SACRAMENTO COUNTY: DATA NOTEBOOK 2015

FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS

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

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FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS

County Population (2014): 1,460,480

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

http://www.dhhs.saccounty.net/BHS/Pages/BHS-Home.aspx

Website for Local County MH Data and Reports:

http://www.dhhs.saccounty.net/BHS/Pages/BHS-Home.aspx

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

http://www.dhhs.saccounty.net/BHS/Pages/Advisory-Boards-Committees/Mental-Health-Board/BC-Mental-Health-Board.aspx

Specialty MH Data[1] from 2013: See Archives folder at http://www.caleqro.com

Total number of persons receiving Medi-Cal in your county (2013): 437,842

Average number Medi-Cal eligible persons per month: 361,646

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 47.9 %

Adults, 18 and over: 52.1 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2013): 19,746

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 46.1 %

Adults, 18 and over: 53.9 %

[1] Downloaded July 2014 from the former APS Healthcare website, www.caeqro.com.
[2] Serious Mental Illness, term used for adults 18 and older.
[3] Severe Emotional Disorder, term used for children 17 and under.

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Introduction: Purpose, Mandates, and Data Resources

What is the "Data Notebook?"

It is a structured format for reviewing information and reporting on the mental health services in each county. For some questions, the Data Notebook supplies data for each county from public resources (e.g., mental health (MH) data from the External Quality Review Organization[4] and substance use disorders treatment reports). For other questions, we request that local mental health boards obtain information from their county behavioral health department because there is no public source.

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates[5] to review the local county mental health services and report on performance every year
- function as an educational resource about mental health data for local boards
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

Every year, the mental health boards and commissions are required to review data about the services for mental health in their county. The local boards are required to report their findings to the CMHPC every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information. The Data Notebook is organized to provide data and solicit responses from the mental health board regarding specific topics so that the information can be readily analyzed and reported by the CMHPC each year. These data are compiled in a report to inform policy makers, stakeholders and the general public.

The CMHPC serves under the umbrella of the Department of Health Care Services (DHCS) and must fulfill certain legal mandates to report on the public mental health system every year. We analyzed all Data Notebooks received in 2014 from the mental health boards and commissions; information which represented 41 counties that comprised a geographic area containing 83% of this state's population.[7] Our analyses produced the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Documents/CMHPCCSIDataNBReport2015.pdf

[4] See www.CALEQRO.com for county level data. Select the Archives folder containing reports for each county MH Plan, or check "New Reports" as available for the most recent year data.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W.I.C. 5772 (c), requires annual reports from the California Mental Health Planning Council.
[7] An additional six counties submitted their documents after our report was completed, for a total participation of 47 counties in partnership with their local advisory boards.

Other recent reports from various committees of the CMHPC can be found at: http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function.

Data Resources for the Data Notebook

Selected questions request input from members of the local boards. Your experience and perspectives are valuable, and that is one reason these boards exist. Most important, stakeholder input is taken into account by legislators and agency policy makers when they design and implement programs.

Some information is available from your local Department of Behavioral Health. Besides your county's Director of Behavioral Health or the staff for MH board liaison, other key contacts may include the Administrator for Alcohol and other Drug Programs, your Quality Improvement Coordinator or the MHSA Coordinator. For your questions about healthcare disparities and related outreach efforts, you may wish to contact the county's Cultural Competence Coordinator or the related committee.

Data about local specialty MH services may be found in reports from the external quality review organization (EQRO) (www.CALEQRO.com). Check the "Archives" file for "Reports." Select the most recent "EQRO MHP Report" for your county. For detailed numbers, see "Appendix D" in the report. For an estimate of the percent of clients with serious mental illness (SMI) who also have substance use disorders (SUD), consult the section titled "Information Systems Review."

Finally, we are very excited about a new data resource for your reports. We have arranged with DHCS to obtain substance use disorders treatment data to share with you. These data are made available for publication by the CalOMS-Tx[8] group at the Office of Applied Research and Analysis after review by the office charged with protecting patient privacy and HIPAA compliance.

We have customized each report by placing the data for your county within the substance use disorders section, followed by discussion questions on this topic. We also provide statewide reference data so that you can compare it to the information for your own community.

[8] CalOMS-Tx herein refers to both the "outcomes management system" for data about substance use treatment (Tx), and to the DHCS unit that performs the data collection, analyses, and reporting.

Instructions for Completing the Data Notebook 2015

Most county Departments of Mental Health are now Departments of Behavioral Health. Many local advisory boards have re-named themselves in terms of behavioral health, not just mental health boards or commissions. Some define their mission in more specific terms, as "Mental Health and Drug and Alcohol Boards." However, not all groups are ready to make such changes at this time.

