communities can improve the lives of those in recovery by extending opportunities for meaningful daily activities, such as jobs, school, volunteerism, family caretaking, or creative endeavors. Local communities can play a significant role in supporting those in recovery as they gain the independence, income, and resources necessary to fully participate in society.

What events occur during Recovery Month?

Every September—and throughout the year—hundreds of events occur to celebrate **Recovery Month**. These events, ranging from recovery walks and rallies to online web chats and group barbecues, encourage the following audiences to address the continued need for prevention, treatment, and recovery support services.

- Active military and veterans
- Friends and family members
- Civic leaders
- High school-aged students
- Communities
- Justice system personnel
- College-aged students
- Policymakers
- Educators
- Prevention, treatment, and recovery organizations
- Employers
- Peer recovery
- Faith-based organizations
- Recovery community
- Faith leaders
- Social service organizations
- First responders
- Youth and young adults

Where can people find treatment for mental and/or substance use disorders?

Many treatment options exist. SAMHSA's Behavioral Health Treatments and Services webpage, <https://samhsa.gov/treatment>, helps people find mental and substance use disorder treatment facilities and programs across the country. SAMHSA's National Helpline, **1-800-662-HELP (4357)** or **1-800-487-4889 (TDD)**, provides 24-hour, free, and confidential information about mental and substance use disorders, and prevention, treatment, and recovery referrals in English and Spanish. Additionally, the "Treatment and Recovery Support Services" section in this toolkit provides an overview of support options.

ISSUE **RECOVERY MONTH** PROCLAMATIONS

A proclamation is an official announcement that publicly recognizes an initiative, such as **Recovery Month**. Proclamations are typically signed and issued by federal officials, governors, state legislators, or other government officials at the local level.

The solicitation and gathering of proclamations from state, territory, city, or county entities in support of **Recovery Month** is another way to promote and raise awareness for behavioral health, and spread the message that prevention works, treatment is effective, and people recover.

Last year, **32** proclamations were signed to support **Recovery Month**, including one issued by President Barack Obama. For the past 16 years, the Executive Office of the President of the United States has supported the Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://samhsa.gov>), within the U.S. Department of Health and Human Services (HHS) (<https://hhs.gov/>), by working to raise public awareness and support for those with behavioral health conditions, as well as their communities and families. The Presidential Proclamation recognizes the importance of prevention, treatment, and recovery across the country. Equally important are the hundreds of proclamations issued at the state, territory, and local levels each year.

The **Recovery Month** theme, "*Join the Voices for Recovery: Strengthen Families and Communities*," encourages local communities (citizens, friends, families, businesses, faith-based organizations, and local governments) to be inclusive and supportive of those with mental and/or substance use disorders. To differentiate your proclamation from those issued in previous years, we recommend that you create one that highlights this year's theme.

The information below includes tips to help draft and promote a **Recovery Month** proclamation.

CONTACT PUBLIC OFFICIALS...

Before drafting a proclamation to designate September as **Recovery Month** in your area, you may wish to research local officials to gauge their interests and beliefs about prevention, treatment, and recovery support services. You will want to engage someone who is passionate about this issue, if possible, or try to generate passion for the issue as a result of your outreach. Remember that many public officials can issue a proclamation, including:

- Governors
- Senators and Representatives
- Mayors
- City council members
- State legislators
- County managers
- Tribal nation leaders

Since many legislatures and city governments are not in session during the summer months, try to contact public officials at least 3 months in advance of **Recovery Month**. Write a letter or send an email to initiate correspondence with an official's communications office, and follow up with a phone call. Include a link to <https://recoverymonth.gov> in your correspondence. During the initial conversation, explain the **Recovery Month** observance, detail scheduled local activities, and discuss the importance of their support for this annual event. If the official's office is unfamiliar with the proclamation process, explain that it's a simple way for the government to recognize the importance of prevention, treatment, and recovery support services for mental and substance use disorders—and that it can encourage those in need to seek help.

Once the office confirms that the official might support **Recovery Month** and issue a proclamation, it's time to start writing.

DECIDE ON A STYLE...

There are two styles of proclamation writing: traditional and modern. While these two styles differ in format, they can both generate awareness of **Recovery Month**.

Traditional proclamations begin with a series of statements starting with the words “whereas,” which detail the current state of affairs and suggest the reasoning behind the proclamation. Each clause notes the problems or issues being addressed and is followed by a concluding phrase beginning with “therefore,” which specifically requests the support or action needed.

Modern proclamations are written in a letter format. They highlight the same points as a traditional proclamation, but are written as statements. See examples of proclamations at <https://recoverymonth.gov/promote/proclamations> and on the **Recovery Month** website at <https://recoverymonth.gov/toolkit#media-outreach> under the “Proclamations” section. In addition, samples of both formats are included at the end of this document.

DEVELOP A PROCLAMATION...

Once you are familiar with the different proclamation styles, use the following list when drafting a proclamation and working to gain public support for **Recovery Month**.

- Determine the official’s preferred writing style (traditional or modern).
- Offer to draft the proclamation.
- Refer to the examples at the end of this document to help draft the proclamation.
- Insert local information or statistics that will resonate with community members.
- Submit the proclamation to the official’s office early and allow time for the official to review and sign the proclamation.
- Follow up frequently to check the status of the proclamation.
- Display copies of the proclamation in public places once it has been signed.
- Post the proclamation on the **Recovery Month** website – submit to Recoverymonth@samhsa.hhs.gov, as well as the **Recovery Month** Facebook page (<https://facebook.com/RecoveryMonth>) and Twitter account (<https://twitter.com/recoverymonth>).

PERSONALIZE...

You can personalize the proclamation for your community and include important messages about recovery. Consider including or consulting the following resources about treatment and recovery services.

- **SAMHSA’s National Survey on Drug Use and Health and other data from SAMHSA** (<https://samhsa.gov/data/population-data-nsduh>)
- **SAMHSA’s National Survey on Substance Abuse Treatment Services (N-SSATS)** (<https://samhsa.gov/data/substance-abuse-facilities-data-nssats>)
- **SAMHSA’s Treatment Episode Data Set** (<https://samhsa.gov/data/client-level-data-teds>)
- **SAMHSA’s Drug Abuse Warning Network** (<https://samhsa.gov/data/emergency-department-data-dawn>)
- **SAMHSA’s Mental Health Facilities Data (NMHSS)** (<https://samhsa.gov/data/mental-health-facilities-data-nmhss>)
- **SAMHSA’s Recovery and Recovery Support Webpage** (<https://samhsa.gov/recovery>)
- **SAMHSA’s Behavioral Health Treatments and Services Webpage** (<https://samhsa.gov/treatment>)

PUBLICIZE...

Publicizing the proclamation will bring more attention to **Recovery Month** and generate momentum for the national observance in your community. Visit local businesses, health clubs, libraries, hotel lobbies, schools, college campuses, treatment and recovery centers, community mental health centers, and government buildings to see if they allow you to display copies of proclamations and other **Recovery Month** resources. If permitted, display a **Recovery Month** poster to garner additional attention and increase interest.

To create additional publicity, arrange a press conference or town hall meeting and have local officials sign or present the proclamation. This event can be accompanied by a roundtable discussion on issues related to mental and substance use disorders. Ideas for panelists include treatment and service providers, families affected by mental and/or substance use disorders, young adults affected by these disorders, and other individuals already in recovery. For information on how to plan a **Recovery Month** event, refer to the “Promote **Recovery Month** with Events” section in this toolkit.

Lastly, arrange for a proclamation to be featured in a local publication to increase awareness. Distribute electronic copies of the document to the local or metro desks of local newspapers, along with a press release to announce the signing of the **Recovery Month** proclamation. For tips on how to write an effective press release, refer to the “Press Materials for Your **Recovery Month** Event” section in this toolkit.

SHARE...

Post a copy of the proclamation on the **Recovery Month** website (<https://recoverymonth.gov/events/plan-events/social-media-tools>) and send it electronically to recoverymonth@samhsa.hhs.gov or in hard copy to:

Substance Abuse and Mental
Health Services Administration
ATTN: Consumer Affairs/**Recovery Month**
Center for Substance Abuse Treatment
5600 Fishers Lane
13E33B
Rockville, MD 20857

Be sure to share it on your social media channels!

Inclusion of websites and event examples in this document and on the *Recovery Month* website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

SAMPLE PROCLAMATION 1: TRADITIONAL FORMAT

WHEREAS, behavioral health is an essential part of health and one’s overall wellness; and

WHEREAS, prevention of mental and substance use disorders works, treatment is effective, and people recover in our area and around the nation; and

WHEREAS, preventing and overcoming mental and substance use disorders is essential to achieving healthy lifestyles, both physically and emotionally; and

WHEREAS, we must encourage relatives and friends of people with mental and/or substance use disorders to implement preventive measures, recognize the signs of a problem, and guide those in need to appropriate treatment and recovery support services; and

WHEREAS, an estimated **XX [Thousand/Million]** people in **[City or State]** are affected by these conditions; and

WHEREAS, to help more people achieve and sustain long-term recovery, the U.S. Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the White House Office of National Drug Control Policy (ONDCP), and **[Name of State, City, County or Treatment Organization]** invite all residents of **[State/City/Town]** to participate in ***National Recovery Month (Recovery Month)***; and

NOW, THEREFORE, I **[Name and Title of Your Elected Official]**, by virtue of the authority vested in me by the laws of **[City, State, or Locality]**, do hereby proclaim the month of September 2017 as

NATIONAL RECOVERY MONTH

In **[City or State]** and call upon the people of **[City or State]** to observe this month with appropriate programs, activities, and ceremonies to support this year’s ***Recovery Month*** theme, “*Join the Voices for Recovery: Strengthen Families and Communities.*”

In Witness Whereof, I have hereunto set my hand this **[Day of Month]** day of **[Month]**, in the year of our Lord two thousand seventeen, and of the Independence of the United States of America the two-hundred and forty-second.

Signature

[Insert City/State or Other Official Seal]

SAMPLE PROCLAMATION 2: MODERN FORMAT

Mental and substance use disorders affect all communities nationwide, but with commitment and support, people with these disorders can achieve healthy lifestyles and lead rewarding lives in recovery. By seeking help, people who experience mental and/or substance use disorders can embark on a new path toward improved health and overall wellness. The focus of **National Recovery Month (Recovery Month)** this September is to celebrate their journey with the theme “*Join the Voices for Recovery: Strengthen Families and Communities.*” **Recovery Month** spreads the message that behavioral health is essential to health and one’s overall wellness, and that prevention works, treatment is effective, and people recover.

The impact of mental and substance use disorders is apparent in our local community, and an estimated **XX [Thousand/Million]** people in **[City or State]** are affected by these conditions. Through **Recovery Month**, people become more aware and able to recognize the signs of mental and substance use disorders, which can lead more people into needed treatment. Managing the effects of these conditions can help people achieve healthy lifestyles, both physically and emotionally.

The **Recovery Month** observance continues to work to improve the lives of those affected by mental and/or substance use disorders by raising awareness of these diseases and educating communities about the prevention, treatment, and recovery resources that are available. For the above reasons, I am asking the citizens of **[City or State]** to join me in celebrating this September as **National Recovery Month**.

I, **[Name and Title of Elected Official]**, do hereby proclaim the month of September 2017 as

NATIONAL RECOVERY MONTH

In **[City or State]** and call upon our community to observe this month with compelling programs and events that support this year’s observance.

Signature

[Insert City/State or Other Official Seal]

RECOVERY MONTH PUBLIC SERVICE ANNOUNCEMENTS

Every year, public service announcements (PSAs) are created for **Recovery Month** to encourage individuals in need of treatment and recovery services to seek help. PSAs are unpaid advertisements that air on television and/or radio stations, as well as online, at no cost.

To support the 2017 **Recovery Month** campaign, SAMHSA created two radio and television PSAs in English and Spanish. The spots reflect this year's **Recovery Month** theme, "*Join the Voices for Recovery: Strengthen Families and Communities,*" and advertise SAMHSA's National Helpline. They highlight the messages that behavioral health is essential to overall health, prevention works, treatment is effective, and people recover from mental and substance use disorders.

These PSAs can be used year-round to promote prevention, treatment, and recovery. At the end of each PSA, SAMHSA's National Helpline, **1-800-662-HELP (4357)** or **1-800-487-4889 (TDD)**, is highlighted. This toll-free number, available in English or Spanish, provides 24-hour, confidential information about mental and substance use disorders and prevention, treatment, and recovery referrals. All **Recovery Month** PSAs are freely available for public use without permission from, or charge by, HHS or SAMHSA.

