Sacramento County Mental Health Board

April 26, 2019

The Honorable Board of Supervisors
County of Sacramento
700 H Street, Suite 1459
Sacramento, CA 95814

Dear Supervisors:

I am pleased to present the 2018 Annual Report of the Sacramento County Mental Health Board. This report provides an Executive Summary as well as detailed descriptions of the accomplishments of the Mental Health Board during the 2018 calendar year.

If you have any questions, I can be reached at ann@arneill.com or 916-529-5602.

Sincerely,

Ann Arneill, Chair
Sacramento County Mental Health Board

Enclosure (1)

CC: Chiefs of Staff

ANNUAL REPORT ON THE SACRAMENTO COUNTY MENTAL HEALTH BOARD

Calendar Year 2018

Approved by the Sacramento County Mental Health Board – April 3, 2019

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Executive Summary

This annual report on the Sacramento County Mental Health Board (MHB) provides the MHB's mission and statutory mandate. It includes a list of members according to their seat, membership category, and appointing supervisorial district. The Goals for calendar year 2018 are outlined, and the status of their implementation is reported. The MHB's committees are detailed. Of note is the participation of MHB members on Division of Behavioral Health Services (DBHS) committees and liaison representation on other community-based committees. Finally, the accomplishments of the MHB for the 2018 calendar year and the presentations that were provided at monthly MHB General Meetings are described.

MHB Accomplishments 2018

- February 2018 – Appointment of MHB members as liaisons to DBHS committees and community-based organizations.
- March 2018 – Public Hearing on the Mental Health Services Act (MHSA) Three-Year Plan for Fiscal Years 2017-18, 2018-19, & 2019-20. At this hearing, members of the African American community testified about the mental health and wellness needs of African Americans who have experienced trauma and/or mental health challenges. As a result of this testimony, DBHS initiated a planning process that resulted in a new MHSA Prevention and Early Intervention Program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.
- June 2018 – Approved a letter to the Board of Supervisors on the MHB's position on the Proposed Budget for Fiscal Year 2018-19.
- July 2018 – Approved a letter of support to Board of Supervisors for the Alcohol and Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

MHB Mission

The mission of the Sacramento County Mental Health Board is to enable children with serious emotional disturbances and adults with severe mental illness to access services and programs that assist them, in a manner tailored to each individual, to better manage their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

MHB Statutory Mandate

The statutory mandate for mental health boards is found in Section 5604.2(a) of the California Welfare and Institutions Code (WIC):

(a) The local mental health board shall do all of the following:
   (1) Review and evaluate the community's mental health needs, services, facilities, and special problems.
   (2) Review any county agreements entered into pursuant to Section 5650.
   (3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.
   (4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
   (5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.
   (6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
   (7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.
   (8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

The composition of mental health boards is also specified in statute in WIC Section 5604(a)(2). It is to have 50% consumers (persons with lived experience of mental illness) or the parents, spouses, siblings, or adult children of consumers. At least 20% shall be consumers and at least 20% shall be family members of consumers.

MHB Membership

The table below includes MHB members by appointment category and Board of Supervisor district as of April 3, 2019.

District 1: Phil Serna, Vice-Chair
District 2: Patrick Kennedy, Chair
District 3: Susan Peters
District 4: Sue Frost
District 5: Don Nottolli

Member	Appointment Category	District
Ann Arneill, Chair	Consumer	1
Maria Padilla-Castro	Public Interest	1
Tanya J. Kilpatrick, Vice-Chair	Family Member	1
Laura Bemis	Consumer	2
Supervisor Patrick Kennedy	Board of Supervisor	2
Caroline Lucas	Family Member	2
Mike Nguy	Public Interest	2
Christopher Barton, Public Information Secretary	Consumer	3
Collette Johnson-Schulke	Family Member	3
Dan Niccum	Public Interest	3
Bryan Richter	Family Member	4
Mark Rodgers	Public Interest	4
Vacant	Consumer	4
Dmitri Godamunne	Family Member	5
Silvia Rodriguez	Public Interest	5
Vacant	Consumer	5
Supervisor Don Nottoli	Alternate	5

MHB General Meeting Date and Location

The MHB meets the first Wednesday of every month from 6:00 p.m. to 8:00 p.m. at the County Administration Building at 700 H Street, Sacramento, CA 95814. The MHB met offsite at La Familia Counseling Center at 3301 37th Avenue, Sacramento, CA 95824 in July 2018.

MHB Annual Retreat

The MHB held their Annual Retreat on February 17, 2018, at the Grantland L. Johnson Center for Health & Human Services from 10 am – 2 pm. Liaison roles and duties were assigned, the 2018 calendar year meetings and presentations were planned, and the 2018 MHB Goals were established.

MHB Successful Goals for 2018

Goal 1: Community Outreach
Educate community members on the role of the MHB

- Meeting announcements and agendas for monthly MHB General Meetings are distributed by email to approximately 100 recipients consisting of community members, contracted service providers, and other system partners.
- Monthly meeting agendas are posted on the County MHB website, at the Sacramento County Mental Health Treatment Center, the kiosk at 700 H Street, and the lobby of the Grantland L. Johnson Center for Health & Human Services.
- Held an MHB General Meeting offsite at La Familia Counseling Center at 3301 37th Avenue, Sacramento, CA 95824 in July 2018.
- Staffed an information table at the Peer Empowerment Conference on June 29, 2018. MHB brochures and applications were distributed to community members and mental health consumers in attendance.

Goal 2: Older Adult Population
Advocate for service programs for the older adult population

- Held a presentation at the February 2018 MHB General Meeting on the Older Adult Continuum of Care and 2017 Data Notebook required by the California Behavioral Planning Council, which had extensive information in it on the Older Adult Continuum of Care.
- The MHB submitted the 2017 Data Notebook to the California Behavioral Health Planning Council in April 2018 (Attachment 1).
- Maria Padilla-Castro attended the bi-monthly Older Adult Coalition meetings and provided reports back to the MHB on information obtained at the meetings.

Goal 3: Homeless Population
Advocate for mental health services for the homeless

- Presentation on No Place Like Home (Proposition 2) was given at the January 2019 MHB General Meeting.

MHB Committees

MHB Budget Committee:
MHB Members: Dmitri Godumnne (lead), Ann Arneill, Silvia Rodriguez
Purpose: To advise the MHB on budget concerns and to provide recommendations for consideration by the MHB.

MHB Executive Committee:
MHB Members: Kindra Montgomery-Block, Past Chairperson; John Puente, Past Vice-Chairperson, Tom Campbell, Past Chairperson, Ann Arneill, Public Information Secretary, Matt Gallagher, Past At-large Member
Purpose: To prepare an agenda for the retreat and to carry out any responsibilities delegated to it by the MHB for any activities that do not require approval of the full MHB. To fulfill the MHB's responsibilities only when sensitive matters arise and urgent response is required but the entire MHB cannot be convened. These actions must be approved by the MHB at a subsequent meeting.

DBHS Committee Membership and Liaison Activities

MHB members serve as members of DBHS committees and as liaisons to DBHS committees and to community-based organizations. These members provide the MHB perspective on the committees on which they are members, and they report back to the MHB on the important policies discussed and adopted by these committees. The liaisons to committees and community-based organizations monitor the activities of these entities and report back to the MHB so that it can stay abreast of those activities and concerns in the community.

DBHS: Mental Health Services Act Steering Committee
MHB Member: Ann Arneill
Purpose: Makes recommendation to DBHS for MHSA programs and funding by:

- Engaging clients, family members, and other community stakeholders to develop MHSA plans;
- Reviewing and ranking proposals developed with stakeholder input; and,
- Making specific program recommendations consistent with MHSA goals, guidelines, and requirements.

DBHS Quality Improvement Committee
MHB Member: Ann Arneill
Purpose: The Mental Health Plan (MHP) Quality Improvement Committee (QIC) is chaired by the MHP Quality Management Program Manager. The QIC meets on a monthly basis. It includes consumers, family members, and representatives of the contracted service provider system, Mental Health Access Teams, Research and Evaluation, Quality Management, Cultural Competence, psychiatry, pharmacy, and Alcohol and Drug Services Unit. The QIC structure is the umbrella for standing subcommittees, ad hoc subcommittees, and/or workgroups that are developed to meet the changing needs of the MHP. Subcommittees report to the monthly QIC meetings where information is reviewed and comments are received from all parts of the system. These deliberations result in approval, new initiatives, and recommendations for new directions and constitute a critical communication forum for the MHP.