Additionally, in terms of resources, some counties have inpatient facilities and/or crisis response teams to meet the needs of individuals experiencing a mental health crisis. Some counties have just one such resource available and some counties have none.

In respect of all these differences, we are presenting topics covering two critical issues for review by the local advisory boards in this year's Data Notebook. Please review the data we provide within the report. Of course, you are welcome to consult other resources for further background if you so choose.

Please discuss and answer the questions for these topics:

A. Strategies to Meet the Needs of Persons Experiencing Mental Health Crises: Treatment Options and Alternatives to Locked (Involuntary) Facilities

B. Integrated Care: Treating Individuals with both MH and SU Disorders

Please submit your completed Data Notebook report to the CMHPC at:

DataNotebook@CMHPC.ca.gov

For more information, please call (916) 449-5249, or email the address above.

Thank you for participating in our project.

Strategies to Meet Needs of Persons Experiencing a Mental Health Crisis

Treatment Options and Alternatives to Locked (Involuntary) Facilities

While every effort is made to notify Californians of the availability of services and to encourage individuals to seek services early, sometimes a crisis occurs and immediate intervention is needed. In a worst case scenario, law enforcement is called to respond but in a better case scenario, a multi-disciplinary team that includes a mental health professional and a peer will meet with the individual in crisis. The toll and costs of hospitalizations and incarceration of individuals experiencing a mental health crisis are high on both the individual and public system. Many counties have implemented diversionary programs to help persons in crisis manage the situation, de-escalate their symptoms and recover without having to enter an institution.

We are seeking to identify the resources and options that are available to promote the least restrictive environment that will help individuals experiencing a MH crisis to stabilize and move toward recovery. Our goal is to highlight effective programs that meet this essential need on the continuum of services. Effective programs are an excellent way to reduce stigma, and to reduce costs allowing those savings to be used in other areas of the service system. By sharing information about programs with a substantial track record, we wish to promote programs of quality, excellence and safety.

Continuum of Care for SMI in your Community

1. Do you have these types of facilities <u>in</u> your county? Please check all that apply. Please mark 'Other' (and describe) if your county contracts for beds <u>outside</u> of your county.

XX IMDs (Institutions for Mental Diseases, used often for placement of MH clients who are under conservatorship and others)

XX PHFs (Psychiatric Health Facilities)

XX SNF with PTP (Skilled Nursing Facility with Psychiatric Treatment Program)

___ State Hospital beds

XX Psychiatric hospital beds

___ None of the above

XX Other, please describe:

Contracted State Hospital Beds (out of county), Mental Health Rehabilitation Center (MHRC)(in county)

2. If you do not have any of the above facilities in your county and you have a need that goes beyond crisis intervention, how do you handle a need for a longer term hospitalization (14-90 days)? Not applicable

___ Transport to out-of-county psychiatric care facility

___ Crisis intervention services

___ Licensed adult residential facility (board and care home) that receive extra funding from the county (or placing agency) for additional MH-related services

___Other, please describe_____

3. What alternatives to a locked facility do you have for those experiencing an immediate MH crisis? Please check all that apply.

XX Crisis Stabilization Service (23 hours)

XX Crisis Residential

XX Mobile Crisis Intervention Teams

___ Transport to another county for treatment

___ Transport to another state for treatment

___ Assisted Outpatient Treatment (AOT) teams (Laura's Law type programs)

___ Licensed adult residential facility (board and care home) that receives extra funding from the county (or placing agency) for additional MH-related services

___Other, please list or describe _____

4. Does your county have a MH court, jail diversion program, or similar mechanism to help individuals whose MH crisis or illness contributed to their involvement with the criminal justice system? Please check all that apply.

XX MH court

XX Drug Court (some counties have combined into “problem-solving courts”)

XX Jail diversion program (a court-ordered MH program where client avoids jail)

XX Re-entry programs with MH/BH services to assist persons released into the community after leaving a correctional facility (e.g. programs funded by AB 109, Proposition 47, or related services)

XX Other, please describe

Co-Occurring Court, Commercially Sexually Exploited Children (CSEC) Court

___ None of the above

5. Creative Solutions. Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?

XX Yes ___No

___If yes, please list and describe

Community Support Team (CST): The Community Support Team consists of Peer/Family Support Specialists and Sacramento County Mental Health Counselors who provide a mobile response to community members experiencing a crisis. Its goal is to ameliorate the crisis and the potential need for emergency psychiatric or acute care services. The team assists post discharge from acute care services such as the Mental Health Treatment Center, or with contacts such as law enforcement and emergency rooms. The team ensures there is appropriate follow-up care, including any necessary safety plans, and provides support and education to individuals and family members to help prevent a relapse back into crisis.