CUSTOMIZE...

Each year, **Recovery Month** PSAs are distributed to television and radio stations nationwide. To maximize their circulation, these pre-recorded PSAs are available in 30-, 20-, and 15-second versions. Additionally, "open-ended" versions are available to add your local information to personalize the spots. If possible, work with a local production company to insert supplementary information, such as a website, phone number, or logo. Otherwise, you can promote them "as is."

If stations are unable to play the PSAs during September, remind them that these PSAs can be played year-round. If local television or radio stations do not have the 2017 PSAs, suggest emailing recoverymonth@samhsa.hhs.gov to receive a copy. The PSAs are also available online in the PSA section of the **Recovery Month** website at <https://recoverymonth.gov/promote/public-service-announcements>.

USE SCRIPTS...

A 30-second example and a 15-second example of radio PSA scripts are provided at the end of this section. Radio hosts can read these scripts "live" on the air. They can be easily tailored to promote a **Recovery Month** event in the local community. When customizing the live-read scripts to promote an event, keep in mind the following points.

- Include only crucial event details to limit the scripts to the allotted time.
- Refer viewers and listeners to a website or phone number for more information.
- Weave in local statistics or information about the prevalence of mental and substance use disorders that resonate with the local community.
- Ask radio stations if their most popular radio personalities or a community leader who may be visiting the station can help promote the PSAs by reading them live.

DISTRIBUTE SCRIPTS...

Distribute the live-read PSA scripts to local radio stations to promote an event or the **Recovery Month** campaign in September. Before reaching out to radio stations, identify which stations are most appropriate for the target audience, considering demographic data such as age, gender, race, and location. After selecting your top choices, contact these radio stations to determine if they are interested in receiving the live-read scripts. Also, ask for a specific person who handles these requests, such as a PSA director. When sending PSAs to local stations, it's important to include a cover letter, explaining the importance of the event and the **Recovery Month** campaign. Be sure to include contact information in case stations have questions. Refer to the "Work with the Media" section in this toolkit for a customizable pitch letter, and tailor it for use with PSA directors.

PROMOTE PRE-RECORDED PSAs...

Stress to radio and television stations the importance of these PSAs and how they motivate people in need to seek help by spreading the message that recovery from mental and substance use disorders is possible. Start by writing down bullet points or creating a script to use when calling television and radio stations to explain the **Recovery Month** PSAs in detail.

To spread the word online, email the PSAs to **Recovery Month** supporters. Ask them to forward the pitch email, along with the PSA spots, to anyone who might find them useful. Be sure to include your contact information and an explanation of why the PSAs are important. If the supporters you contact have a website, they can embed the PSAs from the **Recovery Month** website (<https://recoverymonth.gov/events/plan-events/social-media-tools>), Facebook page (<https://facebook.com/RecoveryMonth>), and YouTube channel (<https://youtube.com/user/recoverymonth>). Typically, an “embed code” link is included near the video, which enables copying and pasting the video to other websites. For questions regarding embedding **Recovery Month** PSAs, email recoverymonth@samhsa.hhs.gov for assistance.

If you host a **Recovery Month** event, you can play the PSAs during the event to enhance the message. Set up a TV and play the PSAs on repeat, or display them on a big screen with loudspeakers. For additional information on how to plan a successful **Recovery Month** event, refer to the “Promote **Recovery Month** with Events” section in this toolkit.

Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

PERSONALIZE...

Below are resources to help strengthen your message and convey the importance of recovery to a station’s listeners.

- **SAMHSA’s Recovery and Recovery Support Webpage** (<https://samhsa.gov/recovery>)
- **SAMHSA’s National Survey on Drug Use and Health** (<https://samhsa.gov/data/population-data-nsduh>)
- **SAMHSA’s National Survey of Substance Abuse Treatment Services (N-SSATS)** (<https://samhsa.gov/data/substance-abuse-facilities-data-nssats>)
- **SAMHSA’s Treatment Episode Data Set** (<https://samhsa.gov/data/client-level-data-teds>)
- **SAMHSA’S Drug Abuse Warning Network** (<https://samhsa.gov/data/emergency-department-data-dawn>)
- **SAMHSA’s Mental Health Facilities Data (NMHSS)** (<https://samhsa.gov/data/mental-health-facilities-data-nmhss>)
- **SAMHSA’s Behavioral Health Treatments and Services Webpage** (<https://samhsa.gov/treatment>)

For more information on **Recovery Month** and services available, please refer to the “Resources” section of this toolkit.

2017 LIVE-READ RADIO PSA SCRIPTS

:30 SECONDS

Mental and substance use disorders affect millions of Americans. Supporting recovery strengthens our families and our communities, encourages public awareness, and helps people begin their recovery journeys. If you or someone you know is struggling, call **1-800-662-HELP** for treatment referral **[or replace this number with a local treatment and service provider's]** or visit <https://recoverymonth.gov> for information on prevention, treatment, and recovery support services. You can help yourself or someone you love take the first step toward recovery. Celebrate ***National Recovery Month***, and spread the messages that prevention works, treatment is effective, and people recover.

:15 SECONDS

Mental and substance use disorders affect millions of Americans. Supporting recovery strengthens our families and our communities, encourages public awareness, and helps people begin their recovery journeys. Celebrate ***National Recovery Month*** and call **1-800-662-HELP** for treatment referral **[or replace this number with a local treatment and service provider's]** or visit <https://recoverymonth.gov> for more information.

JOIN THE VOICES FOR RECOVERY
**STRENGTHEN FAMILIES
AND COMMUNITIES**



JOIN THE VOICES FOR RECOVERY STRENGTHEN FAMILIES AND COMMUNITIES

Mental and substance use disorders affect millions of Americans and directly touch the lives of individuals, family members, neighbors, and colleagues. Families often deal with the complex dynamics of supporting loved ones living in recovery while, at the same time, learning how to take care of their own well-being. Given the widespread impact and societal cost of behavioral health conditions, it's important for communities to make prevention, treatment, and recovery support services available and accessible to all those who need them.

Every September, the Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://samhsa.gov/>), within the U.S. Department of Health and Human Services (HHS) (<https://hhs.gov/>), sponsors **National Recovery Month (Recovery Month)** to increase awareness of behavioral health conditions and support those in recovery. This celebration promotes the message that behavioral health is essential to overall health, prevention works, treatment is effective, and people can, and do, recover from mental and substance use disorders.

The 2017 **Recovery Month** theme, "*Join the Voices for Recovery: Strengthen Families and Communities*," inspires communities to be socially inclusive, offering support to those with mental and/or substance use disorders. It also encourages members of the community to seek help when needed, lend a hand, and contribute to their community as citizens, parents, employees, students, volunteers, and leaders.

Recovery Month celebrates and supports these efforts through outreach, cross-promotion, and materials that can be found on the campaign's website (<https://recoverymonth.gov/>). The **Recovery Month** site provides printable materials, as well as web, television, audio, and social media resources to help communities as they encourage individuals to seek treatment and recovery services.

To help those on the path to recovery, you can:

- Share your recovery story and learn from others (<https://recoverymonth.gov/personal-stories>)
- Find out about and post recovery events in your community (<https://recoverymonth.gov/events>)
- Watch the *Road to Recovery* television series (<https://recoverymonth.gov/road-to-recovery>)
- Download web banners and flyers to promote **Recovery Month** (<https://recoverymonth.gov/promote/banners-logos-flyers>)
- Spread the word on Twitter, Facebook, and other online forums

“
RECOVERY IS POSSIBLE.
OPPORTUNITY IS
POSSIBLE. HOPE
IS POSSIBLE.

FRANCIS

“
RECOVERY FOR ME
MEANS I AM MORE
TODAY THAN I WAS
YESTERDAY. I GET TO
LIVE MY LIFE AND BE
IN CHARGE OF IT.

BECKY

CONNECT WITH *RECOVERY MONTH*

FACEBOOK: [HTTPS://FACEBOOK.COM/RECOVERYMONTH](https://facebook.com/recoverymonth)

YOUTUBE: [HTTPS://YOUTUBE.COM/RECOVERYMONTH](https://youtube.com/recoverymonth)

TWITTER: [HTTPS://TWITTER.COM/RECOVERYMONTH](https://twitter.com/recoverymonth)

WHY SUPPORTING RECOVERY IS IMPORTANT

The prevalence of mental and substance use disorders continues to have a significant impact on communities across the United States. In 2015, approximately 20.8 million people aged 12 or older were classified with a substance use disorder.¹ Among adults aged 18 or older, 43.4 million (17.9 percent of adults) had any mental illness in the past year.² Despite the high prevalence of these conditions, most Americans believe that recovery from a mental illness³ or a substance use disorder is possible.⁴

In fact, the right support system can help ensure that those in need are addressing the following four key aspects of recovery:⁵

- **Health:** Learning to overcome or manage a condition(s) or symptom(s)—and make informed, healthy choices that support physical and emotional well-being;
- **Home:** Having a stable and safe place to live;
- **Purpose:** Participating in meaningful daily activities, such as a job, school, volunteer opportunities, family caretaking, or creative endeavors; and having the independence, income, and resources to participate in society; and
- **Community:** Maintaining relationships and social networks that provide support, friendship, love, and hope.

This year's *Recovery Month* observance focuses on specific ways the recovery community can connect with four audiences: rural/frontier communities, the criminal justice system, community- and faith-based organizations, and local public health agencies. Rural/frontier communities and the criminal justice system have significant and well-known behavioral health needs. Community- and faith-based organizations, as well as community public health organizations, are positioned to strengthen and support recovery in local areas. Specific information on each target audience follows.

- **Rural and frontier communities.** Nearly one in four Americans lives in a rural or frontier area. People in these communities experience unique risk factors associated with mental and substance use disorders and face specific barriers to accessing treatment and support services.^{6,7,8} Estimates suggest that of 62 million people who lived in frontier and rural areas in 2008, 15 million have experienced a substance use, mental, or co-occurring disorder.⁹ It is critical that rural and frontier communities are aware of their behavioral health needs, have access to care and support services, and come together to support their friends, neighbors, and loved ones in recovery.
- **The criminal justice system.** Many people in the criminal justice system, including incarcerated individuals and those recently released from jail or prison, have unmet behavioral health needs.¹⁰ Almost two thirds (64.5 percent) of the inmate population in the United States meet the criteria for a substance use disorder.¹¹ One-third (32.9 percent) of the 2.3 million prison and jail inmates has a diagnosis of a mental illness.¹² A quarter (24.4 percent) of prison and jail inmates has both a substance use disorder and a co-occurring mental health disorder.¹³ Moreover, people with mental illness have remained incarcerated nearly twice as long as other inmates due to an inability to make bail and the extremely limited availability of alternatives to detention and incarceration.¹⁴ Individuals with mental and/or substance use disorders also face many barriers to reentry into the community after being released.¹⁵ Those who are incarcerated, ex-offenders, and those who work in the criminal justice and courts systems need education on navigating the systems with which they interact so that necessary treatment and support services can be accessed. Effective treatment of inmates improves their well-being and can reduce the likelihood that they will commit new crimes or violate probation once released.¹⁶

- **Community- and faith-based organizations.** Community-based organizations and faith-based organizations are influential bodies in the community. They can open the doors to many “pathways” to recovery for those affected by mental and/or substance use disorders. They can join the voices of recovery by sharing factual information about behavioral health needs, conveying messages of compassion and understanding, supporting those who might be in need, and encouraging people to speak out about their personal journeys.
- **Public health professionals and departments of public health.** Public health professionals work to address behavioral health needs in their communities, from strengthening local health systems to increasing access to services. City and county health departments and their staff, and others who work in public health, can empower residents with information, access, and an environment that enables healthy living. Their voices should reinforce the fact that recovery is possible and make it known that resources and support are available to help community members. They can act as important links between residents and resources.

Specific resources and detailed information about the audiences described above can be found in the “Targeted Outreach” sections of this toolkit.

SAMHSA RESOURCES

SAMHSA has developed the following resources to improve behavioral health and help people on the path to recovery.

