



Mental Health Board Recommendations for
Expenditure of Mental Health Services Act
Funds

August 2019

SUMMARY

All recommendations should enable equitable distribution of services to ensure the optimal mental health of all populations, particularly for unserved and underserved diverse populations.

Ad Hoc Children and Youth Committee

Goal: Increase satisfaction with psychiatric crisis services and reduce out-of-county placements

Recommendation: Establish Children's Crisis Residential Program using Community Services and Supports funds

Goal: Prevent onset of serious behavioral disorders in children and reduce expulsions from pre-school and childcare for children age 0-5

Recommendation: Expand early childhood mental health consultation services provided to pre-schools and childcare providers using Mental Health Services Act (MHSA) Prevention and Early Intervention funds

Goal: Prevent the development of serious emotional disturbances in children in future years

Recommendation: Expand screening and referral services for children age 0-5 who have developmental and behavioral problems using MHSA Prevention and Early Intervention funds

Ad Hoc Adult Committee

Goal: Increase the number of Board and Care beds and mental health services for consumers in Board and Care facilities

Recommendation: Establish an Augmented Care and Treatment Program using MHSA Community Services and Support funds

Goal: Increase services for maternal perinatal depression

Recommendation: Establish a MHSA Early Intervention and Prevention Program

Ad Hoc Older Adult Committee

Goal: Reduce isolation and loneliness experienced by older adults

Recommendation: Increase MHSA Prevention and Early Intervention funding for programs that help to reduce isolation and loneliness in the lives of older adults.

Goal: Reduce homelessness among older adults with serious mental illnesses

Recommendations: The Division of Behavioral Health Services (DBHS) should allocate some of the new 87 units funded by the No Place Like Home grant for older adults with serious mental illness experiencing homelessness.

Sacramento County's Homeless Initiatives and the DBHS Homeless Services should increase outreach to older adults with serious mental illness experiencing homelessness.

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INTRODUCTION

At its retreat in February 2019, the Sacramento County Mental Health Board (MHB) established goals to identify the top mental health issues for three target populations--children and youth, adults, and older adults--and to develop solutions or programs to address those issues.

The MHB established committees for each target population to work on this project. The membership on these committees is provided in Appendix A of this report. These committees have met since March 2019, holding committee meetings each month through June 2019. Committees solicited information from consumers, family members, mental health providers, older adult advocates, maternal mental health experts, representatives of other community organizations, and DBHS staff.

Based on this input, the MHB has developed program proposals to provide mental health services to address the unmet needs that have been identified for the target populations. Most of these programs relate to prevention and early intervention; thus, over half of the recommendations are for expenditure of MHSAs Prevention and Early Intervention funds.

This report was prepared to respond to the DBHS initiative to spend unspent MHSAs funds. The MHB submitted this report to the Board of Supervisors, the Division of Behavioral Health Services, and the Director of County Homeless Initiatives to inform them about the recommendations.

AD HOC CHILDREN AND YOUTH COMMITTEE

Children's Crisis Residential Program

Goal: Increase satisfaction with psychiatric crisis services and reduce out-of-county placements

Statutes of 2017, Chapter 704, (AB 501, Ridley-Scott) created children's crisis residential programs to be used as a diversion from psychiatric hospitalization for children and youth up to age 21. The primary function of a children's crisis residential program is to provide short-term crisis stabilization, therapeutic intervention, and specialized programming in an unlocked, staff-secured setting with a high degree of supervision and structure. The goal is to support the rapid and successful transition of the child back to the community.

The MHB's Ad Hoc Children's Committee met with Youth Advocates and Family Advocates to solicit their opinions about this treatment option. One Youth Advocate contrasted crisis residential programs with inpatient hospitalization programs, which she described as gloomy, depressing, and dark. She said that inpatient programs are diagnosis focused. They are not recovery focused or goal oriented. They provide medications but not that much other treatment. They have group therapy, but the groups are not very welcoming and are not very effective for introverted persons. Crisis

residential programs are more home-like and community based and help clients develop coping skills.

Another Youth Advocate described her experience at Koionia, the Crisis Resolution Center in Placer County. It is a 28-day program in a 3-4 bedroom house. There were not a lot of people there so it was not a chaotic environment. She was not able to stabilize at home. This program gave her a schedule and a structure, which was therapeutic. She had her own room so she was able to go there to relax and have private time for reflection. It was a family-like environment with everyone having dinner together. Another strength of the program was the peer support that it provided. The program worked with families and incorporated natural supports into discharge plans.