Regional Support Teams (RST) Community Care Teams: As a result of the Mental Health Services Act, Community Supports and Services exansion community planning process, each of the four RSTs will implement a Community Care Team. The teams’ purpose will be enhancing engagement and timely access to services at the RSTs using culturally and linguistically competent services. These teams will deliver flexible, recovery-based individualized services, allowing for seamless transitions throughout the continuum of outpatient services and supports available in Sacramento County. Staffing for each team will include a team lead, clinician/social worker, psychiatrist and nurse, peer/family provider, resource specialist. It is anticipated that this new team will begin providing services late summer of 2015.

6. <u>Prevention</u>. Does your county have any programs implemented specifically as alternatives to locked facilities that haven't been addressed above? This is an open question that could include MHSA-funded prevention programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). This question could also be addressed by other strategies that engage public (county) and private partnerships, regardless of funding sources.

<u>Early Diagnosis and Preventative Treatment</u> (<u>SacEDAPT</u>) SacEDAPT is administered by the U.C. Davis Department of Psychiatry and focuses on early onset of psychosis for those aged 12 to 26. It is a nationally recognized treatment program utilizing an interdisciplinary team of physicians, clinicians, support staff, consumers and family advocates to provide assessment, early identification and treatment of the onset of psychosis. The program continues to engage in outreach services throughout Sacramento County with a particular focus on underserved populations.

<u>Respite Partnership Collaborative (RPC):</u> The RPC is a DBHS Innovation Project spanning from 2011 to 2016. The RPC was designed to be a community-driven collaborative comprised of community partners committed to developing, providing and supporting a continuum of respite services and supports designed to reduce mental health crisis in Sacramento County. The RPC has awarded 11 grants for mental health respite services. Below are the 11 providers/programs and a brief description of their respite model.

- *<u>Capital Adoptive Families Alliance (CAFA):</u>* Works to improve family stability by providing family respite camp for adoptive parents and their emotionally disturbed children, expanding peer support and developing children's social skills.
- *<u>Del Oro Caregiver Resource Center</u>*: Helps decrease hospitalizations due to mental health crisis in family caregivers of dementia patients, primarily by providing respite care and respite counseling, and helping caregivers develop skills and a care plan to stabilize their situation.
- *<u>Turning Point Community Programs Abiding Hope Respite House:</u>* Helps decrease hospitalizations due to mental health crisis by providing residential and peer-directed respite services at *Abiding Hope Respite House,* a home-like environment for adults age 18 and older.
- *<u>Iu-Mien Community Services:</u>* Works to reduce mental health crisis in the Iu-Mien community by raising awareness of mental health issues through intergenerational respite support that is culturally and linguistically appropriate. Respite services support youth through older adults, with a crisis hotline as part of the services.
- *<u>Saint John's Program for Real Change:</u>* Works to de-escalate a mental health crisis for adult women by providing short-term respite and on-site support services and linkages to community services on site at the shelter.

- *TLCS, Inc. Crisis Respite Center:* Promotes stabilization for adults experiencing a mental health crisis by providing 24-hour/7 day-a-week mental health crisis respite services that can be accessed on a drop-in basis in a warm and supportive community-based setting.
- *Sacramento LGBT Community Center:* Will work to de-escalate mental health crisis for lesbian, gay, bisexual, transgender, queer, questioning and allied youth by providing short-term respite and drop-in support groups in a safe place.
- *Wind Youth Services*: Will work to reduce mental health crisis for youth between the ages of 13 to 25 who are homeless or at risk of being homeless by providing linkages to community services and peer-directed respite.
- *A Church For All*: Will work to de-escalate mental health crisis for adults by offering short-term peer-run drop in respite services in a safe space.
- *Gender Health Center*: Will work to promote stabilization for adults in crisis through neighborhood based drop-in respite services and supportive activities.
- *Sacramento LGBT Community Center*: Will work to promote stabilization for adults age 25 and older.

Triage/Peer Navigators: This program is funded through the SB 82 grant and will serve individuals from all age groups experiencing a mental health crisis. The program will provide triage, recovery-focused crisis intervention, peer support, system navigation services, and linkages to community services and supports. The Triage/Peer Navigators will ensure there is appropriate follow-up care, including any necessary safety plans and will provide support and education to individuals and family members to help prevent a relapse back into crisis. Triage/Peer Navigators will provide services at key access points such as the county's Crisis Stabilization Unit, the main jail, the Loaves & Fishes campus, and local emergency rooms.

Community Alternatives for Recovery and Engagement Plus (CARE+) :
CARE+ is an innovative program that joins intensive outpatient mental health services with case managed conservatorship. This program unifies the programmatic strengths offered by intensive case management and conservatorship to help clients live as independently as possible within our community. It was designed to support clients on their path to recovery and do whatever it takes to help them succeed in this process.

7. Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

Crisis Services. The community planning processes undertaken by DBHS have highlighted crisis services as an unmet need. The unmet need for crisis services increases hospitalization rates and emergency room usage. These services are

generally the most expensive available in Sacramento County and often inappropriate for persons experiencing a mental health crisis. DBHS planning efforts specifically show crisis respite as well as crisis residential facilities for youth under 18 years of age as a particularly acute need in our community.

Exploited Children. DBHS community planning efforts also highlight the identification and treatment of commercially sexually exploited children as another unmet need in our community. DBHS participates in ongoing collaborative initiatives with child protective services, the courts, and the probation department to address this unmet need.

8. If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

The Sacramento County Mental Health Board, in an August 5, 2015, public meeting, decided that its top three priorities as asked above would be the following:

- Reopening the Crisis Stabilization Unit to direct access, as operated by Sacramento County prior to 2009. The Mental Health Board previously stated this priority in a March 13, 2015, letter to the Sacramento County Board of Supervisors.

- Additional crisis residential beds. The Mental Health Board previously stated this priority in a March 13, 2015, letter to the Sacramento County Board of Supervisors.

- Establishment of a mental health “urgent care” center. In stating this priority, the Mental Health Board echoes the sentiment of a March 24, 2015, letter by the Mental Health Improvement Coalition. This letter reports that the opening of a behavioral health urgent care center is an “area of agreement” in the ongoing effort to rebalance the Sacramento County behavioral health continuum.

Integrated Care: Treating Individuals with both MH and SU Disorders[9]

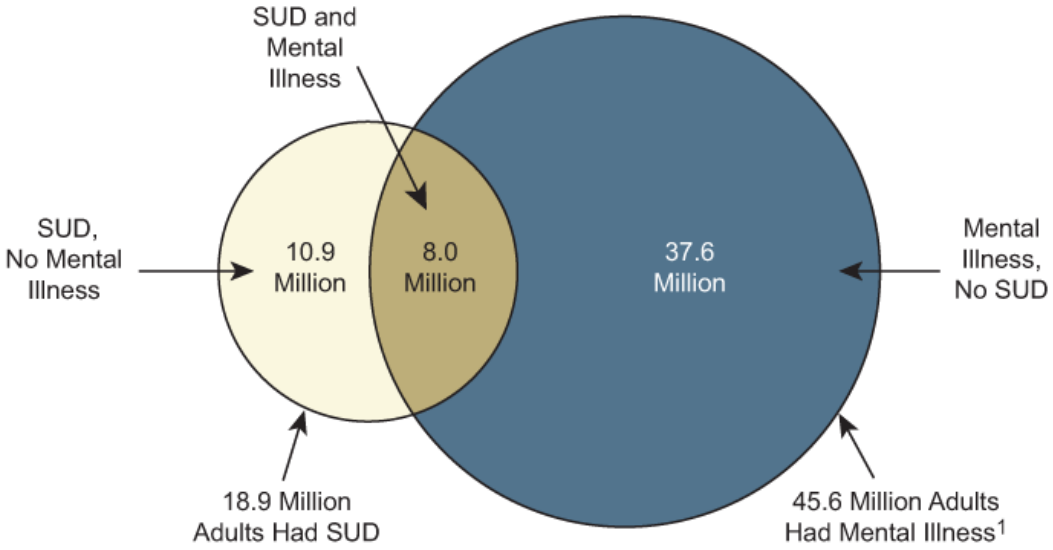
Understanding the Scope of the Problem using National Statistics

We show examples of national data from the NSDUH[10] survey to give perspective on the data for our local communities and state. Many experts believe these data are an under-estimate of the true scope of the problem. All figures in this introduction are from this NSDUH survey report. We ask: how many people are affected by these disorders?

The report describes adults who had any mental illness, or a substance use disorder, or both problems in 2011, the most recent year for which there is national data.

- A total of 45.6 million adults had a mental illness. Of that group, 8 million (17.6 percent of total) also had a substance use disorder.
- Among the 18.9 million adults with substance use disorder, 8.0 million (42.3 percent) also had a mental illness.

Past Year Substance Dependence or Abuse and Mental Illness among Adults Aged 18 or Older: 2011



[9] SU = substance use. SUD= Substance use disorders, referring to problems with abusing drugs, alcohol, or both. Drugs refer to both illegal substances and prescription drugs used for purposes other than those legally prescribed or intended. See www.drugabuse.gov for more information.

[10] **NSDUH**: The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. population. See more information at: http://archive.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.htm

The problem is even more serious as we consider the risks for those with severe mental illness (SMI), a subset of those with "any" MH disorder shown above.