- **SAMHSA’s Website** (<https://samhsa.gov/>): Provides numerous resources and helpful information related to mental health and substance use issues.
- **SAMHSA’s Find Help Webpage** (<https://samhsa.gov/find-help/>): Provides web links and phone numbers for mental and substance use disorder treatment and recovery services.
- **SAMHSA’s National Helpline, 1-800-662-HELP (4357) – or 1-800-487-4889 (TDD)** (<https://samhsa.gov/find-help/national-helpline/>): Provides 24-hour, free, and confidential treatment referral and information about mental and substance use disorders, prevention, treatment, and recovery in both English and Spanish.
- **SAMHSA’s National Suicide Prevention Lifeline, 1-800-273-TALK (8255)** (<https://www.suicidepreventionlifeline.org/>): Provides a free, 24-hour helpline for anyone in suicidal crisis or emotional distress.
- **SAMHSA’s Behavioral Health Treatments and Services Webpage** (<https://samhsa.gov/treatment/>): Provides information on common mental illnesses and substance use disorders and describes how SAMHSA helps people access treatment and services.
- **SAMHSA’s Homelessness Resource Center** (<https://homeless.samhsa.gov/>): Provides resources about homelessness, mental illness, substance use, co-occurring disorders, and traumatic stress.
- **SAMHSA’s Recovery and Recovery Support Page** (<https://samhsa.gov/recovery/>): Provides information on how recovery-oriented care and recovery support systems help people with mental and/or substance use disorders manage their conditions.
- **SAMHSA’s Wellness Initiative** (<https://samhsa.gov/wellness-initiative/>): Promotes the improved wellness of people with mental and/or substance use disorders by engaging, educating, and training providers, consumers, and policymakers.

This list is not exhaustive of all available resources. Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the United States Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

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- ¹ Center for Behavioral Health Statistics and Quality. (2016). *Behavioral Health Trends in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 21. Web. 23 Sep. 2016.
- ² Center for Behavioral Health Statistics and Quality. (2016). *Behavioral Health Trends in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 2.
- ³ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2006). National Mental Health Anti-Stigma Campaign: *What a Difference a Friend Makes* (SMA07-4257), p. 2. Retrieved from <https://store.samhsa.gov/shin/content/SMA07-4257/SMA07-4257.pdf>.
- ⁴ Substance Abuse and Mental Health Services Administration. (2008). Summary report CARAVAN® survey for SAMHSA on addictions and recovery. Rockville, MD: Office of Communications, SAMHSA.
- ⁵ SAMHSA Blog. (2012). *SAMHSA's Working Definition of Recovery Updated*. Retrieved from <https://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated/>.
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PEOPLE LIVING IN RURAL AND FRONTIER COMMUNITIES:

SUPPORT FOR THOSE WITH LIMITED ACCESS



PEOPLE LIVING IN RURAL AND FRONTIER COMMUNITIES:

SUPPORT FOR THOSE WITH LIMITED ACCESS

THE ISSUE

About one-fourth of the American population lives in a rural area. With the unique challenges that rural communities face, there is a need to provide access to treatment and support for individuals living in rural areas who experience mental and/or substance use disorders. Poverty, unemployment, and isolation are all factors that contribute to behavioral health conditions in this population.^{1,2} It is therefore critical to educate individuals in rural communities, and their families and friends, that local and national treatment resources are available.

The following recent data highlight the fact that millions of Americans in rural and frontier communities are affected by mental and substance use disorders.

- Rural admissions to substance abuse facilities were more likely than urban admissions to report alcohol as the primary drug abuse (49.5 percent vs. 36.1 percent). Non-heroin opiates (10.6 percent vs. 4.0 percent) and marijuana (20.9 percent vs. 17 percent) were also more prevalent in rural admissions than in urban admissions.³
- In 2015, 4.7 percent of individuals who live in nonmetropolitan areas have experienced serious mental illness in the past year.⁴ In addition, an estimated 2.6 million rural adults suffer from depression.⁵
- However, 60 percent of rural Americans live in areas with a shortage of mental health professionals.⁶
- Research has indicated that of the 62 million people who live in frontier and rural areas, 15 million experienced a substance use, mental, or co-occurring disorder.⁷

FINDING SUPPORT

There are unique barriers to behavioral health care in rural locations compared to metropolitan areas. Challenges include higher unemployment⁸; geographic considerations, such as distance to treatment services; and cultural misconceptions about receiving treatment.⁹ It is important to open up lines of communication to increase understanding of behavioral health care and to ensure that those in need receive treatment. One way that barriers are being addressed, and lines of communication are being opened, is through telehealth. Telehealth allows health care professionals to reach individuals seeking treatment for their behavioral health condition without the limitations of geography. Telehealth has been shown to yield better behavioral health care results than implementing practice-based collaborative care with locally available staff, including the treatment of depression, among individuals living in rural areas and can be used as a supplement with locally available care.¹⁰

Families and friends can play a major role in helping to prevent mental and substance use disorders, identifying when someone has a problem,^{11,12} and connecting those in need with the treatment resources and services for their recovery journey.¹³ For information about how communities play a role in the path to recovery, visit the **Communities in Recovery** section of the toolkit.

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RECOVERY HAS GIVEN ME THE HOPE THAT ANYTHING IS POSSIBLE AND MORE IMPORTANTLY, RECOVERY HAS GIVEN ME MY LIFE BACK.

STAS

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FOR MORE INFORMATION ABOUT SAMHSA'S EFFORTS TO ENSURE THAT AMERICANS LIVING IN RURAL AND FRONTIER COMMUNITIES AND THEIR FAMILIES CAN ACCESS BEHAVIORAL HEALTH TREATMENT AND SERVICES, VISIT [HTTPS://SAMHSA.GOV/SPECIFIC-POPULATIONS/OTHER](https://samhsa.gov/specific-populations/other).

Individuals in rural and frontier communities, their friends, and families are not alone. Visit **Recovery Month's** Personal Recovery Stories (<https://recoverymonth.gov/personal-stories>) to see first-person accounts of recovery from people across the nation.

PROMOTING RECOVERY: HELPFUL RESOURCES

There are many organizations, services, and resources available to support people living in rural and frontier areas and those who care for them. The following resources provide assistance for individuals experiencing a mental and/or substance use disorder in these communities.

- **Rural Mental Health and Substance Abuse Toolkit** (<https://www.ruralhealthinfo.org/community-health/mental-health>): Provides strategies on developing and implementing programs to improve community behavioral health in rural areas using evidence-based approaches and techniques.
- **Rural Community Health Toolkit** (<https://www.ruralhealthinfo.org/community-health/rural-toolkit>): Provides rural communities with the information, resources, and materials they need to develop a community health program.
- **Health Resources & Services Administration's (HRSA) Rural Community Programs** (<http://www.hrsa.gov/ruralhealth/community/index.html>): Provides funding to increase access to care in rural communities and to address their unique health care challenges.
- **HRSA's Federal Office of Rural Health Policy** (<https://www.hrsa.gov/ruralhealth/community/index.html>): Addresses health care issues that impact rural communities, including access to quality health care and health professionals, viability of rural hospitals, and rules and regulations on financing health care in rural areas.
- **The SAMHSA-HRSA Center for Integrated Health Solutions, Telebehavioral Health Training and Technical Assistance Series** (<http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>): Provides guidance and assistance to safety net providers and rural health clinics so they can understand and adopt telebehavioral health services.

- **The National Rural Health Association** (<https://www.ruralhealthweb.org/>): Provides leadership on rural health issues through advocacy, communication, education, and research. Members include a diverse group of individuals and organizations with interests in rural health.
- **SAMHSA's National Frontier and Rural Addiction Technology Transfer Center** (<http://www.attcnetwork.org/national-focus-areas/?rc=frontierrural>): Aims to accelerate the adoption and implementation of evidence-based addiction treatment and recovery-oriented practices and services in rural and frontier areas. Attempts to increase the awareness, knowledge, and skills of individuals working in the behavioral health care field, and to foster regional and national alliances among stakeholders.
- **Rural Health Research Gateway** (<https://www.ruralhealthresearch.org/>): Aims to move new research findings on rural health to various end users as quickly and efficiently as possible.
- **State Offices of Rural Health** (<https://www.ruralhealthinfo.org/organizations/state-office-of-rural-health>): Provides information on individual state offices of rural health for individuals seeking local information about health care in their area.

The challenges facing rural and frontier communities are considerable and complex. However, they are not insurmountable, and with the help of the community, recovery is possible.

For more information, including **Recovery Month** resources for families and the community, public service announcements, events across the country, and social media tools, visit the **Recovery Month** website at <https://recoverymonth.gov>.

This list is not exhaustive of all available resources. Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the United States Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

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INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM:
SUPPORT FOR RECOVERY



INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM: SUPPORT FOR RECOVERY

THE ISSUE

Many individuals who come in contact with law enforcement and the criminal justice system have a mental and/or substance use disorder.¹ More than two thirds of jail detainees and half of the people in prison have a substance use disorder, compared with 9 percent of people in the general population.^{2,3} Similarly, rates of serious mental illnesses are four to six times higher in jails and three to four times higher in prisons than in the general population.⁴ Research indicates that individuals with mental illness have remained incarcerated nearly twice as long as other inmates due to an inability to make bail and the extremely limited availability of alternatives to detention and incarceration, among other reasons.⁵

According to a survey of state and federal prisons from the Bureau of Justice Statistics, half of the prisoners met criteria for drug abuse or dependence and fewer than 20 percent received the treatment they needed.⁶ Without treatment, mental and substance use disorders can linger or worsen, which increases the likelihood of further involvement in the criminal justice system.

Recent data describe the prevalence of individuals in the criminal justice system experiencing a mental and/or substance use disorder.

- Studies have found that for youth in the juvenile justice system, 60 percent met the criteria for a substance use disorder.⁷
- Alcohol and drugs have been implicated in an estimated 80 percent of offenses leading to incarceration in the United States, such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public order offenses.⁸
- Over half of prison and jail inmates had a mental health disorder, with local jail inmates experiencing the highest rate (64 percent). Additionally, the majority of inmates with a mental health disorder also had a substance or alcohol use disorder.⁹
- Approximately 14.5 percent of men and 31 percent of women in jails were reported to experience serious mental illness¹⁰ compared to 4.0 percent of the general population.¹¹
- Only one in three state prisoners, one in four federal prisoners, and one in six jail inmates who had mental health problems received treatment after being incarcerated.¹²
- Seventy-five percent of inmates with a mental illness also experienced substance use disorders. This highlights the need for offenders to be screened for co-occurring disorders, and possibly treated for both, which would require adopting integrated treatment approaches.¹³

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*TODAY I WORK FOR
AN ADDICTION CLINIC.
I HELP THOSE PERSONS
WITH THE SAME
DISEASE THAT I HAVE.*

BRANDI

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Individuals with behavioral health needs also face many barriers to reentry into the community after being released from incarceration. These barriers include a lack of health care, education, housing, childcare, and employment, which can increase the probability of a return to the criminal justice system.¹⁴ More than 40 percent of offenders return to state prison within 3 years of their release (75 percent of men and 83 percent of women return to prison for using illegal drugs¹⁵). According to the National Institute of Corrections, prison and jail inmates who have physical, mental and/or substance use disorders experience more reintegration difficulties upon leaving prison, making access to care a priority for returning to the community.¹⁶ Effective health care and other recovery support resources can reduce the likelihood that individuals will return to prison for new crimes or parole violations.¹⁷

PROVIDING VITAL SUPPORT

The majority of people in the criminal justice system in need of treatment are not receiving services either during the pretrial period, while in prison, or after release.¹⁸ Those who remain dependent on substances are more likely to return to the criminal justice system, making it critical for these individuals to find support and receive treatment.¹⁹ With basic supports such as housing, employment, health care, and childcare, people in the criminal justice system have an increased chance of becoming and remaining substance-free.²⁰

Court systems, probation and parole officers, and jails and other correctional facilities—in partnership with treatment and other health providers in the community—can play a vital role in making sure people learn about health care coverage and gain access to primary and behavioral health care. This can be facilitated by educating court, jail, and prison personnel on health insurance opportunities; providing educational materials to public defenders, law firms, and other key personnel; and engaging community organizations, businesses, and faith-based organizations to assist ex-offenders in applying for health insurance.²¹

At the federal, state, and local levels, criminal justice reforms are changing the landscape of criminal justice policies and practices. In 2015, federal efforts on reentry services and support for justice-involved individuals with mental and/or substance use disorders resulted in an expansion of programs and services.²²

Law enforcement, pretrial, prosecutorial, and jail diversion programs offer opportunities to send some individuals with substance use and/or mental disorders to treatment instead of incarceration. Those diverted have fewer arrests after diversion compared to 12 months before, have fewer jail days, and use less alcohol and fewer drugs.²³

PROMOTING RECOVERY: HELPFUL RESOURCES

If access to treatment has not been available or utilized in the community, U.S. jails and prisons are often the first chance for people with mental and/or substance use disorders to receive treatment and support. Effective treatment of people in the justice system improves their well-being and can reduce the likelihood that they will commit new crimes or violate their probation once released.²⁴ Recovery also can be promoted through diversion programs that offer individuals with behavioral health conditions an appropriate balance of supervision, accountability, and community treatment and support.²⁵ These individuals have unique behavioral health and treatment needs, and with support, there is hope for recovery.