The Family Advocates discussed the experience of having a child or youth seen at an Emergency Room. They can wait in a hall way for 3-5 days with a Security Guard sitting with them.

Sacramento County has a shortage of acute inpatient beds for children, with only 47 beds that are also used by other counties. Children and youth are sent out of county to Vallejo, Santa Rosa, or Walnut Creek, for example. Families do not have easy access to their children and youth in these situations.

The Family Advocates said that a crisis residential program would preserve the dignity of child and youth and of the family. It would also provide a healing environment. Because their children and youth would be local, they could directly participate in treatment and would not have to do it by phone as they have to when their children are placed out of county. They would also not have the transportation costs that they incur with out-of-county placements.

Creating a children's crisis residential program would add 16 beds to the psychiatric crisis continuum of care, easing the shortage of acute psychiatric resources. This program is also a treatment alternative preferred by Youth and Family Advocates.

Recommendation

Establish a Children's Crisis Residential program using Community Services and Supports funds

Early Childhood Mental Health Consultation

Goal: Prevent onset of serious behavioral disorders in children and reduce expulsions from pre-school and childcare for children age 0-5

Young children's healthy social and emotional development is critical to school readiness and positive long-term outcomes. (National Research Council & Institute of Medicine, 2000; Raver & Knitzer, 2002; Thompson & Rakes, 2007). Although most children progress in their development without any significant challenges, research on the high rates of preschool expulsion due to challenging behaviors (Gilliam 2005) coupled with

estimates suggesting that one in 10 children exhibit problem behaviors (Raver & Knitzer, 2002) underscores that this is not the case for all children. In fact, early childhood providers have increasingly voiced concerns about young children showing signs of serious emotional distress and have expressed the need for training and assistance around managing challenging behaviors (Knitzer, 2000). Behaviors include anti-social, aggressive actions toward other children; defiance; repeated disruption in class; and inability to transition between classroom activities leading to acting out.

Early Childhood Mental Health Consultation (ECMHC) is an approach to addressing challenging behaviors that also promotes social and emotional health and prevents the onset of more serious behavioral issues. This approach is gaining popularity among early childcare and education programs. Recent reviews of research indicate that ECMHC yields positive social and emotional outcomes for young children in early childhood settings, including reductions in preschool expulsions (Perry, Brennan, et al, 2006). Locally, the Quality Childcare Collaborative that provides these services, in the second quarter of FY 17/18, consulted on five cases. Two children were removed from childcare; one of those was removed from its current setting because the parent moved the child to another childcare provider. Only one was removed because the intervention was unsuccessful. In addition, research shows positive outcomes among early childcare and education program staff receiving consultation services, such as increased staff confidence in dealing with young children's difficult behavior's and overall improvements in classroom climate (Brennan, Bradley, et al, 2008).

Unlike traditional one-on-one therapeutic mental health services, ECMHC is primarily an indirect approach. Early childhood mental health consultants strive to improve children's social and emotional well-being by building the capacity of early childcare and education program staff, parents, and other caregivers to promote healthy child development and manage challenging behaviors. Consultants educate, train, and "coach" staff so that they develop the skills and confidence to effectively address children's social and emotional needs. Although the consultant may provide some direct services (e.g. observing children, conducting individual assessments, modeling effective practices), these activities are ultimately designed to enhance caregiver competence. In sum, ECMHC is both a problem-solving and capacity-building intervention (Duran, Hepburn, et al).

Role of the Behavioral Health Consultant in Sacramento County Program

- Perform variety of informational consultations with childcare and pre-school providers, including in-person, phone consultation, or emails with attachments
- For consultation on child with behavior problems
 - Perform Ages and Stages (www.agesandstages.com) screening on the child
 - One-on-one consultation with childcare and pre-school providers, training them on how to handle the behavioral problems the child is presenting
 - Meet with the child and sometimes with the parents
- Referral for services, if needed, to a variety of providers
 - Developmental issues probably causing the behavioral problems in age 0-3 referred to Sacramento County Office of Education Infant Development Program; in age 3+ referred to School District