DBHS Cultural Competence Committee (CCC)
MHB Liaison: Mark Rodgers
Purpose: A subcommittee of the Quality Improvement Committee. Acts as an advisor to DBHS on cultural competence issues, including outreach, accessibility, linguistic requirements, human resources, and strategies to improve penetration rates. The CCC takes an active role in the continued monitoring of current state-mandated Cultural Competence Plans (CCPs) and the development of subsequent CCPs in Sacramento County. The CCC also reviews all services and programs, Quality Assurance Annual Workplan Reports, and MHSA Annual Update plans with respect to cultural competence issues.

Alcohol and Drug Advisory Board
MHB Liaison: Silvia Rodriguez
Purpose: Promotes a healthy community and reduces the harmful effects associated with alcohol and drug use.

First Five Sacramento Commission
MHB Member: Silvia Rodriguez, Vice-Chair
Purpose: Makes strategic investments based on best practices and a community driven plan. Investments are made into programs that meet the highest needs of children and families in Sacramento County.

Human Services Coordinating Council
MHB Members: Collette Johnson-Schulke, Tanya Kilpatrick
Purpose: Serves as an advisory body to the Board of Supervisors on matters relating to health and human services planning and policy issues.

Sacramento County Maternal Mental Health Collaborative
MHB Member: Silvia Rodriguez, Vice Chair
Purpose: Increases knowledge of maternal mental health disorders and resources available to address them among mothers, healthcare providers, policy makers, and other stakeholders.

Older Adult Coalition
MHB Liaison: Maria Padilla-Castro
Purpose: The Older Adult Coalition (OAC) provides an educational forum regarding Sacramento County community-based services and supports to promote older adult mental health recovery. The OAC meets every other month, including the Annual Mental Health & Aging Conference. The OAC is comprised of a broad cross-section of the mental health, health, and social service professional community in the public and private sector. Its voluntary membership also reflects public citizens, consumers, family members, retired professionals, mental health and older adult advocates.

National Alliance on Mental Illness (NAMI)
MHB Liaisons: Laura Bemis, Tanya Kilpatrick
Purpose: A grassroots organization that provides a community of support, education, resources, and outreach activities to families, friends, and persons with mental illness so as to improve their general welfare and to reduce the stigma of mental illness.

MHB Accomplishments 2018

- February 2018 – Appointment of MHB members as liaisons to DBHS committees and community-based organizations.
- March 2018 – Public Hearing on the Mental Health Services Act (MHSA) Three-Year Plan for Fiscal Years 2017-18, 2018-19, & 2019-20. At this hearing, members of the African American community testified about the mental health and wellness needs of African Americans who have experienced trauma and/or mental health challenges. As a result of this testimony, DBHS initiated a planning process that resulted in a new MHSA Prevention and Early Intervention Program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.
- June 2018 – Approved a letter to the Board of Supervisors on the MHB's position on the Proposed Budget for Fiscal Year 2018-19 (Attachment 2).
- July 2018 – Approved a letter of support to Board of Supervisors for the Alcohol and Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver (Attachment 3).

Presentations Provided at MHB General Meetings

February 7, 2018 – Older Adult Continuum and Data Notebook
The presentation provided demographics on the older adult population in the county and numbers of older adults served by the DBHS. It included a description of the continuum of older adult services from MHSA Prevention and Early Intervention programs through to more intensive MHSA Full Service Partnerships. Client satisfaction data were included as well.

The Data Notebook is a requirement of the California Behavioral Health Planning Council for gathering information on performance data from county mental health programs and for obtaining interpretation of that data from local mental health boards. The Data Notebook for this year focused on older adults. It asked for information on a number of topics, including a description of services available to older adults, identification of populations unserved and underserved due to limited English proficiency, and identification of significant barriers to obtaining services for older adults.

May 2, 2018 – DMC-ODS Waiver
This presentation provided a comprehensive overview of the DMC-ODS Waiver, including the waiver authority, client eligibility for services, new services available through the waiver, state and county responsibilities, provider requirements, fiscal provisions, and evaluation requirements.

September 13, 2018 – California Association of Local Behavioral Health Board & Commissions (CALBHB/C)
Ms. Theresa Comstock, CALBHB/C President; Mr. Jerry Jeffe CALBHB/C Executive Director; and, Ms. Yvonne Bond, CALBHB/C Governing Board Member & Chair of the Placer County Mental Health Alcohol and Drug Advisory Board gave a presentation. CALBHB/C supports the work of California's 59 local mental/behavioral health boards and commissions by providing resources, training, and opportunities for communication and statewide advocacy. Ms. Comstock provided information regard an annual training for

MHB members, The Best Practices Handbook, and current statewide mental health issues.

October 03, 2018 – My Brother's Keeper Sacramento Youth Fellowship
My Brother's Keeper Sacramento Collaborative is bringing systems leaders, community partners, youth-serving organization, and youth together to collectively address health, education, employment, and justice disparities for young men of color through policy, advocacy, systems reform, and support for effective programs. Young men from the program attended the meeting and spoke about their involvement in the program and what the experience has meant to them.

November 7, 2018 – Sacramento Maternal Mental Health Collaborative
This presentation stated the vision, mission, and purpose of the Sacramento Maternal Mental Health Collaborative and described its activities. The presentation explained why maternal mental health mattered and the relationship between trauma and maternal mental health. It outlined five key focus areas for the Collaborative: health equity, public awareness, provider training, policy and advocacy, data, and resource mapping. It also detailed opportunities for future collaborative investments.

Conclusion
The MHB is fulfilling its mission regarding children with serious emotional disturbances and adults with severe mental illness. Its activities are guided by its statutory mandate. It is comprised of consumers, family members, public interest representatives, and a Board of Supervisors representative. This diverse membership guarantees that all important perspectives are included in the work conducted by the MHB. It has successfully completed three goals related to community outreach, older adults, and the homeless. It has committees to which it delegates specific responsibilities. The MHB has extensive representation on DBHS committees and liaison relationships with other committees and community-based organizations. These relationships ensure that the viewpoint of the MHB is heard and that the MHB is informed of the policies adopted by these entities and of trends in the community. The MHB has also acted on various public policy issues at its meetings. Finally, the MHB has apprised itself of many important programs in the community through the presentations that it has had at its General Meetings throughout the year.

SACRAMENTO COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

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

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SACRAMENTO COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2017): 1,524,524

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

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

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	107,779	6,863
Hispanic	94,815	3,269
African-American	70,073	4,418
Asian/Pacific Islander	75,755	1,571
Native American	3,173	226
Other	72,079	3,649
Total	423,673	19,996

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

Supplemental County Data Page

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

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

Population (2010): 1,422,348

Adult population over 18: 1,058,549

Civilian veterans: 98,345 (9.3% of the adult population)

Total civilian noninstitutionalized population: 1,402,325

With a disability, all ages: 180,228 (12.9%)

Under 18 years with disability: 15,683 (4.3% of those within this age group)

Age 18-64 years with a disability: 99,682 (11.3% of those in this age group)

Total population age 65 years and older: 157,135 (11.0 % of total population).

Age 65 and older with a disability: 64,863 (41.3% of those in this age group)

Total households: 512,496 (100%) Population in households: 1,394,582 (98.5%)

Households with a member 65 years or over: 117,042 (22.8%)

Householder living alone, age 65 years and over: 44,816

Grandparents living with own grandchildren under 18 years: 36,484

Responsible for grandchildren: 10,560 (28.9% of those living with grandchildren)

Grandparents who are female: 6,881 (65.2%)

Grandparents who are married: 7,120 (67.4%)

Percentage of all families whose prior year income was below poverty level: 12.4%

Percentage of all persons living under the federal poverty level: 16.5%

Percentage of aged 65 and over with prior year income under poverty level: 8.4%

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

[2] All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 1,422,348 in the year of the last U.S. census, 2010.

[3] http://www.labormarketinfo.ca.gov/file/census2012/sacdp2012.pdf, see pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc.

INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How Do the Data Sources Define Older Adults?

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

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

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

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

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

Resources: Where do We Get the Data?

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

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

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

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

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

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

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

HEALTHY AGING AND THE OLDER ADULT SYSTEM OF CARE
Social Supports and Community Engagement for Mental Health

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

Examples of services for older adults include:

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

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

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

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

Integrated Health Care for Older Adults: Treating the Whole Person

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

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

   The County of Sacramento did not apply for the Whole Person Care Pilot Program. The City of Sacramento applied and was awarded the grant. The County of Sacramento will be providing mental health services and alcohol and drug treatment services to individuals enrolled in the Whole Person Care Pilot Program administered by the City of Sacramento.