Resources for law enforcement officers and court systems to support individuals in the criminal justice system are provided below.

- **Association of Drug Court Professionals** (<http://www.nadcp.org>): Provides resources to improve the justice system by using a combination of judicial monitoring and effective treatment to compel drug-using offenders to change their lives.
- **Bridging the Gap** (<https://www.vera.org/publications/bridging-the-gap-improving-the-health-of-justice-involved-people-through-information-technology>): Highlights the problems of disconnected justice and health systems and shares possible solutions using health information technology (HIT).
- **Center for Health and Justice** (<http://www2.centerforhealthandjustice.org/>): Provides resources on diversion, reentry, and systems change, focusing on practical solutions to identify and place people with mental and/or substance use disorders into appropriate services in the community.
- **Justice and Health Connect** (<http://www.jhconnect.org/>): Serves as a national resource to increase the ability of government agencies and community organizations to share information across health and justice systems.
- **Mental Health America – Criminal Justice** (<http://www.mentalhealthamerica.net/issues/criminal-justice>): Provides information on the issues that states, communities, and criminal justice systems face to reduce the number of individuals who rotate in and out of jails and prisons. This resource includes information on state and local initiatives.

- **Mental Health First Aid** (<http://www.mentalhealthfirstaid.org/cs/>): Teaches people how to identify, understand, and respond to the signs of mental illness and substance use disorders.
- **National Alliance for Model State Drug Laws (NAMSDL)** (<http://www.namsdl.org/>): Serves as a resource for those seeking information on comprehensive and effective state drug and alcohol laws, policies, regulations, and programs.
- **National Association of Counties** (<http://www.naco.org/addressing-mental-illness-and-medical-conditions-county-jails>): Provides a report addressing mental illness and medical conditions in county jails. Includes key findings and case studies.
- **National Association of State Alcohol and Drug Abuse Directors** (<http://nasadad.org/2016/02/departments-of-justice-doj-nasadad-priority-programs/>): Identifies programs and sources of funding that support their members work to improve the substance use service systems throughout the United States.
- **The National Association of State Mental Health Program Directors** (<http://www.nasmhpd.org/>): Works with states, federal partners, and stakeholders toward the recovery of people with mental health disorders, including those in the criminal justice system.
- **National Council for Behavioral Health** (<http://www.thenationalcouncil.org/>): Unites 2,800 organizations that serve adults, children, and families living with mental health and/or substance use disorders. Its mission is to advance the ability of member organizations to deliver health care to those in need.
- **National Drug Court Institute** (<http://www.ndci.org/>): Provides insight on the latest research, best practices, and cutting-edge innovations to treat justice-involved individuals with mental and/or substance use disorders.
- **National Institute on Drug Abuse's Criminal Justice and Drug Abuse Web Page** (<https://www.drugabuse.gov/related-topics/criminal-justice-drug-abuse>): Provides materials and identifies other helpful resources that can be used in educating people in the justice system about the science related to drug use, misuse, and addiction. This site supports those who work with juveniles and adults within the court system, including judges, counselors, social workers, case workers, and others.
- **National Reentry Resource Center** (<https://csgjusticecenter.org/reentry/>): Provides education, training, and technical assistance to states, tribes, territories, local governments, service providers, non-profit organizations, and corrections institutions working on prisoner reentry.
- **SAMHSA's Behavioral Health Treatment Services Locator** (<https://findtreatment.samhsa.gov/>): Serves as a confidential and anonymous source of information for persons seeking treatment for behavioral health problems in the United States or its territories.
- **SAMHSA's Criminal and Juvenile Justice Web Page** (<https://samhsa.gov/criminal-juvenile-justice/>): Provides resources to promote early intervention and treatment as healthier alternatives than detaining people with behavioral health conditions in U.S. justice system.
- **SAMHSA's GAINS Center for Behavioral Health and Justice Transformation** (<https://samhsa.gov/gains-center/>): Provides training for criminal justice professionals to raise awareness about trauma and its effects. "How Being Trauma-Informed Improves Criminal Justice System Responses" is a 1-day training for criminal justice professionals.
- **SAMHSA's Law Enforcement and Behavioral Health Partnerships for Early Diversion** (<https://samhsa.gov/gains-center/grants-grantees/early-diversion/>): Works to keep people with mental and/or substance use disorders out of the criminal justice system.
- **SAMHSA's National Helpline, 1-800-662-HELP (4357) – or 1-800-487-4889 (TDD)** (<https://samhsa.gov/find-help/national-helpline/>): Provides 24-hour, free, and confidential treatment referral and information about mental and substance use disorders, prevention, treatment, and recovery in both English and Spanish.
- **SAMHSA's Quick Guide for Clinicians: Continuity of Offender Treatment for Substance Use Disorder from Institution to Community** (<https://store.samhsa.gov/product/Continuity-of-Offender-Treatment-for-Substance-Use-Disorder-from-Institution-to-Community/SMA15-3594>): Helps substance misuse treatment clinicians and case workers assist offenders in the transition from the criminal justice system to life after release. Discusses assessment, transition plans, important services, special populations, and confidentiality.

- **The Justice Center: Mental Health Home** (<https://csgjusticecenter.org/mental-health/>): Supports policymakers at every level of government by providing practical, nonpartisan advice and evidence-based, consensus-driven strategies to increase public safety and strengthen communities.
- **The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System** (<http://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system>): Provides a national landscape on the processing and treatment of mentally ill individuals in the criminal justice system.
- **United States Department of Justice's Violence Reduction Network** (<https://www.bja.gov/Programs/VRN.html>): Provides guidance on an approach to violence reduction that brings together city police departments with Justice Department law enforcement and grant-making components to reduce violence in some of the country's most violent cities.

For more information, including **Recovery Month** resources for families and the community, public service announcements, events across the country, and social media tools, visit the **Recovery Month** website at <https://recoverymonth.gov/>.

This list is not exhaustive of all available resources. Inclusion of websites and resources in this document and on the Recovery Month website does not constitute official endorsement by the United States Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

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COMMUNITIES IN RECOVERY: SUPPORTING INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS



COMMUNITIES IN RECOVERY: SUPPORTING INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS

THE ISSUE

Many people with mental and/or substance use disorders can feel isolated from the society around them. Community-based organizations, faith-based organizations, and employers are in a unique position to support these individuals by conveying messages of compassion and understanding. Leaders from these organizations—which can include teachers, city and county officials, clergy members, counselors, and volunteers—can encourage and motivate individuals to seek prevention, treatment, or recovery support services for mental and substance use disorders.

SAMHSA's National Survey on Drug Use and Health highlights the millions of Americans nationwide who are affected by mental and/or substance use disorders.

- In 2015, an estimated 20.8 million individuals aged 12 or older were classified with a substance use disorder in the past year.¹
 - + In 2015 8.3 percent of persons aged 12 or older who needed or felt the need for substance use treatment were deterred from treatment because they were concerned their community would have a negative opinion of them.²
- An estimated 43.4 million individuals aged 18 or older had any mental illness in the past year for 2015.³
 - + In 2015 10.5 percent of persons aged 18 or older who had perceived unmet needs for mental health treatment were deterred from treatment because they were concerned their community would have a negative opinion of them.⁴
- In 2015, approximately 8.1 million adults had a co-occurring substance use disorder and any mental illness in the past year.⁵

Unaddressed behavioral health problems can result in lost productivity and increase costs across community systems, including health care; emergency and social services; special education; and services for homelessness, law enforcement, and criminal justice. Community- and faith-based organizations can engage with these individuals to offer them the support they need to recover and lead healthy lives.

It is important for communities to take into account that integrated treatment, that is, treatment that addresses mental and substance use conditions at the same time, is associated with lower costs and better outcomes, such as reduced substance use, improved psychiatric symptoms and functioning, and an improved quality of life.⁶

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*MY DESIRE IS TO
INSPIRE, ENCOURAGE,
AND ENLIGHTEN THOSE
WHO ARE IN RECOVERY
OR ON THEIR WAY TO
RECOVERY SO THAT
THEY CAN LIVE A LIFE IN
PEACE AND SERENITY.*

NATALIE

”

PROVIDING SUPPORT

Community partners can work together to increase awareness of behavioral health needs and make it easier for people to seek help. Support from faith-based organizations and schools is important to the long-term recovery of people living with behavioral health conditions. For example, the connectedness of adolescents to their schools has been shown to protect against suicidal thoughts and behaviors.⁷

Leaders of community organizations can provide support for individuals seeking recovery by:

- Identifying opportunities to discuss the facts about substance use and mental illness within their organizations. They can discuss the roles their organizations can play in supporting individuals living with mental and/or substance use disorders, such as encouraging them to seek help.
- Organizing meetings, dinners, or other gatherings so that community members can have conversations about mental and substance use disorders.
- Developing relationships with local mental health and substance use disorder service providers and directing individuals and families in need to available services.
- Creating a welcoming, supportive, safe, and non-judgmental environment for addressing behavioral health conditions.
 - + Let people know it is okay to talk about mental health and substance use.
 - + Talk about mental health and substance use using an approach that supports prevention, treatment, and recovery.
 - + Encourage people experiencing mental and/or substance use disorders—and their families—to seek help and assist them when needed.
 - + Foster opportunities to build connections with individuals and families dealing with mental health and substance use challenges to create a spirit of trust and acceptance.

Host learning sessions to promote health and wellness (<https://samhsa.gov/wellness>), which, as defined by SAMHSA, is the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. There are Eight Dimensions of Wellness (<https://samhsa.gov/wellness-initiative/eight-dimensions-wellness>), that when practiced, help individuals develop healthy habits that can have a positive impact on their physical and mental health.

PROMOTING RECOVERY: HELPFUL RESOURCES

Community and faith-based organizations have the power to change perceptions and spread messages of hope about the effectiveness of prevention and treatment. Through education and encouragement, leaders of local organizations can affect individuals' decisions to seek help for behavioral health conditions.

Resources and background information for community leaders are provided below.

- **Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals** (<http://www.cadca.org/resources/assessment-primer-analyzing-community-identifying-problems-and-setting-goals>): Provides anti-drug coalitions with clear guidelines for defining their communities and assessing the real needs within the community.
- **7 Strategies for Effective Community Change** (<http://www.preventrxabuse.org/about-the-tool-kit/7-strategies-to-effective-community-change/#.V-7RSPkrKCg>): Details seven common strategies typically used by coalitions to change individual behaviors and community conditions.
- **Components of an Effective Coalition** (<https://samhsa.gov/capt/tools-learning-resources/components-effective-coalition>): Learn more about assessing community resources and readiness.
- **National Institute on Drug Abuse's (NIDA's) What to Do If Your Adult Friend or Loved One Has a Problem with Drugs** (<https://www.drugabuse.gov/related-topics/treatment/what-to-do-if-your-adult-friend-or-loved-one-has-problem-drugs>): Includes a list of the warning signs of drug abuse as well as resources and information to help someone who might have a drug abuse problem.
- **NIDA's What to Do If Your Teen or Young Adult Has a Problem with Drugs** (<https://www.drugabuse.gov/related-topics/treatment/what-to-do-if-your-teen-or-young-adult-has-problem-drugs>): Provides parents of teens/young adults with information on how to identify and handle possible drug misuse situations.
- **NIDA's Family Checkup: Positive Parenting Prevents Drug Abuse** (<https://www.drugabuse.gov/family-checkup>): Provides information about evidence-based parenting skills that are important in preventing the initiation and progression of drug use among youth as well as videos with positive and negative examples of parenting skills.