- 0-5 cognitive problems referred to Family Resource Center Warm Line or Alta Regional Center
- More severe social emotional problems referred to Division of Behavioral Health Services Access Line

Recommendation

Expand ECMHC services provided to pre-schools and childcare providers using MHSAs Prevention and Early Intervention funds

- Increase the number of Behavioral Health Consultants
- Increase capacity to conduct group level trainings to pre-school and childcare providers on social/emotional issues in the classroom and strategies to overcome challenging behaviors

Screening and Referral Services for 0-5 Children

Goal: Prevent the development of serious emotional disturbances in children in future years

Screening and referral services for children age 0-5 who have developmental and behavioral problems, such as Help Me Grow, has been shown to be effective in preventing grade retention in school and placement in special education in elementary school for low-income children. (Reynolds, Temple, et al, 2001; Anderson, Shinn, et al, 2003.) Programs, such as Help Me Grow in Connecticut, improved language, cognitive, and academic skills thereby reducing the disadvantages that children bring to kindergarten and potentially carry throughout their school experience (Child and Health Institute of Connecticut, 2013).

Between 9.5% and 14.2% of children between birth and five years old experience social-emotional and behavioral problems that affect their language development (Qi & Kaiser, 2003) functioning, and school readiness (Cooper et al, 2009). Research shows that children who live in poverty are at an increased risk of developmental delay and learning disabilities. An especially vulnerable group is children in the welfare system who have experienced abuse and/or neglect. Estimates are that one fourth of these children younger than age three have significant delays in motor development, and even more have language and cognitive delays (Jaudes & Shapiro, 1999). Another group of children for whom early detection through screening is important are those at risk due to psychosocial factors, such as family and environmental conditions that impede optimal socio-emotional development, learning, and school readiness (Glascoe & Leew, 2010). Intervening before kindergarten saves society between \$30,000 and \$100,000 per child in academic and social services costs (Shonkoff & Phillips, 2000).

To assure that every child has the opportunity to develop along the top trajectory to school readiness, it is imperative to identify those with documented development delays and disabilities as early as possible. The gateway to assuring these children receive supports is early detection through screening. Moreover, their early connection to intervention services is essential (Child and Health Institute of Connecticut, 2013).

Target Population

Disadvantaged children, including children in foster care and in high need communities, such as those with high poverty rates or limited access to resources and services. Help Me Grow is currently serving the community at large.

Elements of Program

- Centralized Access Hub with toll-free number for parents to call into to request screening of their children 0-5
- Ages and Stages and Ages and Stages-Social/Emotional Screening Tools that are used on each child referred for screening
- Outreach by Screening and Referral Specialists to:
 - Child Protective Services case workers and foster family agencies to identify foster children in need of screening
 - Community centers, faith-based organizations, subsidized pre-schools and childcare providers and other appropriate entities in high need communities
- Do ACE-Q screening for children identified
https://pediatricsociale.fondationdrjulien.org/wp-content/uploads/2017/05/CYW_ACEQ_UserGuide.pdf
- For referred children, Screening and Referral Specialists conduct a home visit, or at location preferred by family, to meet with family and child to provide case management and develop a plan, which includes referral to resources and developmentally appropriate educational and social emotional activities to support the child's optimal development
- Follow-up with parents to ensure that they have been able to access services at referral agencies
- To ensure school readiness, the case management plan will help families with the transition from pre-school/childcare into kindergarten
- A Behavioral Health Consultant will be available to Screening and Referral Specialists to provide direct support for families experiencing challenges with their child's behavior and social emotional development. The consultant will provide the following services:
 - Help the families develop skills and strategies to deal with social emotional and behavioral challenges
 - Identify strategies and resources to be included in case management plan
 - Assess if there is a need for more intensive intervention; in which case, recommend accessing county mental health services
- Due to the diversity of Sacramento County's population, interpretation/translation services in a variety of languages will be needed to successfully support families and assist the Screening and Referral Specialists
- Maintenance of comprehensive set of community resources for referring parents and their children identified with development delays or behavioral problems

Recommendation

Expand screening and referral services for children age 0-5 who have developmental and behavioral problems using MHSA Prevention and Early Intervention funds

- Hire Screening and Referral Specialists
- Hire Behavioral Health Consultants
- Translation Services

AD HOC ADULT COMMITTEE

Goal: Increase number of Board and Care beds and mental health services for consumers in Board and Care facilities

Augmented Care and Treatment

Based on anecdotal information, the number of Board and Care homes has dropped from a high of 500 down to 10 over the years, creating a crisis in access to needed beds. Clients pay for living in Board and Care homes with their Social Security Income/State Supplemental Payment (SSI/SSP). SSI/SSP is insufficient to cover the costs incurred by the Board and Care operators (California Behavioral Health Planning Council, 2018) dramatically reducing the number of beds.