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

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

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

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

____Other, please specify. _____

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

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

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

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

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

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

[10] California Department of Finance, Demographic Reports and Projections, 2017. www.dof.ca.gov.
[11] California State Plan on Aging – 2013-2017, California Department of Aging, www.aging.ca.gov.
[12] Due to statistical reasons regarding sampling, this report combined totals into "All Others, Non-Hispanic" for the following categories: American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Some Other Race, and Two or More Races. Due to rounding, percentages may not sum to 100 %.

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

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

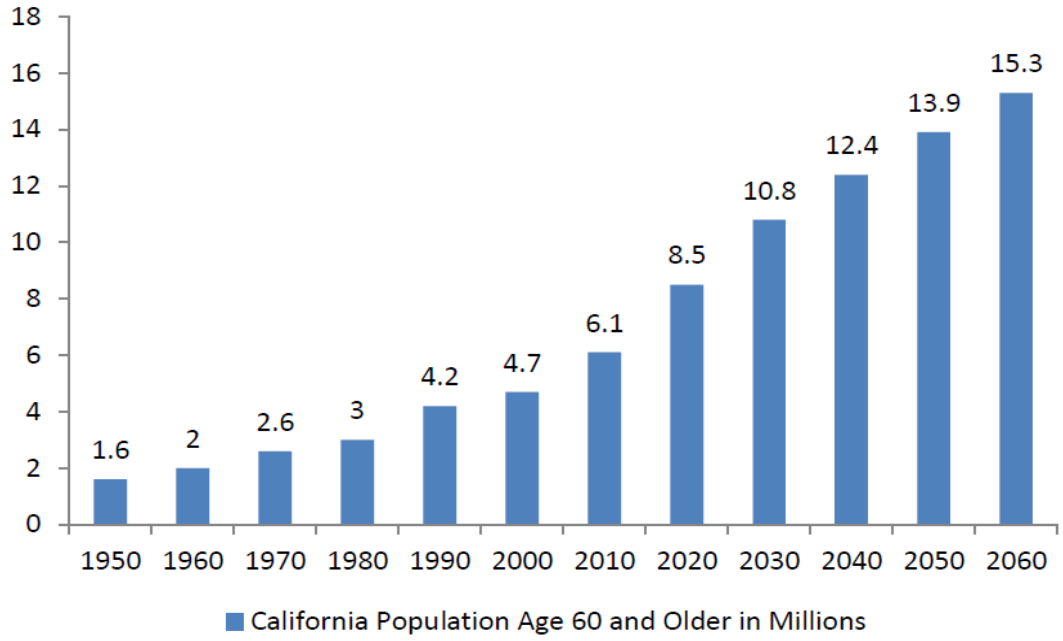


Figure 1. Projected Increases in Population Age 60 and over in California. [13]

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

	2010 Population age 60+	2030 Population age 60+	Per Cent Change over 20 years
Sacramento County	**230,675**	**414,877**	**80 %**
California	**6,016,871**	**10,879,098**	**81 %**

- Is your county doing any advanced planning to meet the mental health and substance use service needs of your changing older adult population in the coming years?

Yes_**X**__ No___ If yes, please describe briefly.
Yes, Sacramento County's Alcohol and Drug Services is working with Sacramento

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

County Senior and Adult Services looking at access to care, barriers to care, treatment options and support for this population.

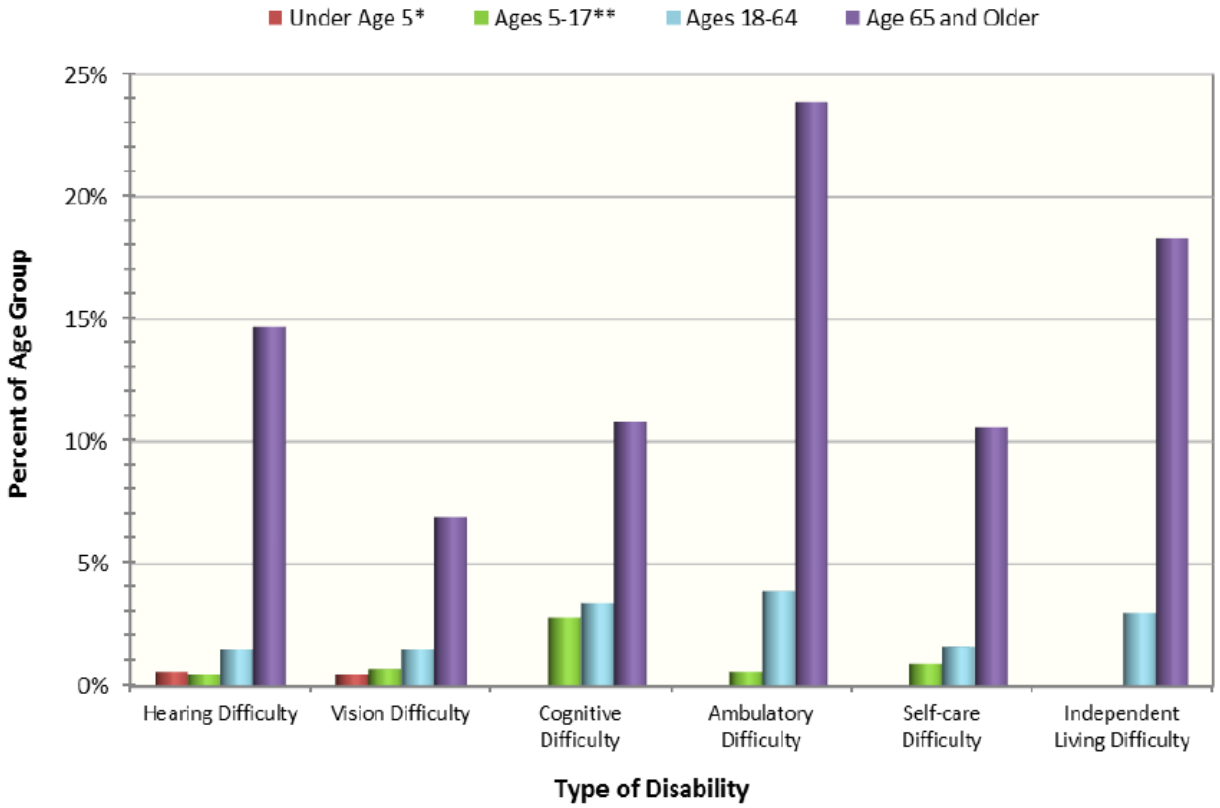
Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

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

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

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



*For children under 5 years old, only questions regarding hearing and vision difficulties were asked.
**For children between the ages of 5 and 14, only questions regarding hearing, vision, cognitive, ambulatory, and self-care difficulties were asked. F

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

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

In your county, the data show:

Sacramento County (2011): There were 157,135 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 64,863. That number represents 41 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

Next, we consider some data about the older adults that describe some challenges for

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

The California Department of Aging prepared the following demographic projections[14] for 2016 for older adults (60+) in your county:

Sacramento County (2016):

Age 60+: 285,594	Age 75+: 82,852
Nonminority:[15] 181,444	Minority:[16] 104,150
Low income: 30,415	Non-English proficient: 10,635
Medi-Cal: 55,678	SSI/SSP (65+): 22,034
Lives alone (60+): 58,445	Geo-isolation (60+): 6,251

Limited English Proficiency is a Barrier for Behavioral Health Access

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

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

Several counties have high rates (between 12 and 21 percent) of older adults who have difficulty communicating in English. These include Alameda, San Francisco, San Mateo,

[14] California Department of Aging, 2015, www.aging.ca.gov.
[15] Using federal data guidelines, the Department on Aging defines "nonminority" as non-Hispanic Whites.
[16] The federal data guidelines used by the Department on Aging define "minority" as everyone else, that is, all race/ethnicities that are not Caucasian and are not Hispanic.
[17] http://www.dof.ca.gov/Reports/Demographic_Reports/documents/2011ACS_1year_Rpt_CA.pdf

Santa Clara, Merced, San Benito, Monterey, Tulare, Los Angeles, Orange, and Imperial counties.[5]

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

  Yes_X__ No___

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

  - *Language: **Arabic***
    - *Country of Origin: Iraq*
  - *Languages: **Dari & Pashto***
    - *Country of Origin: Afghanistan*
  - *Language: **Farsi***
    - *Country of Origin: Iran*

  Sacramento County continues to work to improve access for emerging refugees who have originated from Afghanistan, Iran, and Iraq. A few years ago, Sacramento County worked with key community leaders from these emerging refugee communities to develop culturally and linguistically competent mental health/behavioral health outreach brochures. These informational brochures were developed in partnership with the community, featured the images of community members, and were made available in the respective language and in English.