- **Talk. They Hear You.** (<https://samhsa.gov/underage-drinking/mobile-application>): Prepare for one of the most important conversations you may ever have with your kids about underage drinking. SAMHSA's "Talk. They Hear You." app is available on desktop computers and on mobile devices.
- **Symptoms of an Alcohol Use Disorder** (<http://rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/Whats-the-harm/What-Are-Symptoms-Of-An-Alcohol-Use-Disorder.aspx>): Includes information on alcohol use disorders, on how to determine if an individual's drinking pattern is risky, and information on how to reduce an individual's risk of an alcohol-related incident.
- **Signs of a Mental Health Disorder** (<http://www.mentalhealth.gov/what-to-look-for/index.html>): Provides descriptions of different mental health disorders, as well as common symptoms.
- **Community Anti-Drug Coalitions of America (CADCA)** (<http://www.cadca.org/>): Represents those working to make their communities safe, healthy, and drug-free with resources and trainings.
- **SAMHSA's Safe Schools/Healthy Students** (<https://samhsa.gov/safe-schools-healthy-students>): Prevents violence and substance misuse among our nation's youth, schools, and communities.
- **Bringing Recovery Supports to Scale, Technical Assistance Center Strategy (BRSS TACS)** (<https://samhsa.gov/brss-tacs>): Provides peers, peer and family run organizations training and technical assistance, to states, providers, and systems to increase the adoption and implementation of recovery supports for those with behavioral health conditions.
- **Alcoholics Anonymous** (<http://www.aa.org/>): Aims to help alcoholics achieve sobriety through peer-to-peer support, educational services, and counseling.
- **Narcotics Anonymous** (<https://www.na.org/>): Offers recovery support for individuals seeking to pursue and maintain a drug-free lifestyle.
- **SAMHSA's Drug-free Workplace Programs** (<https://samhsa.gov/workplace>): Offers a comprehensive list of programs that address illicit drug use by federal employees and in federally regulated industries.
- **SAMHSA's National Helpline, 1-800-662-HELP (4357) – or 1-800-487-4889 (TDD)** (<https://samhsa.gov/find-help/national-helpline>): Provides 24-hour, free, and confidential treatment referral and information about mental and substance use disorders, prevention, treatment, and recovery in both English and Spanish.

For more information, including **Recovery Month** resources for families and the community, public service announcements, events across the country, and social media tools, visit the **Recovery Month** website at <https://recoverymonth.gov/>.

This list is not exhaustive of all available resources. Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the United States Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

¹ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-51, HHS Publication No. SMA 16-4984. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016, p. 2.

² Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 5.61B*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab5-61b>

³ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-51, HHS Publication No. SMA 16-4984. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016, p. 2.

⁴ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.55B*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-55b>

⁵ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health*, NSDUH Series H-51, HHS Publication No. SMA 16-4984. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016, p. 2.

⁶ “Behavioral Health Treatments and Services.” The Substance Abuse and Mental Health Services Administration, 19 Oct. 2015. Web. 19 Oct. 2016. Retrieved from: <https://www.samhsa.gov/treatment>

⁷ Bearman PS and Moody J. Suicide and friendships among American adolescents. *Am J Public Health* 2004 94:89–95.

PUBLIC HEALTH PROFESSIONALS AND
DEPARTMENTS OF PUBLIC HEALTH:

**IMPROVING ACCESS
TO TREATMENT SERVICES
AND SUPPORTING RECOVERY**



PUBLIC HEALTH PROFESSIONALS AND DEPARTMENTS OF PUBLIC HEALTH: IMPROVING ACCESS TO TREATMENT SERVICES AND SUPPORTING RECOVERY

THE ISSUE

Public health professionals and departments of public health are addressing behavioral health conditions among members of their communities, from strengthening local health systems to increasing access to services. They are vital resources for connecting persons experiencing mental and/or substance use disorders with recovery and support services.

Behavioral health is integral to overall health and well-being and should be treated with the same urgency as physical health.^{1,2,3,4} Mental illness can influence the onset, progression, and outcome of other illnesses and often is linked with substance abuse, tobacco use, and physical inactivity.⁵ In addition, many of the country's foremost medical problems can be linked to substance misuse, from cancer and heart disease to HIV/AIDS.^{6,7,8,9} The following figures from the 2015 National Survey on Drug Use and Health (NSDUH)¹⁰ highlight the need to improve access to treatment services throughout the United States:

- About 1 in 12 people aged 12 or older (20.8 million Americans) in 2015 needed substance use treatment. However, only an estimated 3.7 million people aged 12 or older received substance use treatment of any kind.¹¹
- Among the 43.4 million adults with any mental illness in the past year in 2015, about 18.6 million (43.1 percent) received mental health services.
 - + Of the 9.8 million adults with serious mental illness in the past year, only 65.3 percent received any mental health services in the past year.
- Of the 8.1 million adults with co-occurring mental illness and a substance use disorder, approximately 48.0 percent received either mental health care or substance use treatment at a specialty facility in the past year.¹²

STRENGTHENING LOCAL SYSTEMS

Public health professionals can strengthen support for those living with mental and/or substance use disorders in a number of ways, including:

- Increasing access to care;
- Supporting integrated care; and
- Improving parity. Parity requires insurers to provide comparable coverage for mental health and substance use disorders as they do for physical health.

To accomplish these goals, public health professionals require resources that provide accurate information on mental illness and substance misuse. Increasing access to current information makes it easier to integrate programs, provide interventions, and provide referrals to treatment and recovery support services.

“

I WAS AIDED BY A PLETHORA OF GIVING SOULS INCLUDING... PRIVATE AND PUBLIC PSYCHIATRISTS, PSYCHOLOGISTS, SOCIAL WORKERS AND SPIRITUAL ADVISORS FROM EVERY POSSIBLE BACKGROUND.

ROCKY_BOTTOMS
(ONLINE USER NAME)

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HEALTH PROFESSIONALS CAN SERVE AS KEY PROPONENTS OF SAMHSA'S WELLNESS INITIATIVE TO MAKE A DIFFERENCE IN COMMUNITIES. FOR MORE INFORMATION ON WELLNESS, VISIT: [HTTPS://SAMHSA.GOV/WELLNESS](https://samhsa.gov/wellness)

One of the most important methods for strengthening local systems is to collaborate with an active, engaged recovery community. Recovery communities are composed of individuals in or seeking recovery, their family, friends, and allies who advocate for healthier communities, which may include providers, associations, and public health officials. Public health professionals benefit from ongoing interactions with those in the field who promote, support, and manage mental and substance use treatment and support programs. To strengthen collaboration with the recovery community, public health professionals can:

- Meet with behavioral health organizations, treatment providers, and other stakeholders in the community to discuss their work, understand the services they provide, and learn about the campaigns or events they sponsor. These efforts lay the groundwork for effective referrals and allow health professionals to align efforts when promoting community events.
- Promote positive attitudes about recovery in the community. A positive outlook about patients' conditions and remaining empathetic, respectful, and nonjudgmental has been shown to empower them to seek help and strive to improve their well-being.¹³
- Seek additional training. By educating themselves about relevant behavioral health topics, public health professionals can stay on top of trends and the latest best practices, improving the success of their programs and initiatives.
- Use data to enhance program efforts. SAMHSA provides data on mental and substance use disorders at the national, state, and local levels, which can be used to identify unmet needs, inform policy, and measure programs' impact (<https://samhsa.gov/data>).
- Spread the message that treatment is effective and recovery is possible through disease management. SAMHSA's Strategic Initiatives (<https://samhsa.gov/about-us/strategic-initiatives>) focus on increasing public awareness about mental and substance use disorders, including the fact that through a variety of settings and methods, individuals with mental and/or substance use disorders can achieve long-term recovery.

HELPFUL RESOURCES

To help address mental and substance use disorders in their communities, public health professionals and public health departments can incorporate behavioral health promotion and recovery into chronic disease prevention efforts and collaborate with partners to enhance coordination of care.

HEALTHY PEOPLE, A PROGRAM OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, HAS A 10-YEAR NATIONAL OBJECTIVE FOR IMPROVING HEALTH, WHICH INCLUDES MEETING THE BEHAVIORAL HEALTH NEEDS OF ALL AMERICANS. HEALTHY PEOPLE PROVIDES BENCHMARKS THAT HEALTH DEPARTMENTS CAN CONTRIBUTE TO AND RESOURCES ON IMPROVING HEALTH IN THE UNITED STATES.

Resources and background information for public health professionals and public health departments who work with individuals experiencing behavioral health conditions are listed below.

- **American Public Health Association – Prescription Drug Overdose** (<http://www.apha.org/topics-and-issues/prescription-drug-overdose>): Provides information, case studies, and resources for public health professionals to understand and combat overdose.
- **American Public Health Association – Mental Health** (<http://www.apha.org/topics-and-issues/mental-health>): Provides information, recommendations, and resources for public health professionals to understand mental health challenges and improve access to mental health care.
- **Association of State and Territorial Health Officials (ASTHO) 2017 President's Challenge** (<http://www.astho.org/addictions/>): Unites state health officials, affiliates, and other cross-sector partners and empowers them with resources, tools, and strategies to help health agency implementation at every level.

- **Healthy People 2020 – Mental Health and Mental Disorders Interventions and Resources**
(<https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/ebrs>): Houses evidence-based resources, clinical recommendations, and consumer information on reducing the impact of substance misuse.
- **Healthy People 2020 – Substance Abuse Interventions and Resources**
(<https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/ebrs>): Provides evidence-based resources, clinical recommendations, and consumer information on improving the mental health needs of all Americans.
- **National Association of County and City Health Officials (NACCHO) Resource Hub**
(<http://www.naccho.org/resources>): Houses tools, resources, and information to help local health departments become more effective and efficient and stay on top of emerging trends.
- **National Council for Behavioral Health**
(<http://www.thenationalcouncil.org/>): Advances the ability of America’s community mental health and addictions treatment organizations to deliver integrated health care by providing resources and educational information.
- **National Council for Behavioral Health – Training and Development Courses**
(<http://www.thenationalcouncil.org/events-and-training/training-development-courses/>): Provides a wide variety of trainings for public health professionals on behavioral health topics.
- **Public Health Accreditation Board**
(<http://www.phaboard.org/>): Improves and protects the health of the public by advancing, and ultimately transforming, the quality and performance of state, local, tribal, and territorial public health departments. It includes an online education center with training and preparation for accreditation processes.

For more information, including **Recovery Month** resources for families and the community, public service announcements, events across the country, and social media tools, visit the **Recovery Month** website at <https://recoverymonth.gov>.

This list is not exhaustive of all available resources. Inclusion of websites and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the United States Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

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- ¹ U.S. Department of Health and Human Services. Mental health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services; 1999.
- ² President's New Freedom Commission on Mental Health. Achieving the promise: Transforming mental health care in America. Rockville, MD: U.S. Department of Health and Human Services; 2003.
- ³ Rice DP. Economic Costs of Substance Abuse, 1995. *Proc Assoc Am Phys* 111(2): 119-125, 1999.
- ⁴ Office of National Drug Control Policy (ONDCP). The Economic Costs of Drug Abuse in the United States 1992-1998. NCJ-190636, 2001.
- ⁵ Chapman DP, Perry SG, Strine TW. The vital link between chronic disease and depressive disorders. *Prevent Chronic Dis* 2005;2 [serial pub online]. Available at <https://www.ncbi.nlm.nih.gov/pubmed/15670467>.
- ⁶ McGinnis JM, and Foege WH. Mortality and morbidity attributable to use of addictive substances in the United States. *Proc Assoc Am Phys* 111(2): 109-118, 1999.
- ⁷ Ockene IS, and Miller NH. Cigarette Smoking, Cardiovascular Disease, and Stroke. *Circulation* 96:3243-3247, 1997.
- ⁸ Centers for Disease Control and Prevention. Drug-Associated HIV Transmission Continues in the United States, 2002. Available at <http://www.cdc.gov/hiv/statistics/overview/>.
- ⁹ Centers for Disease Control and Prevention. Viral Hepatitis C Fact Sheet, 2004. Available at <http://www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm>.
- ¹⁰ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from <https://samhsa.gov/data/>.
- ¹¹ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 5.16A*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab5-16a>
- ¹² Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2015 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.htm>
- ¹³ Diagnosis & Treatment of Drug Abuse in Family Problems. National Institute on Drug Abuse website: <http://archives.drugabuse.gov/diagnosis-treatment/diagnosis5.html>.

COMMON MENTAL DISORDERS AND MISUSED SUBSTANCES



COMMON MENTAL DISORDERS AND MISUSED SUBSTANCES

Every September, the Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://samhsa.gov/>), within the U.S. Department of Health and Human Services (HHS) (<https://hhs.gov/>), sponsors **National Recovery Month (Recovery Month)** to increase awareness of behavioral health conditions. This observance promotes the knowledge that behavioral health is essential to overall health, prevention works, treatment is effective, and people can and do recover from mental illness and substance use disorders.