There is also a problem in the county with rising inpatient costs. According to any analysis by DBHS staff, the number of inpatient beds had increased 10% in the last three years. The Augmented Care and Treatment program would help with inpatient costs because it would facilitate placement of patients on involuntary holds at the Mental Health Treatment Center into community placements, thus preventing them from being placed on Administrative Day status. Patients on Administrative Day status no longer need acute inpatient services and are waiting for a community placement. They are using a very expensive level of care. A few patients already on Administrative Day status may be eligible for an Augmented Care and Treatment placement.

The idea of the Augmented Care and Treatment program is to create a fiscal patch that would increase the reimbursement to Board and Care operators, creating an incentive to keep their homes open. It would also require Board and Care operators to prioritize access to their beds for DBHS clients. The patch would also pay for additional mental health services for clients:

- 20-40 hours of life skills training
- coordination with outpatient providers

Recommendation

Establish an Augmented Care and Treatment program. Cost \$3 million in Community Services and Support funds

Maternal Mental Health Services

Goal: Increase services for maternal perinatal depression

The Sacramento Maternal Mental Health Collaborative made a presentation to the MHB in November 2018 on the unmet need for maternal mental health services. The collaborative has over 140 members with representation from all four county hospitals, pediatricians, midwives, obstetricians, nurses, therapists, social services, public health officers, people with lived experience, and many more. Its mission is to develop and maintain an equitable system of prevention, identification, and treatment services addressing the full spectrum of maternal mental health conditions in Sacramento County. At its retreat, the MHB established a goal of advocating for funding of the collaborative's mission. The goal was assigned to the Ad Hoc Adult Committee.

Characteristics and Impact of Maternal Mental Health Perinatal Depression

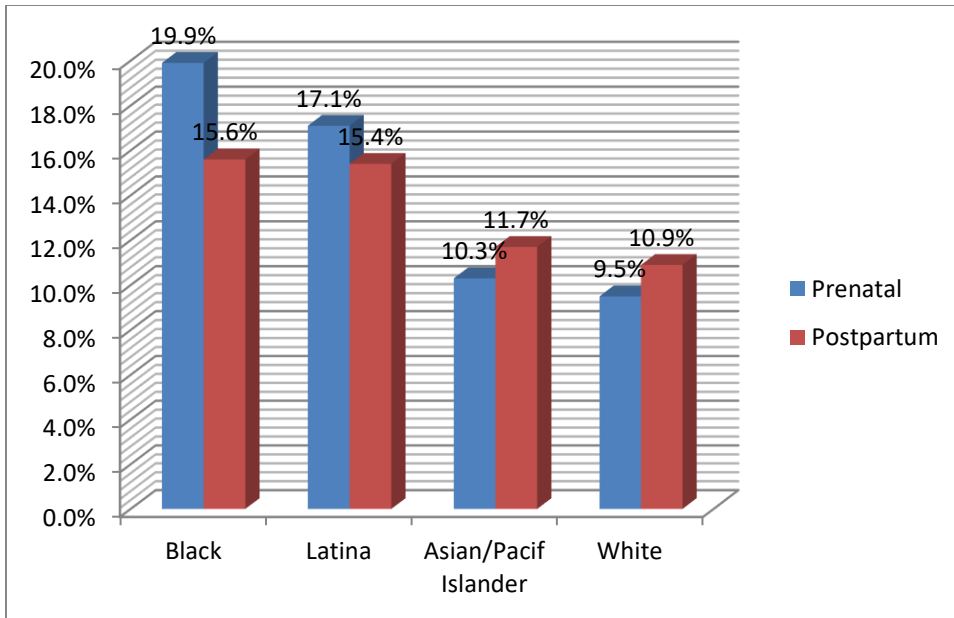
Perinatal depression is characterized by intense feelings of sadness, anxiety, or despair during or after pregnancy that lasts two weeks or longer and prevents women from doing their daily tasks. It can occur at any time from conception through one year postpartum. A serious pregnancy complication requiring treatment, depression differs from the "baby blues," which are common minor changes in mood that occur in the first few days after childbirth (California Department of Public Health, Summer 2018).