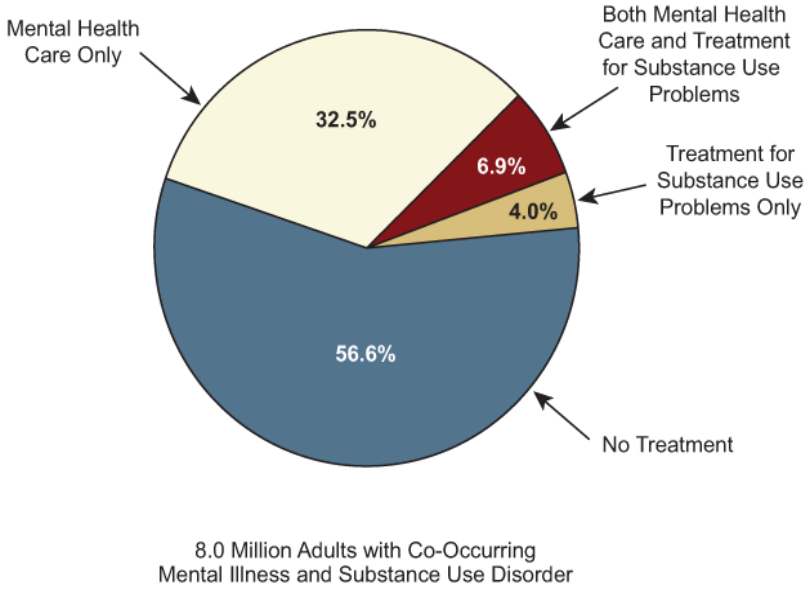
Who received treatment, and what kind? In the co-occurring disorder population, we would expect better recovery outcomes for those who receive treatment for both disorders. However, such integrated treatment may be difficult to access.

For the 8.0 million adults with co-occurring disorders, how many received treatment in the last year for MH disorders, SUD, both, or neither? Data from the NSDUH show that:

- 43.4 percent received some kind of treatment for either SUD or mental illness during the past year, however:
  - 32.5 percent received MH care only,
  - 4.0 percent received SUD treatment only, and
  - just 6.9 percent received treatment for both disorders.

- But more than half -- 56.6 percent received no treatment at all for either disorder.

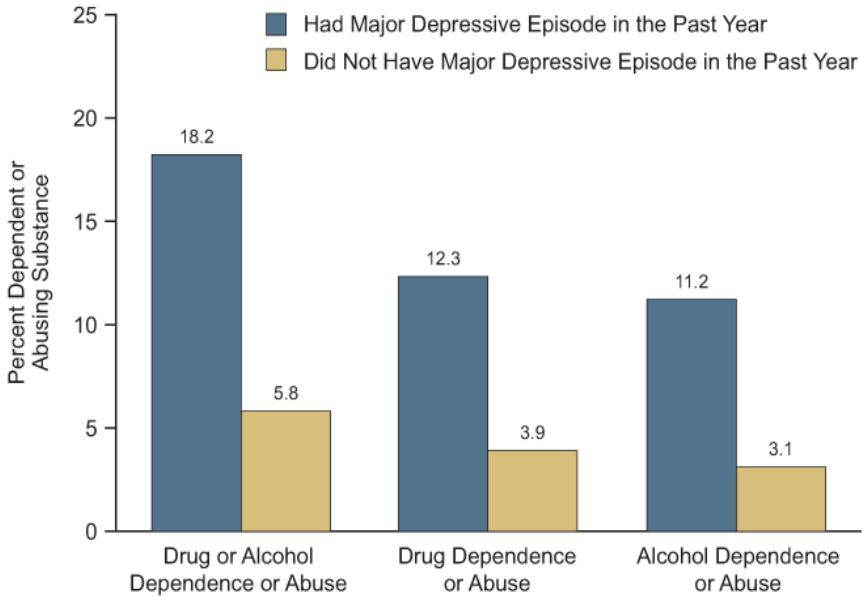
Figure 4.12 Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older with Both Mental Illness and a Substance Use Disorder: 2011



Note: Mental health care is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Treatment for substance use problems refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Children and youth under 18 are also affected. Those who had a major depressive episode were three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who did not have depression. Such episodes may be an early indicator of risk for more severe emotional disorders.

Figure 4.15 Past Year Substance Dependence or Abuse among Youths Aged 12 to 17, by Major Depressive Episode in the Past Year: 2011



The NSDUH report also found that youth with a major depressive episode had an increased risk for use of any type of illicit drug. A related but very serious concern is the increased risk for abuse of prescription drugs (when taken for non-prescribed uses).

Data: Understanding who Receives SUD Treatment in your County

The next two pages will show some county-level information supplied by the data specialists of CalOMS-Tx in the Office of Applied Research and Analysis at DHCS. Before release to us, these data were reviewed by the DHCS offices charged with protecting patient privacy and HIPAA compliance. These data are from Fiscal Year 2013-2014.