This year's **Recovery Month** theme, “*Join the Voices for Recovery: Strengthen Families and Communities,*” encourages communities, in their full dimension, to be inclusive and supportive of those with behavioral health conditions.



Binge Alcohol Use

Nearly **1 in 2** current alcohol users reported binge use in the past month.[†]

BEHAVIORAL HEALTH PREVALENCE IN THE UNITED STATES

Millions of people in the United States live with a mental and/or substance use disorder. The prevalence of these conditions highlights the importance of focusing funding and attention for behavioral health needs.

- In 2015, among people aged 12 or older, 20.8 million people (7.8 percent of this population) were classified with substance use disorders in the past year.¹
 - + An estimated 7.7 million of underage persons aged 12 to 20 (20.3 percent) were current drinkers in 2015, including 5.1 million binge drinkers (13.4 percent) and 1.3 million heavy drinkers (3.3 percent).²
- Data from 2015 demonstrated that among adults aged 18 or older, 43.4 million adults (17.9 percent) had any mental illness (AMI) in the past year.³ *A person with any mental illness is defined as an individual having any mental, behavioral, or emotional disorder in the past year that met Diagnostic and Statistical Manual of Mental Disorders (DSM-V) criteria (excluding developmental and substance use disorders).*⁴
 - + Among adults aged 18 or older, 9.8 million adults (4.0 percent) had a serious mental illness (SMI) in the past year.⁵ *A person with serious mental illness is defined as an individual having any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. AMI and SMI are not mutually exclusive categories; adults with SMI are included in estimates of adults with AMI.*
- In 2015, more than 8.1 million U.S. adults aged 18 or older reported having co-occurring disorders. This means that within the previous year, they experienced both a mental illness and a substance use disorder.⁶
 - + About 5.9 percent of individuals aged 18 to 25 (2.1 million) had co-occurring mental illness and a substance use disorder.⁷
- In 2014, more than 42,000 Americans died as a result of suicide—more than 1 person every 12.8 minutes.⁸
 - + Suicide was the second leading cause of death in 2014 for three age groups: individuals aged 10 to 14, 15 to 24, and 25 to 34.⁹

TO LEARN MORE ABOUT THE MOST COMMON MENTAL AND SUBSTANCE USE DISORDERS AND HOW SAMHSA WORKS TO REDUCE THEIR IMPACT ON AMERICA'S COMMUNITIES, PLEASE VISIT: [HTTPS://SAMHSA.GOV/DISORDERS](https://samhsa.gov/disorders)

Read on to learn about common mental illnesses and misused substances, as well as alternative names for each disorder or substance; signs, symptoms, and adverse health effects; additional information on prevalence; and the average age of first-time use of a substance.

COMMON MENTAL DISORDERS

MENTAL DISORDER	SIGNS AND SYMPTOMS <small>10,11,12</small>	ESTIMATE DESCRIPTION	SURVEILLANCE SYSTEM ^{13,14,15}	ESTIMATE ¹⁶
ANXIETY DISORDERS				
AGORAPHOBIA	Intense fear and anxiety of any place or situation where escape might be difficult; avoidance of being alone outside of the home; fear of traveling in a car, bus, or airplane, or of being in a crowded area	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-A	2.4% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	1.4% of adults
		Average Age of Onset	NCS-R	20 years old
GENERALIZED ANXIETY DISORDER	Excessive worry about a variety of everyday problems for at least 6 months; may excessively worry about and anticipate problems with finances, health, employment, and relationships	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-A	1.0% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	5.7% of adults
		Average Age of Onset	NCS-R	31 years old

MENTAL DISORDER	SIGNS AND SYMPTOMS <small>10,11,12</small>	ESTIMATE DESCRIPTION	SURVEILLANCE SYSTEM ^{13,14,15}	ESTIMATE ¹⁶
ANXIETY DISORDERS				
OBSESSIVE COMPULSIVE DISORDER (OCD)	Intrusive thoughts that produce anxiety (obsessions), repetitive behaviors that are engaged in to reduce anxiety (compulsions), or a combination of both; unable to control anxiety-producing thoughts and the need to engage in ritualized behaviors	Lifetime Prevalence in the United States Among Adults	NCS-A	1.6% of adults
		Average Age of Onset	NCS-R	19 years old
PANIC DISORDER	Unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-A	2.3% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	4.7% of adults
		Average Age of Onset	NCS-R	24 years old
POST-TRAUMATIC STRESS DISORDER (PTSD)	Can develop after exposure to a terrifying event or ordeal (traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, and military combat), persistent frightening thoughts and memories of the ordeal, sleep problems, feeling detached or numb, or being easily startled	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-R	4.0% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	6.8% of adults
		Average Age of Onset	NCS-R	23 years old
SOCIAL PHOBIA	A persistent, intense, and chronic fear of being watched and judged by others and feeling embarrassed or humiliated by their actions; this fear may be so severe that it interferes with work, school, and other activities and may negatively affect the person's ability to form relationships	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-R	5.5% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	12.1% of adults
		Average Age of Onset	NCS-R	13 years old

MENTAL DISORDER	SIGNS AND SYMPTOMS 10,11,12	ESTIMATE DESCRIPTION	SURVEILLANCE SYSTEM ^{13,14,15}	ESTIMATE ¹⁶
ANXIETY DISORDERS				
SPECIFIC PHOBIA	Marked and persistent fear and avoidance of a specific object or situation, such as a fear of heights, spiders, or flying	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-A	15.1% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	12.5% of adults
		Average Age of Onset	NCS-R	7 years old
MOOD DISORDERS				
BIPOLAR DISORDER	Recurrent episodes of highs (mania) and lows (depression) in mood, changes in energy and behavior, an extreme irritable or elevated mood, an inflated sense of self-importance, risky behaviors, distractibility, increased energy, and a decreased need for sleep	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-R	0–3% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	3.9% of adults
		Average Age of Onset	NCS-R	25 years old
ANY MOOD DISORDER (MAJOR DEPRESSIVE DISORDER, DYSTHYMIC DISORDER)	A pervading sense of sadness and/or loss of interest or pleasure in most activities that interferes with the ability to work, study, sleep, and eat; negative impact on a person’s thoughts, sense of self-worth, energy, and concentration	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-R	14% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	20.8% of adults
		Average Age of Onset	NCS-R	30 years old

MENTAL DISORDER	SIGNS AND SYMPTOMS <small>10,11,12</small>	ESTIMATE DESCRIPTION	SURVEILLANCE SYSTEM ^{13,14,15}	ESTIMATE ¹⁶
OTHER MENTAL DISORDERS				
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADD/ADHD)	Inattention or difficulty staying focused; hyperactivity or constantly being in motion or talking; impulsivity, meaning often not thinking before acting	Lifetime Prevalence in the United States Among Youth (13 to 18 Years Old)	NCS-A	9.0% of youth
		Lifetime Prevalence in the United States Among Adults	NCS-R	8.1% of adults
		Average Age of Onset	NCS-R	7 years old
SCHIZOPHRENIA	Hearing voices or believing that others are trying to control or harm the person; hallucinations and disorganized speech and behavior, causing individuals to feel frightened, anxious, and confused	12-month Prevalence in the United States Among Adults	ECA	1.1% of adults
PERSONALITY DISORDERS	Difficulties dealing with other people and participating in social activities; inflexibility, rigidity, and inability to respond to change; deeply ingrained, inflexible patterns of relating, perceiving, and thinking that cause distress or impaired functioning	12-month Prevalence in the United States Among Adults	ECA	9.1% of adults
OPPOSITIONAL DEFIANT DISORDER	Frequent and persistent pattern of angry or irritable mood, argumentative/defiant behavior, or vindictiveness. Symptoms are typically first seen in the preschool years, and often precede the development of conduct disorder	Average Prevalence in the United States Among Children	N/A	3.3%
CONDUCT DISORDER	Persistent pattern of disruptive and violent behaviors that violate the basic rights of others or age-appropriate social norms or rules, and causes significant impairment in the child or family's daily life.	Lifetime Prevalence in the United States Among Children and Youth. (Prevalence increases from childhood to adolescence and is more common among males than females).	N/A	8.5% of children and youth

COMMONLY MISUSED SUBSTANCES

SUBSTANCE: EXAMPLES OF OTHER NAMES FOR SUBSTANCES ^{17,18,19}	NEGATIVE IMMEDIATE INTOXICATION EFFECTS; NEGATIVE HEALTH EFFECTS ^{20,21}	ESTIMATE DESCRIPTION	ESTIMATE ^{22,23}
ALCOHOL, INHALANTS, AND TOBACCO			
ALCOHOL: BOOZE, BEER, WINE, LIQUOR	<i>Immediate Effects:</i> Dizziness, talkativeness, slurred speech, disturbed sleep, nausea, vomiting, impaired judgment and coordination, increased aggression <i>Health Effects:</i> Brain and liver damage, depression, liver and heart disease, hypertension, fetal damage (in pregnant women)	Past-month Use: Rate Among People Aged 12 and Older	51.1%
		Past-month Use: Number of People Aged 12 and Older	138.3 million
		Past-month Use: Rate Among Youth (Aged 12 to 17)	9.6%
		Past-month Use: Number of People Aged 12 to 17	2.4 million
		Average Age of First Use Among People Aged 12 to 49	17.6 years
INHALANTS (GASES, NITRITES, AND AEROSOLS): ETHER, CHLOROFORM, NITROUS OXIDE, ISOBUTYL, ISOAMYL, POPPERS, SNAPPERS, WHIPPETS, LAUGHING GAS	<i>Immediate Effects:</i> Increased stimulation, loss of inhibition, headache, nausea, vomiting, slurred speech, loss of motor coordination, wheezing, cramps, muscle weakness <i>Health Effects:</i> Memory impairment, damage to cardiovascular and nervous systems, unconsciousness	Past-month Use: Rate Among People Aged 12 and Older	0.2%
		Past-month Use: Number of People Aged 12 and Older	527,000
		Past-month Use: Rate Among Youth (Aged 12 to 17)	0.7%
		Past-month Use: Number of People Aged 12 to 17	175,000
		Average Age of First Use Among People Aged 12 to 49	17.4 years
TOBACCO PRODUCTS: CIGARETTES, CIGARS, SMOKELESS TOBACCO, SNUFF, SPIT TOBACCO, CHEW	<i>Immediate Effects:</i> Increased blood pressure and heart rate <i>Health Effects:</i> Chronic lung disease; coronary heart disease; stroke; cancer of the lungs, larynx, esophagus, mouth, or bladder; poor pregnancy outcomes	Past-month Use: Rate Among People Aged 12 and Older	23.9%
		Past-month Use: Number of People Aged 12 and Older	64.0 million
		Past-month Use: Rate Among Youth (Aged 12 to 17)	6.0%
		Past-month Use: Number of People Aged 12 to 17	1.5 million
		Average Age of First Use Among People Aged 12 to 49	17.9 cigarettes and 21.3 smokeless tobacco

SUBSTANCE: EXAMPLES OF OTHER NAMES FOR SUBSTANCES ^{17,18,19}	NEGATIVE IMMEDIATE INTOXICATION EFFECTS; NEGATIVE HEALTH EFFECTS ^{20,21}	ESTIMATE DESCRIPTION	ESTIMATE ^{22,23}
ILLCIT DRUGS			
<p>COCAINE: BLOW, BUMP, C, CANDY, CHARLIE, COKE, CRACK, FLAKE, ROCK, SNOW, TOOT, WHITE LADY</p>	<p><i>Immediate Effects:</i> Increased alertness, attention, and energy; dilated pupils; increased temperature, heart rate, and blood pressure; insomnia; loss of appetite; feelings of restlessness, irritability, and anxiety</p> <p><i>Health Effects:</i> Weight loss, cardiovascular complications, stroke, seizures</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth (Aged 12 to 17)</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>0.7%</p> <p>1.9 million</p> <p>0.2%</p> <p>53,000</p> <p>21.5 years</p>
<p>ECSTASY (A TYPE OF HALLUCINOGEN): ADAM, E, MOLLY, ROLL, X, XTC</p>	<p><i>Immediate Effects:</i> Involuntary tooth clenching, a loss of inhibitions, transfixion on sights and sounds, nausea, blurred vision, chills, sweating, increased heart rate and blood pressure</p> <p><i>Health Effects:</i> Muscle cramping/sleep disturbances; depression; impaired memory; kidney, liver, and cardiovascular failure; anxiety</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth (Aged 12 to 17)</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>0.2%</p> <p>557,000</p> <p>0.1%</p> <p>33,000</p> <p>20.7 years</p>
<p>HALLUCINOGENS: ACID, BOOMERS, DOSES, HITS, LSD, MICRODOT, PEYOTE, SHROOMS, SUGAR CUBES, TABS, TRIPS, PCP</p>	<p><i>Immediate Effects:</i> Dilated pupils, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, tremors</p> <p><i>Health Effects:</i> Disturbing flashbacks that may occur within a few days or more than a year after use</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth (Aged 12 to 17)</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>0.5% (includes Ecstasy, LSD, and PCP data)</p> <p>1.2 million (includes Ecstasy, LSD, and PCP data)</p> <p>0.5% (includes Ecstasy, LSD, and PCP data)</p> <p>121,000 (includes Ecstasy, LSD, and PCP data)</p> <p>19.6 years (includes Ecstasy, LSD, and PCP data)</p>