Depression at any point during the perinatal period increases the risk for mothers of chronic depression and suicide once the baby is born. It increases the risk in children of long-term cognitive and emotional development problems (California Department of Public Health, Summer 2018). Untreated maternal mental health disorders negatively impact the short- and long-term health outcomes of women and their children and often lead to:

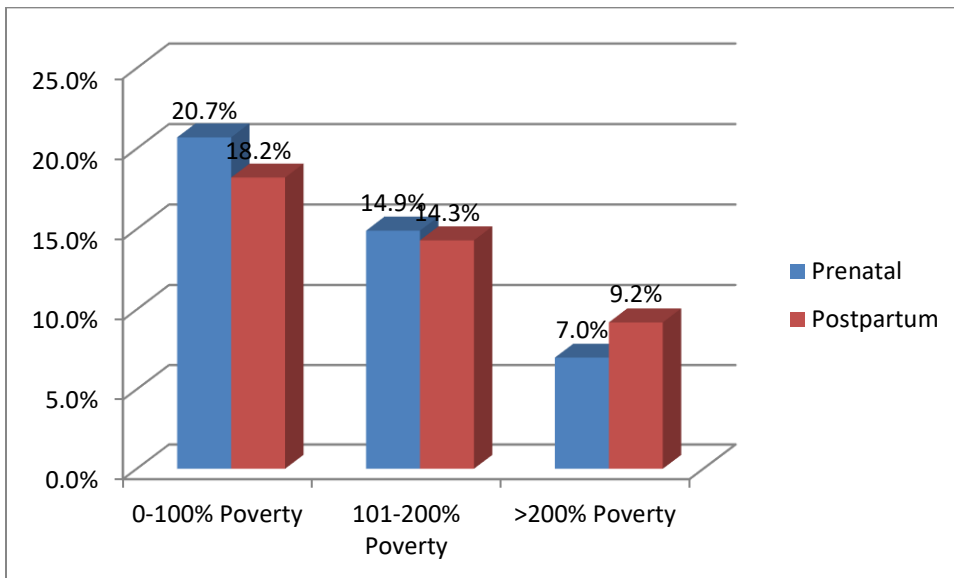
- Adverse birth outcomes
- Impaired maternal-infant bonding
- Poor infant growth; and
- Childhood emotional and behavioral problems (Satyanarayana et al, 2011)

Even mild to moderate distress during pregnancy can have serious adverse health effects on a fetus, and research suggests untreated depression and anxiety during pregnancy are a leading cause of preterm birth and low birthweight babies (Hobel et al, 2008).

Depressive symptoms are at least as common during pregnancy (14.1%) as they are postpartum (13.5%). There are ethnic differences in the rate for prenatal and postpartum depression. Black and Latino women experience the highest percentage of depressive symptom of all racial and ethnic groups during both the prenatal and postpartum periods as displayed in the following graph (California Department of Public Health, Summer 2018).



Poverty and low income are well-documented risk factors for maternal mental health conditions. In California, prenatal and postpartum symptoms of depression are highest among women with incomes below poverty. Prevalence of symptoms decreases as income increases as displayed in the following graph (California Department of Public Health, Summer 2018).



In Sacramento County, 18.4% of women overall experience perinatal depression. This rate of depression amounts to 3,500 women in the county (California Department of Public Health, Summer 2018). The cost to the county of not treating a mother with maternal perinatal depression is \$7,211, totaling \$25 million for the 3,500 mothers in the

county. In addition, the cost attributable to each child born to a depressed mother reaches \$15,323 (Diaz & Chase, October 2010). A detailed breakdown of the cost for mother and child can be found in Appendix B.

Statutes 2018, Chapter 755 (AB 2193, Maienschein) requires health care service plans and health insurers to develop a maternal mental health program designed to promote quality and cost-effective outcomes. The program shall be developed consistent with sound clinical principles and processes. A licensed health care practitioner who provides prenatal and postpartum care for a patient shall ensure that a mother is offered screening for maternal mental health conditions. One health plan has a case management program that lasts 90 days for most mothers experiencing perinatal depression.