Some data cells may not have any numbers, but instead are marked by an asterisk, "*****" which means that the numbers have been redacted (hidden) to protect patient privacy because the total number is too small. Counties with small populations may see many such asterisks, with the result that only limited data can be seen for those counties.

Access: Who Receives Services? The first part will present data for the demographics of those admitted for SUD treatment and the type of services. Demographics include age, gender, major race/ethnicity groups, and county. Service types in this dataset are outpatient, detox, or residential.

What are the Client Outcomes? The second part contains data regarding client outcomes. Discharge outcomes after thirty days include:

- return to substance use
- arrests
- employment
- housing situation (homeless vs. stable housing of any type)
- social supports within the last 30 days (includes 12-step programs as well as general social support activities, more than 4 or fewer than 4).

You will see that there is a certain percentage of data assigned as "missing." These are not redacted (hidden) numbers. "Missing data" indicates the numbers of clients for which no further data could be obtained by the treatment program. Some clients are no longer reachable by program staff or are otherwise lost to follow-up.

Finally, please examine the California State Data reference pages at the end of this document. We live in a highly diverse state and so your county data may or may not resemble the statewide data. However, these data are worth review and discussion as you consider advocacy and policies regarding demographic disparities in service access and unmet needs.

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

County: SACRAMENTO

Service Type:

Outpatient	DETOX	Residential	Total
3,788	389	888	5,065
74.79%	7.68%	17.53%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
818	902	1,512	1,833	5,065
16.15%	17.81%	29.85%	36.19%	100%

Gender:

Male	Female	Total
2,867	2,198	5,065
56.6%	43.4%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
64	147	1,000	1,176	256	2,422	5,065
1.26%	2.9%	19.74%	23.22%	5.05%	47.82%	100%

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge

Discharges in FY 2013-2014

County: SACRAMENTO

Substance Use:

None	Use Data Missing	Use Documented	Total
807	1,586	208	2,601
31%	61%	8%	100%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
16	1,586	999	2,601
1%	61%	38%	100%

Employment:

Employed	Data Missing	None	Total
242	1,586	773	2,601
9%	61%	30%	100%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
133	1,586	882	2,601
5%	61%	34%	100%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
588	427	1,586	2,601
23%	16%	61%	100%

The Impact of Substance Abuse on the MH System of Care in your County

9. This next question may help define the nature and scope of the substance use problem in your community. Resources for such information may include the Alcohol and Other Drug Administrator for your county, your county Sheriff's Department, or the Behavioral Health Director.

What substances are the most commonly abused in your county? Please select the top three drug categories below (and indicate estimated percentage if known).

23% Alcohol
__ Marijuana, hashish or synthetic marijuana-like drugs (e.g. 'spice', 'bath salts')
41% Amphetamines, methamphetamine, prescription stimulants (ADHD drugs)
___ Cocaine, 'crack' cocaine
20% Opioids (heroin, opium, prescription opioid pain relievers)
___ Club Drugs (MDMA/Ecstasy, Rohypnol/flunitrazepam, GHB)
___ CNS depressants (prescription tranquilizers and muscle relaxants)
___ Hallucinogens (LSD, Mescaline/peyote/cactus, Psilocybin/mushrooms)
___ Dissociative Drugs (Ketamine, PCP/phencyclidine/angel dust, Salvia plant species, dextromethorphan cough syrup)
___ Inhalants (solvents, glues, gases, nitrites/laughing gas)

10. With respect to SUD treatment in your county, what are the main barriers to access and engagement with treatment?

XX Transportation

XX Wait list to enter treatment

XX Language and/or cultural issues

XX Client not ready to commit fully to stopping use of drugs and/or alcohol

XX Failure to complete treatment program

XX Lack of treatment programs or options locally

XX Lack of workforce licensed/certified to treat clients who have co-occurring MH and SUD issues

XX Stigma and prejudice regarding diagnosis or participation in treatment

XX Reduced motivation of clients due to changes in court-required drug treatment programs (Proposition 47 reduced penalties for some substance use crimes, thus individuals may choose not to apply for drug court supervision of their case. Drug court is a way to reduce criminal penalties for some crimes in exchange for the client engaging in treatment for substance use).

XX Other, please describe

Funding. At the systemic level, Sacramento County Alcohol and Drug Advisory Board members all agreed on the fundamental chronic underfunding of substance abuse prevention and treatment services. Among the survey options, “transportation” and “lack of treatment programs or options locally” received the most votes. In addition, “wait list”, “workforce skilled to address co-occurring disorders”, and “stigma and prejudice” were all identified as systemic issues of concern.