SUBSTANCE: EXAMPLES OF OTHER NAMES FOR SUBSTANCES ^{17,18,19}	NEGATIVE IMMEDIATE INTOXICATION EFFECTS; NEGATIVE HEALTH EFFECTS ^{20,21}	ESTIMATE DESCRIPTION	ESTIMATE ^{22,23}
ILLICIT DRUGS			
HEROIN: BIG H, BLACK TAR, BROWN SUGAR, DOPE, HORSE, JUNK, SKAG, SMACK, CHINA WHITE HORSE	<p><i>Immediate Effects:</i> Alternately wakeful and drowsy states, flushing of the skin, dry mouth, heavy extremities, slurred speech, constricted pupils, droopy eyelids, vomiting, constipation</p> <p><i>Health Effects:</i> Collapsed veins, infection of the heart lining and valves, abscesses, cellulitis, liver disease, pneumonia, clogged blood vessels, respiratory complications</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth (Aged 12 to 17)</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>0.1%</p> <p>329,000</p> <p>0.1%</p> <p>5,000</p> <p>25.4 years</p>
MARIJUANA/ HASHISH: BLUNT, DOPE, GANJA, GRASS, HERB, JOINT, BUD, MARY JANE, POT, REEFER, GREEN, TREES, SMOKE, SKUNK, WEED	<p><i>Immediate Effects:</i> Distorted perception, trouble with thinking and problem-solving, loss of motor coordination, increased heart rate</p> <p><i>Health Effects:</i> Respiratory infection, impaired memory, anxiety, exposure to cancer-causing compounds</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth (Aged 12 to 17)</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>8.3%</p> <p>22.2 million</p> <p>7.0%</p> <p>1.8 million</p> <p>19.0 years</p>
METHAMPHETAMINE: CHALK, CRANK, CRYSTAL, ICE, METH	<p><i>Immediate Effects:</i> State of high agitation, insomnia, decreased appetite, irritability, aggression, anxiety, nervousness, convulsions</p> <p><i>Health Effects:</i> Paranoia, hallucination, repetitive behavior, delusions of parasites or insects crawling under the skin, psychosis, severe dental problems, heart attack</p>	<p>Past-month Use: Rate Among People Aged 12 and Older</p> <p>Past-month Use: Number of People Aged 12 and Older</p> <p>Past-month Use: Rate Among Youth Aged 12 to 17</p> <p>Past-month Use: Number of People Aged 12 to 17</p> <p>Average Age of First Use Among People Aged 12 to 49</p>	<p>0.3%</p> <p>897,000</p> <p>0.1%</p> <p>13,000</p> <p>25.8 years</p>

SUBSTANCE: EXAMPLES OF OTHER NAMES FOR SUBSTANCES ^{17,18,19}	NEGATIVE IMMEDIATE INTOXICATION EFFECTS; NEGATIVE HEALTH EFFECTS ^{20,21}	ESTIMATE DESCRIPTION	ESTIMATE ^{22,23}
PRESCRIPTION DRUGS			
PAIN RELIEVERS: VIKE (VICODIN®), OXY, O.C. (OXYCONTIN®), DEMMIES, PERCS, OCTAGONS, SIZZURP, CAPTAIN CODY	<i>Immediate Effects:</i> Pain relief, euphoria, drowsiness, respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, restlessness <i>Health Effects:</i> Muscle and bone pain, drowsiness, seizure, coma, respiratory depression, decreased heart rate	Past-month Use: Rate Among People Aged 12 and Older Past-month Use: Number of People Aged 12 and Older Past-month Use: Rate Among Youth (Aged 12 to 17) Past-month Use: Number of People Aged 12 to 17 Average Age of First Use Among People Aged 12 to 49	1.4% 3.8 million 1.1% 276,000 25.8 years
SEDATIVES: HALDOL®, THORAZINE®, NAVANE®, PROLIXIN®, MELLARIL®, TRILAFON®	<i>Immediate Effects:</i> Slurred speech, shallow breathing, sluggishness, fatigue, disorientation and lack of coordination, dilated pupils, reduced anxiety, lowered inhibitions <i>Health Effects:</i> Seizures; impaired memory, judgment, and coordination; irritability; paranoid and suicidal thoughts; sleep problems	Past-month Use: Rate Among People Aged 12 and Older Past-month Use: Number of People Aged 12 and Older Past-month Use: Rate Among Youth (Aged 12 to 17) Past-month Use: Number of People Aged 12 to 17 Average Age of First Use Among People Aged 12 to 49	0.2% 446,000 0.1% 21,000 28.3 years
STIMULANTS: ADDERALL®, RITALIN®, DESOXYN®, DEXEDRINE®, CONCERTA®	<i>Immediate Effects:</i> Increased blood pressure and heart rate, constricted blood vessels, increased breathing, cardiovascular failure, lethal seizures <i>Health Effects:</i> Increased hostility or paranoia, dangerously high body temperatures, irregular heartbeat, cardiovascular failure, lethal seizures	Past-month Misuse: Rate Among People Aged 12 and Older Past-month Misuse: Number of People Aged 12 and Older Past-month Misuse: Rate Among Youth Aged 12 to 17 Past-month Misuse: Number of People Aged 12 to 17 Average Age of First Misuse Among People Aged 12 to 49	0.6% 1.7 million 0.5% 117,000 22.3 years

SUBSTANCE: EXAMPLES OF OTHER NAMES FOR SUBSTANCES ^{17,18,19}	NEGATIVE IMMEDIATE INTOXICATION EFFECTS; NEGATIVE HEALTH EFFECTS ^{20,21}	ESTIMATE DESCRIPTION	ESTIMATE ^{22,23}
PRESCRIPTION DRUGS			
TRANQUILIZERS: DOWNERS, BENZOS (MEBARAL®, ATIVAN®, XANAX®, VALIUM®, NEMBUTAL®, LIBRIUM®)	<i>Immediate Effects:</i> Slurred speech, shallow breathing, sluggishness, fatigue, disorientation and lack of coordination, dilated pupils, reduced anxiety, lowered inhibitions <i>Health Effects:</i> Seizures; impaired memory, judgment, and coordination; irritability; paranoid and suicidal thoughts; sleep problems	Past-month Use: Rate Among People Aged 12 and Older	0.7%
		Past-month Use: Number of People Aged 12 and Older	1.9 million
		Past-month Use: Rate Among Youth (Aged 12 to 17)	0.7%
		Past-month Use: Number of People Aged 12 to 17	162,000
		Average Age of First Use Among People Aged 12 to 49	25.9 years

The following is not an exhaustive list of all available resources. Inclusion of websites and resources in this document and on the **Recovery Month** website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

[†] Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health, NSDUH Series H-51, HHS Publication No. SMA 16-4984.

¹ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 5.9A*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab5-9a> Web. 23 Sep. 2016.

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³ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.1A and 8.1B*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-1a>

⁴ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

⁵ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.4A and 8.4B*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-4a>

- ⁶ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.23A. Substance Abuse and Mental Health Services Administration, Rockville, MD.* Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-23a>
- ⁷ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.27B. Substance Abuse and Mental Health Services Administration, Rockville, MD.* Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-27b>
- ⁸ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2014). Web-based Injury Statistics Query and Reporting System (WISQARS).
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- ¹⁰ The National Comorbidity Survey Replication (NCS-R). *Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCSR)*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847357/>. Web. 18 Oct. 2016
- ¹¹ The National Comorbidity Survey Replication Adolescent Supplement (NCS-A). *Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement*. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/22474106>. Web. 18 Oct. 2016.
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- ¹⁷ National Institute on Drug Abuse. (n.d.). *NIDA: Commonly Abused Drug Charts*. U.S. Department of Health and Human Services. National Institutes of Health. Retrieved from <https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts>. Web. 23 Sep. 2016.
- ¹⁸ The Partnership at DrugFree.org. (n.d.). Drug guide. Retrieved from <https://www.drugfree.org/drug-guide>. Web. 23 Sep. 2016.
- ¹⁹ National Institute on Drug Abuse. (n.d.). *NIDA: Commonly Abused Drug Charts*. U.S. Department of Health and Human Services. National Institutes of Health. Retrieved from <https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts>. Web. 23 Sep. 2016.
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- ²² Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Substance Abuse and Mental Health Services Administration, Rockville, MD. Web. 23 Sep. 2016.
- ²³ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 21. Web. 23 Sep. 2016

TREATMENT AND RECOVERY SUPPORT SERVICES



TREATMENT AND RECOVERY SUPPORT SERVICES

RECOVERY IS POSSIBLE

Recovery is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.¹ There are numerous treatment and recovery options for mental and substance use disorders and each recovery journey is unique. If you, a family member, or a friend needs help, resources are available. You are not alone.

Each September, the Substance Abuse and Mental Health Services Administration (SAMHSA) (<https://samhsa.gov>), within the U.S. Department of Health and Human Services (HHS) (<https://hhs.gov/>), sponsors **National Recovery Month (Recovery Month)** (<https://recoverymonth.gov>) to increase awareness of behavioral health conditions. This observance promotes the knowledge that behavioral health is essential to overall health, prevention works, treatment is effective, and people can, and do, recover from mental and substance use disorders.

The 2017 theme, “*Join the Voices for Recovery: Strengthen Families and Communities,*” encourages communities to be socially inclusive, offering support to those with mental and/or substance use disorders, as well as the chance to seek help, lend a hand, and contribute to their community as citizens, parents, employees, students, volunteers, and leaders. This year’s **Recovery Month** theme focuses on rural and frontier communities, the criminal justice system, community and faith-based organizations, and public health professionals and departments, highlighting the various entities that support recovery within our society.

CONNECTING THOSE IN NEED TO TREATMENT SERVICES

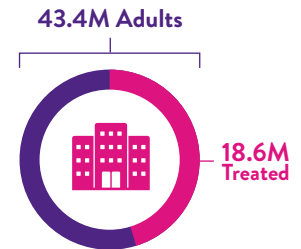
SAMHSA’s 2015 National Survey on Drug Use and Health showed:

- About 1 in 12 people (7.8 percent) needed treatment for a substance use disorder (SUD) in the past year.¹
- An estimated 43.4 million adults aged 18 or older had any mental illness (AMI) in the United States, representing 17.9 percent of all adults in the United States.²
- More than half of the adults with co-occurring AMI and an SUD in the past year did not receive either type of service.³

A person with a mental and/or substance use disorder may find it difficult to initiate getting help alone, but families and support networks can help make the connection to appropriate resources. Seeking help may improve the chances of managing a behavioral health condition and reduce or eliminate associated symptoms.