Committee Process

The Ad Hoc Adult Committee augmented its committee membership with seven experts from the Sacramento Maternal Mental Health Collaborative to explore the needs of mothers with perinatal depression and to consider what programs would meet those needs. The committee recommends that early intervention and prevention programs be developed for those mothers.

Early Intervention and Prevention Programs

To reduce the percent of women who experience perinatal depressive symptoms in the future, attention should be focused on primary prevention activities (California Department of Public Health, Summer 2018). A recent Cochrane review of 28 preventive interventions for postpartum depression (Dennis & Dosswell, 2013) suggests women who received psychosocial or psychological intervention were significantly less likely to experience postpartum depression or depressive symptoms compared to those who receive standard care. Prevention and early intervention programs that increase social support are effective because social relationships in general are found to affect mental health through their influence on an individual's stress level, depression, anxiety, and psychological well-being (Kawachi & Berkman, 2001; Ornish, 1998). Research has demonstrated the association between maternal mental health and social networks where mothers with more supportive networks experience better mental health outcomes (Balaji & Claussen, 2007).

Prenatal prevention and early intervention groups would prevent the negative outcome of prolonged suffering resulting from untreated mental illness because it would prevent mothers from developing postpartum depression. Mothers at risk of developing maternal mental health issues are a chronically underserved population. Only 25% of women diagnosed with maternal mental health disorders receive further assessment and follow-up treatment (California Task Force on the Status of Maternal Mental Health Care, 2017). The location for these groups would be selected so they are conducted in a convenient, accessible, acceptable, and culturally appropriate setting.

Prevention and early intervention programs for postpartum depression delivered during the prenatal period have proven effective. Elliot et al (2000) conducted a study of the Preparation for Parenthood program. Participants were assessed to be “vulnerable” because they lacked social support and had a prior history of depression or anxiety. This group intervention consisted of meetings run by a psychologist. The first five meetings were scheduled prenatally, starting around 24 weeks of pregnancy. Six meetings were scheduled after the birth of the baby. The early sessions included material from audiotapes and videotapes on topics, such as the postnatal period and postnatal depression. Discussion was encouraged from the outset with the leader’s input gradually reduced so that the final sessions functioned as support groups with minimal leader input. Statistically significant results were obtained for the intervention. The Bedford College depression rate for the Preparation for Parenthood group was 19%, half that for the control group, which was 39%.

Another prenatal prevention and early intervention program is Mothers and Babies (Munoz & Huynh-Nhu, 2007). Participants had a history of a major depressive episode or depressive symptoms. This intervention was delivered to a low-income, culturally diverse population, which makes it particularly relevant to the Medi-Cal beneficiaries that would be the recipients of any MHSA Prevention and Early Intervention Program being proposed. The intent of this intervention was to teach participants to recognize which thoughts, behaviors, and social contacts had influence on mood, on health, and the benefits of strengthening maternal-infant bonding. The course was intended to prevent, not treat depression. Among the course content were modules on explaining cognitive behavioral theory of mood and health, increasing awareness of physiological effects of stress, increasing positively reinforcing activities, identifying and modifying cognitive distortion and automatic thoughts, and identifying and increasing positive social networks. “Homework” labeled as a “personal project” was assigned to intervention participants to give them an opportunity to practice monitoring their mood, identifying factors that influence their mood, (e.g. number of cognitive distortions), and using relaxation strategies. The intervention group had a lower incidence of major depression (14.5%) than did the comparison group (25%) although the result is not statistically significant. At 1-year follow-up, findings indicate a small effect size ($h=0.28$) for the intervention group with that group reporting fewer new cases of depression.

A brief psycho-educational group intervention for postnatal depression has proven effective (Honey et al, 2002). Participants screened positive for postpartum depression. The group consisted of eight weekly, two hour meetings. The intervention consisted of three components: (1) educational—providing information on postnatal depression; (2) strategies for coping with difficult childcare situations and eliciting social support; and (3) use of cognitive-behavioral techniques to tackle women’s erroneous cognitions about motherhood and provide strategies for coping with anxiety; and (3) teaching the use of relaxation techniques. The Edinburgh Postnatal Depression Scale (EPDS) was used to measure postnatal depression. This brief psycho-educational group intervention significantly reduced the EPDS scores on the when compared to those for women who received routine primary care. This effect was not related to antidepressant use and was maintained six months after the group had ended.