  Additionally, Sacramento County provides services to undocumented individuals.

  Please note: Arabic is a new threshold language for the County of Sacramento.

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

- **Strategy:** Culturally and linguistically competent outreach and engagement that is tailored for a particular cultural, racial or ethnic community
- **Programs:** Supporting Community Connections

  - Benefits acquisition, access, and linkage to needed services
  - Diversion from crisis services/decreased need for crisis services
  - Reducing risk factors and enhancing protective factors
  - Suicide prevention appropriate and effective for older adults

- Fostering improved life satisfaction and well-being
- Senior peer counseling and monthly support groups
- Support including companionship, emotional support, transportation, phone support, friendship
- Reducing isolation and enhancing connectedness: resource linkage for lonely, isolated, homebound older adults.

Service Providers

Asian Pacific Community Counseling Center
Cantonese/Vietnamese/Hmong populations
G.O.A.L.S. for Women
African American women
Iu-Mien Community Services
Iu-Mien population
La Familia Counseling Center
Latino/Spanish populations
Mental Health America of Northern California
All cultural/ethnic populations – specific to older adult population
Sacramento Native American Health Center
American Indian population
Slavic Assistance Center
Russian-speaking/Slavic populations

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

_X__Transportation
_X__Geographic Isolation
_X__Lack of awareness of services
_X__Mobility issues due to co-occurring physical conditions or disabilities
_X__Lack of geriatric-trained practitioner

BEHAVIORAL HEALTH: OLDER ADULTS CONTINUUM OF CARE

Substance Use Treatment for Older Adults: Barriers and Stigma

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your County: SACRAMENTO

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

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	40 7.02 %	367 64.39 %	76 13.33 %	87 15.26 %	570
Age 37-54	165 10.07 %	548 33.46 %	537 32.78 %	388 23.69 %	1638
Age 26-36	287 13.03 %	754 34.24 %	723 32.83 %	438 19.89 %	2202
Age 15-25	115 8.17 %	277 19.69 %	791 56.22 %	224 15.92 %	1407

CALIFORNIA: Statewide

We could not confirm accuracy because percentages are missing.

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

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

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

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

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

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

   Please check all that apply.

   _X__Outpatient NTP (narcotics treatment program (methadone, etc)

   _X__Outpatient (non-NTP)

   _X__Detoxification

   _X__Residential Treatment

   _X__Dual Diagnoses Programs

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

   _X__Safe housing options for clients working to be clean and sober (also applies to dual diagnosis clients)

   ____SUD Treatment program designed for older military veterans

   ___Other, please specify._____

Mental Health Services for Older Adults[21]

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

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

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

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

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

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

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

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

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

[23] Geriatric Mental Health Foundation, 2008.

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

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

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

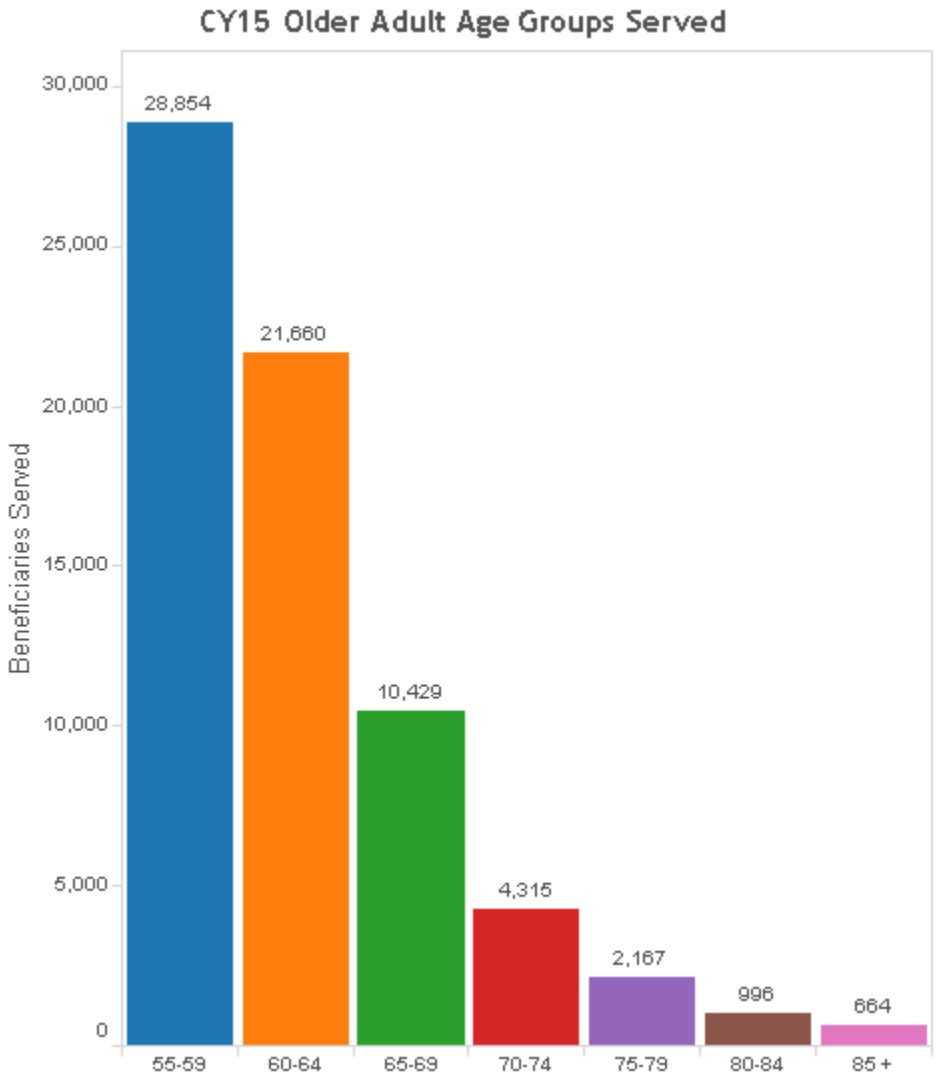


Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).

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

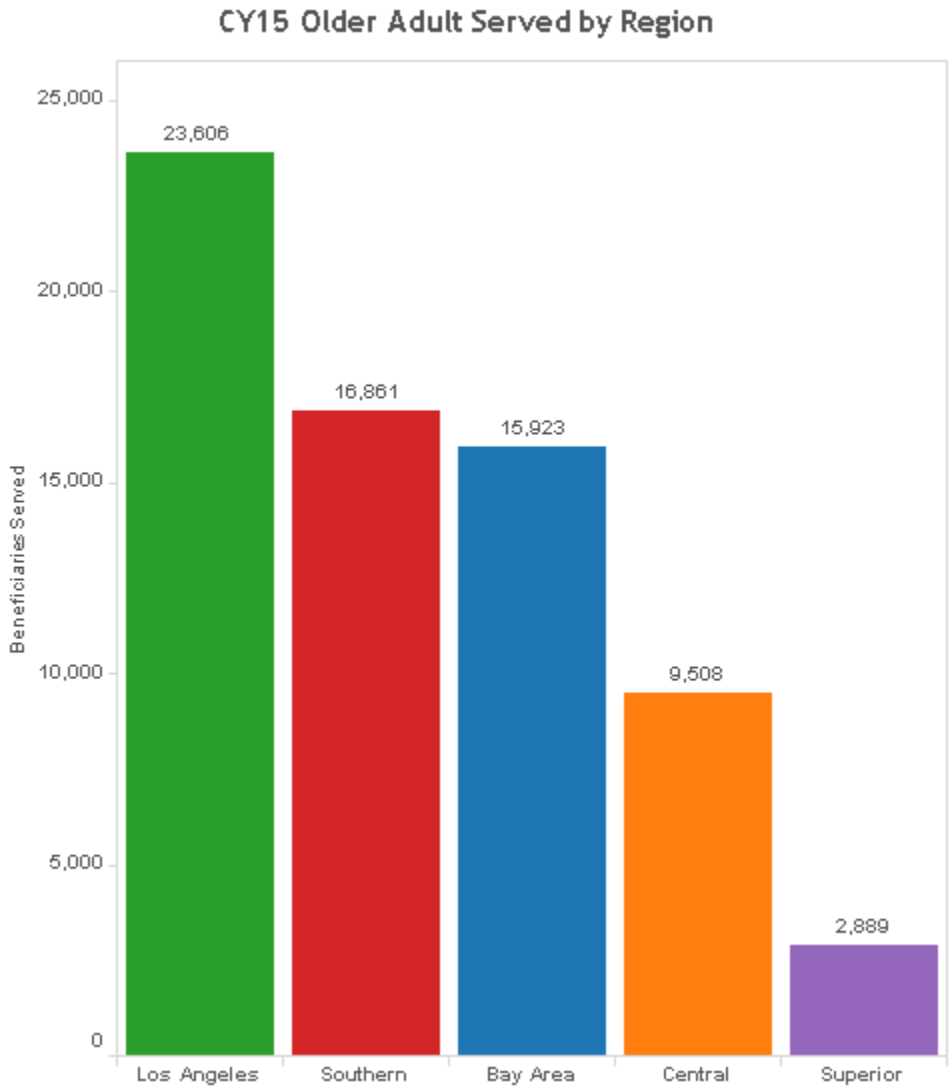


Figure 4. The numbers of persons in each region who received Specialty Mental Health Services ("beneficiaries", CY 2015). Los Angeles County is taken to be its own region.