For example:

- Treatment for depression improves not only psychiatric symptoms, but also a person’s quality of life.⁴
- Treatment for substance use disorders can help people stop substance use, avoid relapse, and lead active lives engaged with their families, workplaces, and communities.⁵
- Treating alcohol dependence and addiction reduces the burden on the family budget and improves life for those who live with the alcohol-dependent individual.⁶



Mental Illness Treatment Gap

Among adults aged 18 or older, **43.4 Million** adults had any mental illness in the past year. **18.6 Million (43%)** received mental health services.[†]

In fact, many individuals who have a mental health condition have already begun the process of recovery through treatment services:

- Of people aged 18 or older who needed substance use treatment, 11.1 percent or 2.3 million received treatment in the past year.⁷
- Among the 43.4 million adults with AMI, 18.6 million (43.1 percent) received mental health services in the past year.⁸
- An estimated 6.8 percent of adults with co-occurring disorders received both mental health care and specialty substance use treatment in the past year.⁹

TREATMENT AND RECOVERY SUPPORT SERVICES

When mental and substance use disorders go unaddressed, they become more complex and more difficult to treat. Intervening early, before behavioral health conditions progress, is among the best and most cost-effective ways to improve overall health. Most communities have trained professionals who can help individuals with behavioral health conditions. Treatment can be provided in different settings—including outpatient, residential, and inpatient—based on the disorder and the intensity of care required. Examples of proven and effective treatments include behavioral therapy, medication-assisted therapy (MAT), and recovery support services. Effective treatment methods are directed at all aspects of the illness (for example, biological, psychological, and social). For more information about various types of treatment and the benefits of each, visit SAMHSA's Behavioral Health Treatments and Services webpage at <https://samhsa.gov/treatment> and the Recovery and Recovery Support webpage at <https://samhsa.gov/recovery>.

The “Resources” section of this document provides a list of national and local resources, including toll-free numbers that can connect you to prevention, treatment, and recovery support services.

RESOURCES

Many options are available to help people seek treatment and sustain recovery. Whichever path a person chooses, it is important to find the treatment and recovery support that works best for him or her. A variety of organizations that provide information and resources on mental and substance use disorders, as well as prevention, treatment, and recovery support services, are described below. The list includes toll-free numbers and websites where people can find help, obtain information, share experiences, and learn from others. It also includes mobile applications that support treatment and recovery.

HOTLINES & HELPLINES

- **SAMHSA's National Helpline, 1-800-662-HELP (4357) or 1-800-487-4889 (TDD)** (<https://samhsa.gov/find-help/national-helpline>): Provides 24-hour, free, and confidential treatment referral and information in English and Spanish on mental and substance use disorders, prevention, treatment, and recovery.
- **SAMHSA's National Suicide Prevention Lifeline, 1-800-273-TALK (8255)** (<https://www.suicidepreventionlifeline.org/>): Provides a free, 24-hour helpline available to anyone in suicidal crisis or emotional distress.
- **Crisis Text Line** (<https://www.crisistextline.org/>): Provides 24/7 support for individuals experiencing a crisis via text message.
- **Loveisrespect.org** (formerly National Dating Abuse Helpline) (<http://www.loveisrespect.org/>): Provides an opportunity for teens and young adults to receive support when dealing with an unhealthy or abusive relationship. The site offers online chats, telephone support, and texting with a peer advocate.
- **National Sexual Assault Hotline** (<https://www.rainn.org/>): Connects callers to a local sexual assault crisis center so they can receive information and support.

ONLINE RESOURCES

- **SAMHSA's website** (<https://samhsa.gov>): Provides numerous resources and helpful information related to mental and substance use disorders, prevention, treatment, and recovery.
- **SAMHSA's Behavioral Health Treatments and Services webpage** (<https://samhsa.gov/treatment>): Contains information on common mental and substance use disorders and explains how SAMHSA helps people access treatments and services.
- **SAMHSA's Recovery and Recovery Support webpage** (<https://samhsa.gov/recovery>): Provides information on how recovery-oriented care and recovery support systems help people with mental and/or substance use disorders manage their conditions.
- **SAMHSA's Find Help webpage** (<https://samhsa.gov/find-help>): Provides links and phone numbers to locators of mental and substance use disorder treatment and recovery services.

- **SAMHSA's Opioid Overdose Prevention Toolkit** (<https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742>): Helps communities and local governments develop policies and practices to prevent opioid-related overdoses and deaths. The toolkit addresses issues of interest to first responders, treatment and service providers, and those recovering from an opioid overdose.
- **SAMHSA's Addiction Technology Transfer Center Network** (<http://www.nattc.org/home/>): Provides research and information for professionals in the addictions treatment and recovery services field.
- **National Institute on Drug Abuse's (NIDA's) What to Do If Your Adult Friend or Loved One Has a Problem with Drugs** (<http://www.drugabuse.gov/related-topics/treatment/what-to-do-if-your-adult-friend-or-loved-one-has-problem-drugs>): Includes a list of the warning signs of drug misuse as well as resources and information to help someone who might have a drug use problem.
- **NIDA's What to Do If Your Teen or Young Adult Has a Problem with Drugs** (<http://www.drugabuse.gov/related-topics/treatment/what-to-do-if-your-teen-or-young-adult-has-problem-drugs>): Provides parents of teens/young adults with information on how to identify and handle possible drug misuse situations.
- **Alcoholics Anonymous** (<http://www.aa.org/>) and **Narcotics Anonymous** (<https://www.na.org/>): Lists resources for those experiencing alcohol or drug dependence; helps individuals find and join a local chapter.
- **Al-Anon/Alateen Family Groups** (<http://www.al-anon.alateen.org/>): Provides support groups for families and friends of people with alcohol problems.
- **Faces & Voices of Recovery** (<http://www.facesandvoicesofrecovery.org/>): Organizes and mobilizes Americans in recovery from addiction to alcohol and other drugs by geographic region so they can promote their rights and obtain the resources they need.
- **Mental Health America (MHA)** (<https://www.mentalhealthamerica.net/>): Offers resources about mental illness. Through its affiliates, MHA provides America's communities and consumers with direct access to a broad range of self-help and professional services.
- **National Council on Alcoholism and Drug Dependence, Inc.** (<https://ncadd.org/>): Provides numerous resources and services dedicated to fighting alcoholism and drug addiction.
- **Patient and Family Opiate Treatment Guide** (<https://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece>): Offers facts about treatment related to opiates and provides resources for responding to an opioid overdose.
- **Psychology Today's Therapy Directory** (<https://therapists.psychologytoday.com/rms>): Allows users to locate, by city or ZIP Code, a therapist, psychologist, or counselor who specializes in mental illness.
- **SMART Recovery®** (<http://smartrecovery.org>): Offers a self-empowering addiction recovery support group network with face-to-face and daily online meetings.
- **Young People in Recovery** (<http://youngpeopleinrecovery.org/>): Mobilizes the voices of young people in recovery.
- **Secular Organizations for Sobriety (SOS)** (<https://www.sossobriety.org/>): Offers resources to help individuals achieve and maintain sobriety and abstinence from alcohol and drug addiction.
- **Life Ring** (<https://lifering.org>): Offers peer-to-peer support and personal strategies to fight addiction to alcohol and drugs.
- **Association of Recovery High Schools** (<https://recoveryhighschools.org/?reqp=1&reqr>): Connects recovery high schools with training, expertise, resources, and best practices to assist every student who is in recovery.
- **Celebrate Recovery** (<https://www.celebraterecovery.com/>): Provides support for those in recovery through summits, groups, and church-centered meetings.
- **Phoenix Multisport** (<https://phoenixmultisport.org/>): Fosters a supportive, physically active community for individuals who are recovering from a substance use disorder.
- **Association of Recovery in Higher Education** (<https://collegiaterecovery.org/>): Provides the education, resources, and community connection needed to help recovering students in higher education.
- **Wellbriety Movement** (<https://wellbriety.com/>): Provides an interconnected online resource across Native Nations about recovery for individuals, families, and communities.

SAMHSA MOBILE APPLICATIONS*

- **Suicide Safe:** Helps providers integrate suicide prevention strategies into their practice, address suicide risk among their patients, and make referrals to treatment and community resources.
- **SAMHSA Disaster App:** Provides responders with access to critical resources, including the Behavioral Health Treatment Services Locator to identify substance use and mental health treatment facility locations.
- **MATx (medication-assisted treatment):** Offers health care practitioners support with medication-assisted treatment for opioid use disorder.
- **KnowBullying:** Provides parents and caregivers with information and guidance on ways to prevent bullying and build resilience in children.
- **Talk. They Hear You.:** Helps parents and caregivers talk to kids about the dangers of underage drinking.

ADDITIONAL MOBILE APPLICATIONS*

- **The Addiction Recovery Guide's Mobile App Listing:** Provides descriptions and links to other apps that support recovery, including self-evaluation, recovery programs, online treatment, and chat rooms. The guide is available at http://www.addictionrecoveryguide.org/resources/mobile_apps.
- **Breathe2Relax:** Walks the user through breathing exercises to lessen anxiety, anger, and heighten mood.
- **Dialectical Behavior Therapy Diary Card and Skills Coach:** Provides users with self-help skills, reminders of therapy principles, and coaching tools for coping.
- **Operation Reach Out:** Provides resources for those experiencing suicidal ideation. It is primarily intended for military members, veterans, and their families. It may be helpful to other communities as well.
- **Optimism:** Allows users to detect patterns in mood, identify triggers, and create an individualized wellness plan to help manage their mental health.
- **PTSD Coach:** Provides useful resources for those suffering from PTSD or PTSD symptoms. The app offers education about the signs and symptoms of PTSD, self-care, and how to find support and emergency access to a suicide hotline or to personal contacts. It also offers relaxation skills, positive self-talk, anger management, and other coping skills for symptoms of PTSD. This app was developed by the Department of Veterans Affairs' National Center for PTSD.

- **Reachout:** Provides social support for people with various health conditions, including mental illness and substance use disorders. Users can share their stories, read others' stories, and interact with one another.
- **ReliefLink:** Facilitates the coordination of follow-up care. It includes features such as a mood tracker, a personalized safety plan, coping strategies, and an emergency button that connects users to friends, hospitals, and other resources.
- **Rise Up + Recover:** Allows users to log meals, snacks, and emotions. This app is based on Cognitive Behavioral Therapy (CBT) approaches and provides a treatment directory for users.
- **SAM Self-Help for Anxiety Management:** Encourages users to record their anxiety levels and identify triggers. It includes over 20 self-help options for users to deal with the physical, emotional, and mental symptoms of anxiety.
- **Twelve Steps – The Companion:** Provides resources, information, and stories to help users through the 12 steps of Alcoholics Anonymous.

This is not an exhaustive list of all available resources.

Inclusion of websites, mobile applications, and resources in this document and on the *Recovery Month* website does not constitute official endorsement by the U.S. Department of Health and Human Services or the Substance Abuse and Mental Health Services Administration.

*Mobile applications can be found by searching for the name in Apple or Android app stores online.

[†] Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health, NSDUH Series H-51, HHS Publication No. SMA 16-4984.

¹ The Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. N.p.: Substance Abuse and Mental Health Services Administration, n.d. SAMHSA Store. SAMHSA, Feb. 2012. Web. 22 Feb. 2017.

² Gelenberg AJ, et al. (2006). The State of Knowledge of Chronic Depression. *Primary Care Companion to Journal of Clinical Psychiatry*, 8;2, 60–65.

³ National Institute on Drug Abuse. (2009). DrugFacts: Treatment Approaches for Drug Addiction. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

⁴ Salize, H. J, Jacke, C., Kief, S., Franz, M., & Mann, K. (2013). Treating alcoholism reduces financial burden on caregivers and increases quality-adjusted life years. *Addiction*, 108, 62–70.

⁵ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 5.2B*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab5-2b>

⁶ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 29.

⁷ Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 33.

⁸ Center for Behavioral Health Statistics and Quality. (2016). *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables: Table 8.1A*. Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved from: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab8-1a>

Contra Costa Behavioral Health Stakeholder Calendar

September 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4  Labor Day	5	6	7 CPAW: 2-5pm 2425 Bisso Ln Concord	8	9
10	11	12	13 Systems of Care: 10am—12 pm 1340 Arnold Dr, Ste 200, Martinez	14 Children's: 11:00-1:00pm, 1340 Arnold Dr, Ste 200, Martinez Social Inclusion: 1-3 pm 2425 Bisso Ln, Concord	15	16 MH Commission: 9:00—3:00 pm 1875 Arnold Way Martinez
17	18 CPAW Membership: 3:00 - 4:30 pm 1340 Arnold Dr, Ste 200, Martinez	19	20	21 CPAW Steering: 3:00 - 4:30 pm 1340 Arnold Dr, Ste 200, Martinez	22	23
24	25 CPAW Innovation: 2:30 - 4:30pm 1340 Arnold Dr, Ste 200, Martinez	26 Adult: 3:00 - 4:30pm 1340 Arnold Dr, Ste 200, Martinez	27 Aging and Older Adult: 2:00 - 3:30 pm 2425 Bisso Ln, Concord AOD Advisory Board : 4 – 6:15pm, 2nd Floor, 1220 Morello, MTZ	28	29	30