A prevention and early intervention program targeting women on public assistance is the ROSE (Reach Out, Stand strong, Essentials for new mothers) (Zlotnick & Tzilos, 2016). Participants were women who screened positive as being at high risk for developing depression. ROSE is an interpersonal therapy-based (IPT) intervention administered to women in small groups (3-5). It is highly structured, contains psychoeducation components, and IPT-based skills for improving relationships and building social supports that includes role-plays and homework with feedback. The intervention consists of four, 90-minute group sessions over a 4-week period and a 50-minute individual booster session within 2 weeks after delivery. At the primary outcome point six months after the intervention, 31% of the control group had onset of postpartum depression compared with 16% of the intervention group, a statistically significant result. Over the full 12-month of follow-up, 40% of controls and 26% of intervention participants had onset of major depression, with the difference between groups being marginally significant ($p=0.052$).

Another type of prevention and early intervention program would be a home visiting program. It would prevent the negative outcome of prolonged suffering resulting from untreated mental illness because it would provide treatment for depression to mothers suffering from depression. As has been previously established, mothers with maternal mental health issues are a chronically underserved population. Services in a home visiting program, which by definition are provided in the home, are in a convenient, accessible, acceptable, and culturally appropriate setting.

Ammerman, Putnam, et al (2013) conducted a clinical trial of In-Home Cognitive Behavioral Therapy (IH-CBT) in which they added cognitive therapy to a standard home visiting program. They used two home visiting models: the Nurse-Family Partnership and Healthy Families America. In the Nurse-Family Partnership, specially trained public health nurses visit first-time mothers starting early in the pregnancy and continuing through the child's second birthday. Healthy Families America offers at least one home visit per week for the first six months after the child's birth. Mothers in this study were postpartum and were diagnosed with a major depressive disorder. Mothers in the IH-CBT condition received IH-CBT+home visiting. IH-CBT was delivered in the home by two licensed master's level social workers. Treatment consisted of 15 sessions that were scheduled weekly and lasted 60 minutes plus a booster session 1 month posttreatment. Mothers receiving IH-CBT reported lower levels of self-reported depression, received lower clinician rating of depression severity, and demonstrated increased overall functioning over time relative to those in standard home visiting (SHV). The impact of IH-CBT was realized from pretreatment to posttreatment and maintained over the 3-month follow-up. For a major depressive disorder diagnosis, a significant effect for group was found ($p=.01$) such that, relative to those in SHV, mothers in the IH-CBT were less likely to receive a diagnosis at posttreatment (29.3% vs. 69.8%) and follow-up (20.5% vs. 52.6%).

Recommendation

Establish an MHSA Early Intervention and Prevention Program for maternal perinatal depression

AD HOC OLDER ADULT COMMITTEE

The older adult population in Sacramento County is going to increase significantly over the next decades as reported by the Area Agency on Aging Area 4 (AAAA4) (Tift, 2019). In 2020 the population 60+ will be 400,000 growing to approximately 440,000 in 2030, reaching 500,000 in 2040, and attaining approximately 560,000 in 2050. According to the AAAA4, centenarians in the region will increase by a factor of 15 from 2000 to 2040. In Fiscal Year 2017/18, the DBHS served 2,538 clients 60+, 2,004 of whom were Medi-Cal beneficiaries.

To identify the unmet need for older adults, the Ad Hoc Older Adult Committee met with the Older Adult Coalition (OAC). The OAC provides an educational forum regarding Sacramento County community-based services and supports to promote older adult mental health recovery. 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. In addition to input from this group, the Ad Hoc Older Adult Committee had a more focused meeting with a subset of the OAC members, including a gerontologist, representation from the AAAA4, adult day healthcare providers, an older adult advocate, and an expert on services to veterans.

Isolation and Loneliness

Goal: Reduce isolation and loneliness for older adults

At both of these meetings, many unmet needs were identified, such as affordable housing, transportation, long term care, lack of gerontologists, and need to train physicians on care of older adults. But, when both groups focused on issues amenable to mental health interventions, the issue that was uniformly expressed as the most significant unmet need is services for isolation and loneliness.