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

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

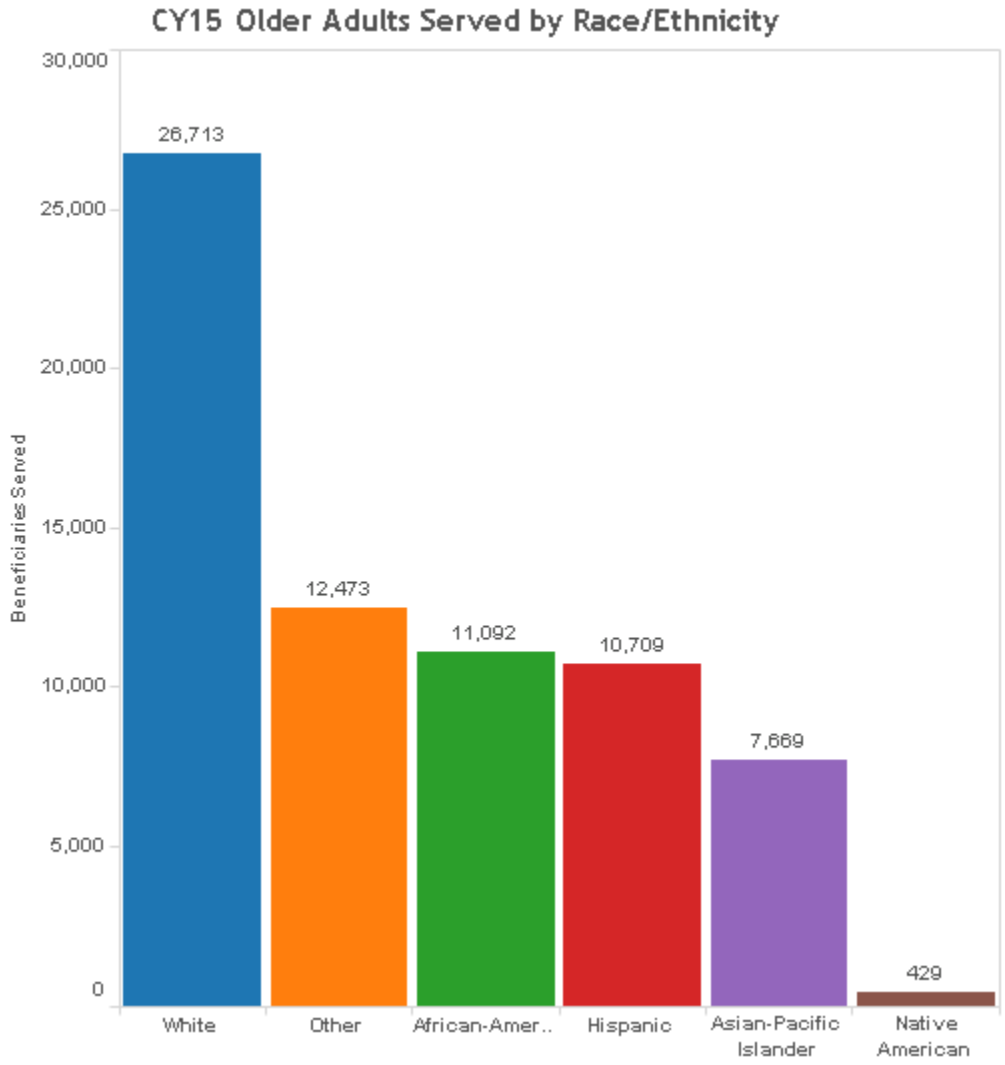


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group ("beneficiaries served").

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

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

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

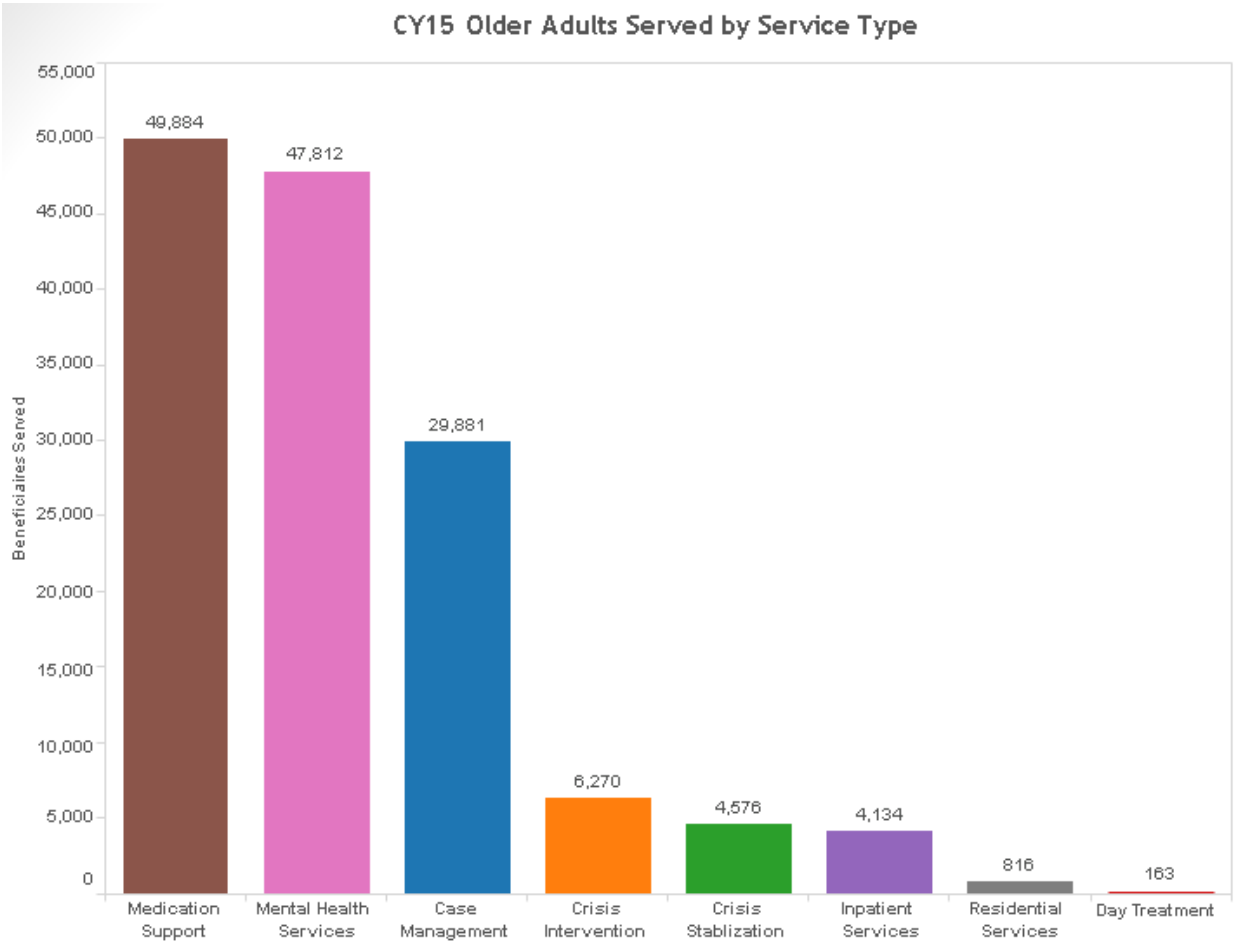
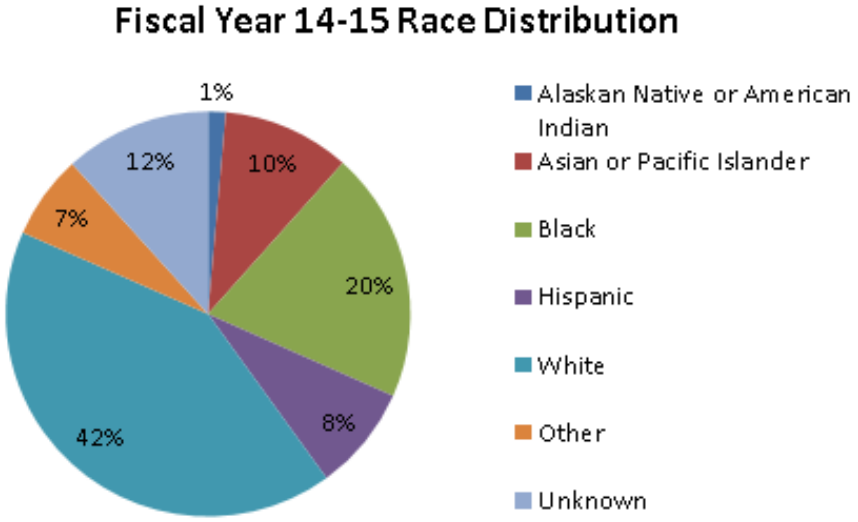


Figure 6. The most frequently used specialty mental health services are shown by the total number of older adults ("beneficiaries served") who received each type of service.