Individual Engagement. Individual engagement was also recognized by the Alcohol and Drug Advisory Board as a critical barrier to successful recovery. Members identified “client is not ready to commit” and “reduced motivation due to changes in court required drug treatment (e.g. Prop 47)” as substantial barriers. In addition, “language and culture”, “transportation”, “wait lists”, “stigma and prejudice regarding diagnosis or participation”, and “failure to complete treatment program” were all identified as individual barriers to successful treatment and recovery.

11. What could be done to increase successful outcomes for SUD recovery in your county? Choose the top three priorities.

XX Ongoing case management

___ Support individuals to make necessary changes in social patterns (new neighborhood; change routes to home, school or work; change circle of friends)

___ Medication services

XX Family treatment/education

___ Health and nutrition classes

___ Parenting classes

___ Onsite access or referrals for primary health care screening and treatment

___ Vocational training and support, including employment readiness classes

XX Other, please describe

Funding. The Sacramento County Alcohol and Drug Advisory Board agreed that addressing the fundamental chronic underfunding of substance abuse prevention and treatment services was the primary priority to increase successful outcomes. Even though the Affordable Care Act, Covered California, expanded MediCal and state waivers will provide new mechanisms to address the funding of substance abuse treatment services, there are specific gaps that need to be addressed. Although Sacramento County provides some matching funds, it doesn't dedicate ongoing county general funds for substance abuse prevention or treatment services.

Wrap Around Services. The Alcohol and Drug Advisory Board identified the need for a comprehensive system of care that includes additional wrap around services shown to be necessary for successful treatment outcomes that won't be fully covered by these new funding mechanisms. These include full case management, residential care, after care, housing, and employment training.

Other. Among the list of survey options "ongoing case management," including after care, and family strengthening opportunities such as "family treatment/education" and "parenting classes," were the highest ranked solutions by the Alcohol and Drug Advisory Board. Additional suggestions highlighted primary health care (including SBIRT), residential treatment, structured clean and sober living, medication services (including buprenorphine) and vocational and employment training. DBHS further suggested funding for transportation (such as bus passes) as a priority.

12. Have any SUD treatment strategies been shown to be especially successful in your county?

Yes XX None ___

If yes, please describe:

- Motivational Interviewing,
- Cogninive Behavioral Therapy,
- Trauma Informed Treatment,
- Seeking Safety
- Substance Misuse/Criminal Thinking programs

13. How does your county support individuals in recovery to increase the rates of success? Please check all that apply in your county.

___ Transportation to outpatient treatment and therapy appointments

XX Motivational interviewing

XX Case management/aftercare/follow-up services and referrals

___ Services more like FSP[11] or wrap-around services

XX Family treatment and/or family education

XX Medication services

___Teaching about activities of daily living

___Parenting classes

___ Smoking cessation classes or treatment

___ On-site health testing and treatment

XX Linkage to primary care clinic for health tests and treatment

___ Job readiness training, vocational services , GED/college classes

XX Facilitate a change in the person's culture, to build new relationships, routines, patterns not linked to alcohol or drug use.

___Peer support, mentors or sponsors in the community

___ Classes about nutrition, cooking, exercise, and care of one's own health

XX Other, please describe

Collaborative Courts, Collaboration with other County agencies (Probation, Child Protective Services, Primary Health, Human Assistance)

In your opinion, which of the above are the four factors most essential to client success in SUD recovery?

- Case Management

[11] Full Service Partnership mental health services, programs funded by the Mental Health Services Act.

- Medication
- Collaboration
- Motivational Interviewing

14. **Prevention**. This last question is about coordinating prevention efforts between different agencies and groups. We believe that prevention and education activities are important to help reduce the number of persons using drugs or abusing alcohol, especially for youth under 18 and young adults.

The evidence shows that prevention efforts are much more effective when coordinated across multiple service systems. Currently, funding for MH efforts have a different source than that for substance abuse prevention[12] and therefore must be devoted to mental health. This results in most programs being separate or 'siloed' which risks producing fragmented, patchwork efforts and less than optimal outcomes for consumers.

Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?

Yes XX No

If yes, please provide a brief description of the program, target audience, and activities.

Alcohol and drug services are divided into treatment programs and prevention programs. While there are no specific ADS prevention programs in DBHS to address prevention of both SUD and mental illness we do have coordinated programs crossing multiple service systems that address SUD and mental illness in children, transition-aged youth and young adults which lead to reduced numbers of persons using drugs and/or abusing alcohol. Some of these programs are listed below.