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

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

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



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

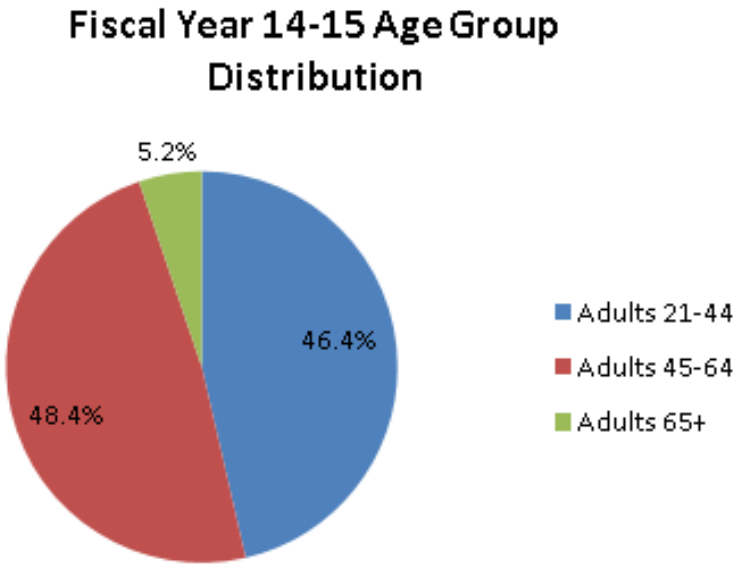


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).[28]

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

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

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

	Adults with 1 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	**11,139**	**317,712**	**3.5%**
Adults 21-44	5,169	173,863	3.0%
Adults 45-64	5,386	102,947	5.2%
Adults 65+	584	40,902	1.4%
Alaskan Native or American Indian	156	2,981	5.2%
Asian or Pacific Islander	1,132	67,691	1.7%
Black	2,231	51,009	4.4%
Hispanic	940	33,859	2.8%
White	4,623	104,574	4.4%
Other	750	39,878	1.9%
Unknown	1,307	17,720	7.4%
Female	6,436	174,215	3.7%
Male	4,703	143,497	3.3%

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

	Adults with 5 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	**8,689**	**317,712**	**2.7%**
Adults 21-44	3,870	173,863	2.2%
Adults 45-64	4,365	102,947	4.2%
Adults 65+	454	40,902	1.1%
Alaskan Native or American Indian	118	2,981	4.0%
Asian or Pacific Islander	933	67,691	1.4%
Black	1,706	51,009	3.3%
Hispanic	746	33,859	2.2%
White	3,571	104,574	3.4%
Other	564	39,878	1.4%
Unknown	1,051	17,720	5.9%
Female	5,042	174,215	2.9%
Male	3,647	143,497	2.5%

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

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

   Yes_X__ No___

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

   Yes. However there is always room for improvement such as:

   - Eliminating learned stigma
   - Remove legal barriers
   - Affordability/insurance coverage

Community Supports for Mental Health Emergencies and Crisis Services

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

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

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

   _X__Mental health providers trained in MH needs of older adults

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

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

   _ X __Crisis Drop-In Center with ability to serve older adults

   _X__Services for older adults at risk for suicide

   _X__23-Hour Crisis Stabilization Services for older adults

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

_X__Crisis residential treatment for older adults

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

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

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

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

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

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

The data for your county show:

Sacramento County (2011):
Total persons age 65 years and older: 157,135 (11.0 % of total population).
Grandparents living with own grandchildren under 18 years: 36,484.
Grandparents responsible for grandchildren: 10,560 (which is 29 % of the grandparents living with children under the age of 18.)

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

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

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

   If yes, please check all that apply below.

   _X__Group therapy or support groups

   ___Counseling/parenting strategies

   _X__Respite care services

   _X__In-home supportive services (IHSS)

   _ X __Stress management program

   _X__Mental health therapy, individual

   _____Other, please specify: _____.

Significant Changes in Behavioral/Cognitive Function in Older Adults

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

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

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

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

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

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

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

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

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

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

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

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

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

   If yes, please provide one example.

   El Hogar Community Services, Inc.
   Sierra Elder Wellness Program Full Service Partnership

Intensive, full service, integrated mental health and medication services for older adults including complex mental health or co-occurring, physical health, and housing needs. 24/7 response.

- Comprehensive Geriatric Assessment
- Psycho-social Rehabilitation and Therapy
- Psychiatric Medication and Follow Up Services
- Groups
- Family Services
- Transportation
- Advocacy
- Case Management
- Housing Support
- Psycho-Education, Nutrition
- Employment and Volunteerism Supports
- Co-Occurring Disorder Programming
- Community Linkage
- Field Based Services

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

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

8. Does your community train and/or utilize the skills and knowledge of <u>older adults</u> as peer counselors, and/or health navigators? Yes_X__ No___

   <u>If yes</u>, then please provide one example of how this occurs.

   El Hogar
   SeniorLink Program

- Individuals with with "lived experience" in the experience of recovery from mental illness and/or substance use disorders provide Peer Support/Counseling.
- Community-based and in-home services for older adults
- Culturally and linguistically informed support services to seniors to reduce the propensity for isolation, anxiety and/or depression
- Collaboration with and linkage to health care providers, transportation, service coordination, referrals, and groups
- Coordination of social activities, advocacy, and liaison to community services, based on clients' service needs.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

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

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

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

___MH Board completed majority of the Data Notebook

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

_X_ Data Notebook placed on Agenda and discussed at Board meeting

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

_X_ MH Board partnered with county staff or director

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

___Other; please describe: _____.

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

Yes_X_ No___

If yes, please provide their job classification __Program Planner_____

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

Name and County: _Stephanie Dasalla, County of Sacramento_____

Email__DasallaS@saccounty.net_____

Phone #___(916) 875-6482_____

Signature: _____

Other (optional): _____

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

Name and County: _John Puente, County of Sacramento____

Email: __JohnPuente@yahoo.com_____

Phone #____(916) 869-0682_____

Signature: _____

REMINDER:

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

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

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.ca.gov.

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

(916) 327-6560

Or, you may contact us by postal mail to:

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

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Executive Summary

This annual report on the Sacramento County Mental Health Board (MHB) provides the MHB's mission and statutory mandate. It includes a list of members according to their seat, membership category, and appointing supervisorial district. The Goals for calendar year 2018 are outlined, and the status of their implementation is reported. The MHB's committees are detailed. Of note is the participation of MHB members on Division of Behavioral Health Services (DBHS) committees and liaison representation on other community-based committees. Finally, the accomplishments of the MHB for the 2018 calendar year and the presentations that were provided at monthly MHB General Meetings are described.

MHB Accomplishments 2018

- February 2018—Appointment of MHB members as liaisons to DBHS committees and community-based organizations.
- March 2018—Public Hearing on the Mental Health Services Act (MHSA) Three-Year Plan for Fiscal Years 2017-18, 2018-19, & 2019-20. At this hearing, members of the African American community testified about the mental health and wellness needs of African Americans who have experienced trauma and/or mental health challenges. As a result of this testimony, DBHS initiated a planning process that resulted in a new MHSA Prevention and Early Intervention Program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.
- June 2018—Approved a letter to the Board of Supervisors on the MHB's position on the Proposed Budget for Fiscal Year 2018-19 (Attachment 2).
- July 2018—Approved a letter of support to Board of Supervisors for the Alcohol and Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver (Attachment 3).

MHB Mission

The mission of the Sacramento County Mental Health Board is to enable children with serious emotional disturbances and adults with severe mental illness to access services and programs that assist them, in a manner tailored to each individual, to better manage their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

MHB Statutory Mandate

The statutory mandate for mental health boards is found in Section 5604.2(a) of the California Welfare and Institutions Code (WIC):

(a) The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

The composition of mental health boards is also specified in statute in WIC Section 5604(a)(2). It is to have 50% consumers (persons with lived experience of mental illness) or the parents, spouses, siblings, or adult children of consumers. At least 20% shall be consumers, and at least 20% shall be family members of consumers.

MHB Membership

The table below includes MHB members by appointment category and Board of Supervisor district as of April 3, 2019.

District 1: Phil Serna, Vice-Chair
District 2: Patrick Kennedy, Chair
District 3: Susan Peters
District 4: Sue Frost
District 5: Don Nottolli

Member	Appointment Category	District
Ann Arneill, Chair	Consumer	1
Maria Padilla-Castro	Public Interest	1
Tanya J. Kilpatrick, Vice-Chair	Family Member	1
Laura Bemis	Consumer	2
Patrick Kennedy	Board of Supervisor Appointee	2
Caroline Lucas	Family Member	2
Mike Nguy	Public Interest	2
Christopher Barton, Public Information Secretary	Consumer	3
Collette Johnson-Schulke	Family Member	3
Dan Niccum	Public Interest	3
Bryan Richter	Family Member	4
Mark Rodgers	Public Interest	4
Vacant	Consumer	4
Dmitri Godamunne	Family Member	5
Don Nottoli	Alternate for Supervisor Kennedy	5
Silvia Rodriguez	Public Interest	5
Vacant	Consumer	5

MHB General Meeting Date and Location

The MHB meets the first Wednesday of every month from 6:00 p.m. to 8:00 p.m. at the County Administration Building at 700 H Street, Sacramento, CA 95814. The MHB met offsite at La Familia Counseling Center at 3301 37th Avenue, Sacramento, CA 95824 in July 2018.

MHB Annual Retreat

The MHB held their Annual Retreat on February 17, 2018, at the Grantland L. Johnson Center for Health & Human Services from 10 am – 2 pm. Liaison roles and duties were assigned, the 2018 calendar year meetings and presentations were planned, and the 2018 MHB Goals were established.

MHB Successful Goals for 2018

Goal 1: Community Outreach
Educate community members on the role of the MHB

- Meeting announcements and agendas for monthly MHB General Meetings are distributed by email to approximately 100 recipients consisting of community members, contracted service providers, and other system partners.
- Monthly meeting agendas are posted on the County MHB website, at the Sacramento County Mental Health Treatment Center, the kiosk at 700 H Street, and the lobby of the Grantland L. Johnson Center for Health & Human Services.
- Held an MHB General Meeting offsite at La Familia Counseling Center at 3301 37th Avenue, Sacramento, CA 95824 in July 2018.
- Staffed an information table at the Peer Empowerment Conference on June 29, 2018. MHB brochures and applications were distributed to community members and mental health consumers in attendance.

Goal 2: Older Adult Population
Advocate for service programs for the older adult population

- Held a presentation at the February 2018 MHB General Meeting on the Older Adult Continuum of Care and 2017 Data Notebook required by the California Behavioral Planning Council, which had extensive information in it on the Older Adult Continuum of Care.
- The MHB submitted the 2017 Data Notebook to the California Behavioral Health Planning Council in April 2018 (Attachment 1).
- Maria Padilla-Castro attended the bi-monthly Older Adult Coalition meetings and provided reports back to the MHB on information obtained at the meetings.

Goal 3: Homeless Population
Advocate for mental health services for the homeless

- Presentation on No Place Like Home (Proposition 2) was given at the January 2019 MHB General Meeting.

MHB Committees

MHB Budget Committee:

MHB Members: Dmitri Godumnne (lead), Ann Arneill, Silvia Rodriguez
Purpose: To advise the MHB on budget concerns and to provide recommendations for consideration by the MHB.

MHB Executive Committee:

MHB Members: Kindra Montgomery-Block, Past Chairperson; John Puente, Past Vice-Chairperson, Tom Campbell, Past Chairperson, Ann Arneill, Public Information Secretary, Matt Gallagher, Past At-large Member

Purpose: To prepare an agenda for the retreat and to carry out any responsibilities delegated to it by the MHB for any activities that do not require approval of the full MHB. To fulfill the MHB's responsibilities only when sensitive matters arise and urgent response is required but the entire MHB cannot be convened. These actions must be approved by the MHB at a subsequent meeting.

DBHS Committee Membership and Liaison Activities

MHB members serve as members of DBHS committees and as liaisons to DBHS committees and to community-based organizations. These members provide the MHB perspective on the committees on which they are members, and they report back to the MHB on the important policies discussed and adopted by these committees. The liaisons to committees and community-based organizations monitor the activities of these entities and report back to the MHB so that it can stay abreast of those activities and concerns in the community.

DBHS: Mental Health Services Act Steering Committee
MHB Member: Ann Arneill
Purpose: Makes recommendation to DBHS for MHSA programs and funding by:

- Engaging clients, family members, and other community stakeholders to develop MHSA plans;
- Reviewing and ranking proposals developed with stakeholder input; and,
- Making specific program recommendations consistent with MHSA goals, guidelines, and requirements.

DBHS Quality Improvement Committee
MHB Member: Ann Arneill
Purpose: The Mental Health Plan (MHP) Quality Improvement Committee (QIC) is chaired by the MHP Quality Management Program Manager. The QIC meets on a monthly basis. It includes consumers, family members, and representatives of the contracted service provider system, Mental Health Access Teams, Research and Evaluation, Quality Management, Cultural Competence, psychiatry, pharmacy, and Alcohol and Drug Services Unit. The QIC structure is the umbrella for standing subcommittees, ad hoc subcommittees, and/or workgroups that are developed to meet the changing needs of the MHP. Subcommittees report to the monthly QIC meetings where information is reviewed and comments are received from all parts of the system. These deliberations result in approval, new initiatives, and recommendations for new directions and constitute a critical communication forum for the MHP.

DBHS Cultural Competence Committee (CCC)
MHB Liaison: Mark Rodgers
Purpose: A subcommittee of the Quality Improvement Committee. Acts as an advisor to DBHS on cultural competence issues, including outreach, accessibility, linguistic requirements, human resources, and strategies to improve penetration rates. The CCC takes an active role in the continued monitoring of current state-mandated Cultural Competence Plans (CCP) and the development of subsequent CCPs in Sacramento County. The CCC also reviews all services and programs, Quality Assurance Annual Workplan Reports, and MHSA Annual Update plans with respect to cultural competence issues.

Alcohol and Drug Advisory Board
MHB Liaison: Silvia Rodriguez
Purpose: Promotes a healthy community and reduces the harmful effects associated with alcohol and drug use.

First Five Sacramento Commission
MHB Member: Silvia Rodriguez, Vice-Chair
Purpose: Makes strategic investments based on best practices and a community driven plan. Investments are made into programs that meet the highest needs of children and families in Sacramento County.

Human Services Coordinating Council
MHB Members: Collette Johnson-Schulke, Tanya Kilpatrick
Purpose: Serves as an advisory body to the Board of Supervisors on matters relating to health and human services planning and policy issues.

Sacramento County Maternal Mental Health Collaborative
MHB Member: Silvia Rodriguez, Vice Chair
Purpose: Increases knowledge of maternal mental health disorders and resources available to address them among mothers, healthcare providers, policy makers, and other stakeholders.

Older Adult Coalition
MHB Liaison: Maria Padilla-Castro
Purpose: The Older Adult Coalition (OAC) provides an educational forum regarding Sacramento County community-based services and supports to promote older adult mental health recovery. The OAC meets every other month, including the Annual Mental Health & Aging Conference. The OAC is comprised of a broad cross-section of the mental health, health, and social service professional community in the public and private sector. Its voluntary membership also reflects public citizens, consumers, family members, retired professionals, mental health and older adult advocates.

National Alliance on Mental Illness (NAMI)
MHB Liaisons: Laura Bemis, Tanya Kilpatrick
Purpose: A grassroots organization that provides a community of support, education, resources, and outreach activities to families, friends, and persons with mental illness so as to improve their general welfare and to reduce the stigma of mental illness.