Juvenile Justice Diversion and Treatment Program (JJDTP): JJDTP is jointly administered by DBHS, Sacramento County Probation Department, and River Oak Center for Children and is contracted for services to The River Oak Center for Children. JJDTP provides screenings, assessments and intensive mental health services and FSP supports to eligible youth (and their families) involved in the Juvenile Justice System. Youth must meet serious emotional disturbance criteria and be between the ages of 13 through 17 at enrollment. Pre-adjudicated

[12] Examples of programs funded from different sources could include MHSA Prevention and Early Intervention programs or the substance Abuse Prevention and Treatment Block Grant. You may know of others in your community.

youth are screened and given an assessment. With court approval, these youth will have the opportunity to avoid incarceration and voluntarily participate in this program as long as clinically necessary up to their 26th birthday. Adjudicated youth are referred, assessed, and have the
opportunity to voluntarily receive intensive, evidence-based services that are delivered in coordination with a specialized Probation Officer. Family and youth advocates compliment clinical services.

Adult and Juvenile Drug Courts: Referrals to mental health programs

Crossover Youth Practice Model (CYPM): The CYPM Model is a particular approach intended to improve the handling and outcomes of youth who penetrate the child welfare and juvenile justice systems by building and enhancing communication and collaboration across multiple systems. The CYPM Model is in the implementation stages in Sacramento County and representatives from child welfare, probation, courts, mental health and education make up the implementation and data teams.

Addendum: Question #15

Resources for local Advisory Boards to carry out their Mandated Roles

These questions address the operations of county mental health boards, behavioral health boards, or mental health commissions, regardless of current title. These items have been included in partnership with the California Association of Local Mental Health Boards and Commissions.

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

___ MH Board completed majority of the Data Notebook

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

XX Data Notebook placed on Agenda and discussed at Board meeting

XX Other; please describe: County and mental health board contribution roughly equal; substance abuse questions involved input from the Sacramento County Alcohol and Drug Advisory Board.

(b) Do you have suggestions for future Data Notebook themes or topics?

Yes____ No__X_ If Yes, please list: _____.

(c) Does your Board have a yearly budget to support its activities?

Yes_____ No__X__ If yes, $_____

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

Yes__X__ No_____

If yes, please provide their job classification:

Mental Health Board:

Program Planner; Staff Counsel

Briefly describe their duties:

Program Planner: Records and writes minutes for public meetings, assists with general board administrative needs.

Staff Counsel: Attends public meetings, provides advice to board members on open meeting and ethics rules.

Alcohol and Drug Advisory Board:

Program Manager and Program Planner (2 positions): Provide Alcohol and Drug Services updates at various meetings and committees, and provides data or information requested by board.

Senior Office Assistant: Records and writes minutes for public meetings, assists with general board administrative needs.

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

Mental Health Board:
Name and County: Billee Willson, Sacramento
Email: willsonb@SacCounty.net
Phone # 916-876-7213

Alcohol and Drug Advisory Board
Name and County: Lori Vallone, Program Manager, Sacramento
Email: ValloneL@saccounty.net
Phone # 916-875-2046

Name and County: Erik Dziuk, Program Planner, Sacramento
Email: DziukE@saccounty.net
Phone # 916-875-2057

Name and County: Rich Daniel, Sr. Office Assistant, Sacramento
Email: DanielR@saccounty.net
Phone # 916-875-2056

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

Mental Health Board:

Name and County: Tom Campbell, Sacramento
Email: tom_campbell@frontiernet.net
Phone # 916-691-9886

Alcohol and Drug Advisory Board:

Name and County: Sara Kahoalii, Sacramento
Email: sarakahoalii@yahoo.com
Phone # (916) 874-9754 (c/o DBHS)

CALIFORNIA State Reference Data for SUD Treatment and Outcomes

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

Totals are for all counties.

Service Type:

Outpatient	DETOX	Residential	Total
89,071	19,904	24,763	133,738
66.60%	14.88%	18.52%	100%

Age at Admission:

Under 18	18 – 25	26 - 35	36 and Older	Total
14,957	23,614	38,042	57,125	133,738
11.18%	17.66%	28.45%	42.71%	100%

Gender:

Male	Female	Total
84,615	49,123	133,738
63.27%	36.73%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
1,612	2,984	16,926	49,352	5,070	57,794	133,738
1.21%	2.23%	12.66%	36.90%	3.79%	43.21%	100%

CALIFORNIA State Data, includes all counties.

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge

For Discharges in FY 2013-2014

Substance Use:

None	Use Data Missing	Use Documented	Total
28,093	29,016	9,553	66,662
42.14%	43.53%	14.33%	100.00%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
1,160	29,016	36,486	66,662
1.74%	43.53%	54.73%	100.00%

Employment:

Employed	Data Missing	None	Total
10,596	29,016	27,050	66,662
15.90%	43.53%	40.58%	100.00%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
3,167	29,016	34,479	66,662
4.75%	43.53%	51.72%	100.00%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
19,306	18,340	29,016	66,662
28.96%	27.51%	43.53%	100.00%

REMINDER:

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

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

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

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

(916) 449-5249

Or, you may contact us by postal mail to:

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