MHB Accomplishments 2018

- February 2018—Appointment of MHB members as liaisons to DBHS committees and community-based organizations.
- March 2018—Public Hearing on the Mental Health Services Act (MHSA) Three-Year Plan for Fiscal Years 2017-18, 2018-19, & 2019-20. At this hearing, members of the African American community testified about the mental health and wellness needs of African Americans who have experienced trauma and/or mental health challenges. As a result of this testimony, DBHS initiated a planning process that resulted in a new MHSA Prevention and Early Intervention Program to address mental health and wellness needs of African American community members who have experienced or have been exposed to trauma.
- June 2018—Approved a letter to the Board of Supervisors on the MHB's position on the Proposed Budget for Fiscal Year 2018-19 (Attachment 2).
- July 2018—Approved a letter of support to Board of Supervisors for the Alcohol and Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver (Attachment 3).

Presentations Provided at MHB General Meetings

February 7, 2018—Older Adult Continuum and Data Notebook

The presentation provided demographics on the older adult population in the county and numbers of older adults served by the DBHS. It included a description of the continuum of older adult services from MHSA Prevention and Early Intervention programs through to more intensive MHSA Full Service Partnerships. Client satisfaction data were included as well.

The Data Notebook is a requirement of the California Behavioral Health Planning Council for gathering information on performance data from county mental health programs and for obtaining interpretation of that data from local mental health boards. The Data Notebook for this year focused on older adults. It asked for information on a number of topics, including a description of services available to older adults, identification of populations unserved and underserved due to limited English proficiency, and identification of significant barriers to obtaining services for older adults.

May 2, 2018—DMC-ODS Waiver

This presentation provided a comprehensive overview of the DMC-ODS Waiver, including the waiver authority, client eligibility for services, new services available through the waiver, state and county responsibilities, provider requirements, fiscal provisions, and evaluation requirements.

September 13, 2018—California Association of Local Behavioral Health Board & Commissions (CALBHB/C)

Ms. Theresa Comstock, CALBHB/C President; Mr. Jerry Jeffe CALBHB/C Executive Director; and, Ms. Yvonne Bond, CALBHB/C Governing Board Member & Chair of the Placer County Mental Health Alcohol and Drug Advisory Board gave a presentation. CALBHB/C supports the work of California's 59 local mental/behavioral health boards and commissions by providing resources, training, and opportunities for communication and statewide advocacy. Ms. Comstock provided information regard an annual training for MHB members, The Best Practices Handbook, and current statewide mental health issues.

October 03, 2018—My Brother's Keeper Sacramento Youth Fellowship

My Brother's Keeper Sacramento Collaborative is bringing systems leaders, community partners, youth-serving organization, and youth together to collectively address health, education, employment, and justice disparities for young men of color through policy, advocacy, systems reform, and support for effective programs. Young men from the program attended the meeting and spoke about their involvement in the program and what the experience has meant to them.

November 7, 2018—Sacramento Maternal Mental Health Collaborative

This presentation stated the vision, mission, and purpose of the Sacramento Maternal Mental Health Collaborative and described its activities. The presentation explained why maternal mental health mattered and the relationship between trauma and maternal mental health. It outlined five key focus areas for the Collaborative: health equity, public awareness, provider training, policy and advocacy, data, and resource mapping. It also detailed opportunities for future collaborative investments.

Conclusion

The MHB is fulfilling its mission regarding children with serious emotional disturbances and adults with severe mental illness. Its activities are guided by its statutory mandate. It is comprised of consumers, family members, public interest representatives, and a Board of Supervisors representative. This diverse membership guarantees that all important perspectives are included in the work conducted by the MHB.

It has successfully completed three goals related to community outreach, older adults, and the homeless. It has committees to which it delegates specific responsibilities. The MHB has extensive representation on DBHS committees and liaison relationships with other committees and community-based organizations. These relationships ensure that the viewpoint of the MHB is heard and that the MHB is informed of the policies adopted by these entities and of trends in the community. The MHB has also acted on various public policy issues at its meetings. Finally, the MHB has apprised itself of many important programs in the community through the presentations that it has had at its General Meetings throughout the year.

Sacramento County Mental Health Board

June 1, 2018

The Honorable Susan Peters, Chair
Sacramento County Board of Supervisors
700 H Street, Suite 1450
Sacramento, CA 95814

Dear Supervisor Peters:

The Sacramento County Mental Health Board (MHB) has reviewed the proposed 2018-2019 budget for the Division of Behavioral Health Services. As the MHB's current elected leaders, we are pleased to offer our comments in the context of our ongoing monitoring of the state of mental health in the region.

We believe in the values reflected in the proposed budget. It shows a strong commitment to creating enhanced services in a responsive community mental health system through public investment. In particular, we agree with the budget's commitment to expanding community mental health treatment for the homeless, for foster youth, for persons in crisis, and for persons facing both mental health and substance use disorders.

We welcome increased dialogue with the Board of Supervisors to share more of the advocacy feedback we receive from the community about immediate mental health community needs. Specifically, we are aware of direct gaps in culturally sensitive mobile mental health treatment services. As well as trauma informed mental health strategies and services for historically disenfranchised neighborhoods impacted by community violence and trauma. We also report service and resource gaps to reach out to severely mentally ill individuals reluctant to seek treatment voluntarily. We look forward to collaborating with the Board of Supervisors in shaping County policy in these areas.

Additionally, we wish to remind the Board of Supervisors of the MHB's previously stated positions on key issues under consideration. For the past two budget cycles, the MHB has officially supported increasing compensation for county mental health contractors through cost-of-living adjustments. We regularly hear from contracted providers about the rising costs of doing business and the overall difficulty in recruiting and retaining quality staff. We highlight their concerns that these issues will in turn reduce the timeliness, accessibility, and quality of county mental health services.

Similarly, MHB members have long expressed concern over the County's rising inpatient hospital payments. Increasing payments for inpatient services while neglecting the economic need of outpatient providers will exacerbate the perceived imbalance in the county's continuum of services. We acknowledge factors beyond the County's control here, but nonetheless urge the County to take an aggressive negotiating stance in developing more cost-effective community-based treatment alternatives.

On behalf of the whole MHB, thank you for the opportunity to advise you in accordance with our statutory directive. Please contact us if we can provide any assistance over the coming year.

Sincerely,

Kindra Montgomery-Block, Chair
Sacramento County Mental Health Board

Tom Campbell, Vice Chair
Sacramento County Mental Health Board

Cc: Sacramento County Board of Supervisors
Sacramento County Chiefs of Staff
Navdeep S. Gill, Sacramento County Chief Executive Officer
Nancy Newton, Sacramento County Assistant County Executive
Bruce Wagstaff, Sacramento County Interim Deputy County Executive
Sandy Damiano, Sacramento County Interim Director of Health Services
Uma K. Zykofsky, Sacramento County Behavioral Health Services Director

Sacramento County Mental Health Board

May 23, 2018

The Honorable Susan Peters, Chair
Sacramento County Board of Supervisors
700 H Street, Suite 1450
Sacramento, CA 95814

Dear Supervisor Peters:

The Sacramento County Mental Health Board (MHB) would like to thank you for your continued support of mental health and substance use disorder treatment services in Sacramento County.

During the Sacramento County's Fiscal Year 2018-19 budget deliberations, you will have the opportunity to consider and support the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. The MHB respectfully requests consideration of the draft Sacramento County DMC-ODS waiver implementation plan.

The paths in mental health and substance use disorder often intersect. The mental health community has long recognized the importance of treating these two co-occurring disorders in a systematic way. To this end, the Mental Health Services Act Regulations, California Code of Regulations Section, 3620 et al, allows for Full Service Partnerships to coordinate services for individual with co-occurring disorders. The DMC-ODS provides one more opportunity to coordinate this much needed care.

Additionally, with the goal of improving health outcomes, the DMC-ODS waiver will fund residential treatment, withdrawal management (detoxification), case management services and recovery services for all Drug Medi-Cal beneficiaries with substance use disorders. Currently, the above services are not reimbursable services and only pregnant and postpartum women are eligible to receive DMC-funded residential treatment.

The DMC-ODS waiver also gives Sacramento County an opportunity to better serve, coordinate, and receive reimbursement for criminal justice populations, individuals with serious mental health illness, people experiencing homelessness, senior/older adults, and youth in Sacramento County. Critical elements of the waiver include increase local control and accountability, as well as coordination with primary health care and other systems of care to improve health outcomes while decreasing system-wide health care costs. The wider array of services offered under the waiver will allow for increase access to care that is needed for sustainable, successful recovery for Sacramento County beneficiaries.

We are dedicated to our community and its needs in the areas of substance use disorders, particularly those with mental health co-occurring disorders. The waiver is an opportunity for Sacramento County.

Sincerely,

Kindra Montgomery-Block, Chair
Sacramento County Mental Health Board

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