Many factors contribute to isolation and loneliness for older adults in today's society:

- The evolution of the nuclear family where multigenerational living is no longer common, leaving older adults to live alone
- Parents living alone because they do not want to be a burden on their children
- Older adults not wanting to reveal vulnerability for fear of removal from their homes
- People generally living longer
- Lack of available social supports

According to the AAAA4, another problem is the shifting Parent:Child ratio. The Traditionalist Generation (born 1903-1935) typically had a 4:2 Parent:Child ratio, which meant that the family could provide support to the parents. With the Baby Boomer Generation (born 1946-1964) the Parent:Child ratio is shifting to 2:4. This change is

occurring because Baby Boomers have typically had 2 children before, during, or after a series of marriages with other Boomers who may or may not have already had children of their own. This situation leaves 2 children with 4 parents to support, reducing the amount of support available from the children to any one parent.

Isolation and loneliness is a risk factor for suicide (Illinois Department of Public Health), which is a serious problem for older adults. In 2017 the suicide rate for adults 65-74 was 15.56%; for 74-85 it was 18.01%; and for 85+ it was 20.1%. These are among the highest rates for any age group (American Foundation for Suicide Prevention, 2017). White males 85+ are especially at risk with their rate over four times higher than the nation's overall rate of suicide (Mental Health America).

Recommendation

Increase MHSA Prevention and Early Intervention funding for programs that help to reduce isolation and loneliness in the lives of older adults.

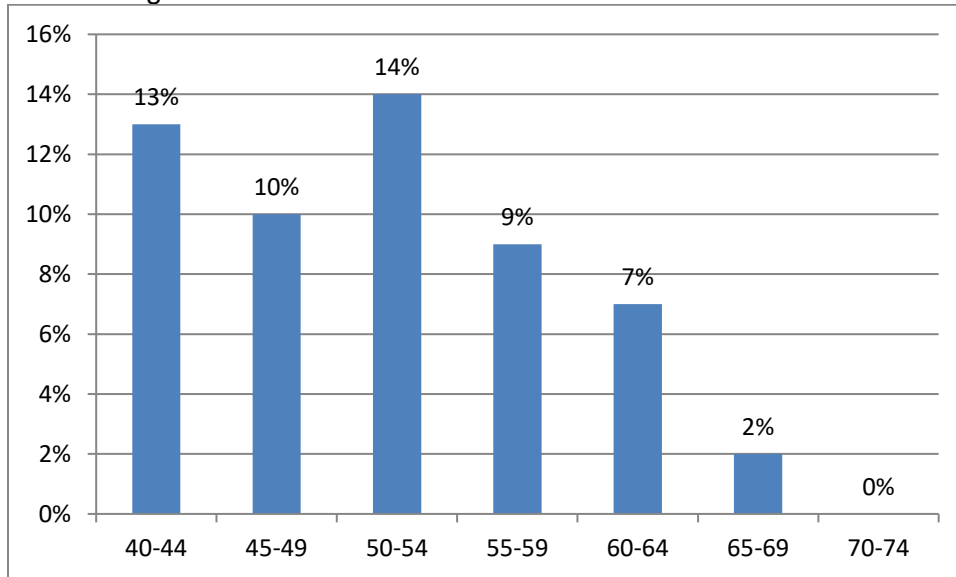
Homelessness

Goal: Reduce homelessness among older adults with serious mental illness

Two main reasons account for homelessness in later life (Baiocchi et al, 2019). First, some chronically homeless individuals are gradually maturing into older age after years of living on the street. Second, others are facing housing insecurity for the first time due to a sudden destabilizing event, such as employment change, divorce, or foreclosure (Burns et al, 2018). Many older adults are susceptible to housing insecurity given insufficient savings and retirement plans, but also due to the mismatch between the rapid increase in the costs of housing and fixed-incomes of most seniors who rent. (Baiocchi et al, 2019).

According to the 2019 Point-in-Time Count, Homelessness in Sacramento (Baiocchi et al, 2019), on a single night in January approximately 1,079 older adults (55+) were experiencing homelessness in Sacramento County, comprising 19.4% of the 5,570 total homeless persons in the county. However, there is also a clear decline in the number of unsheltered individuals over age 59. This pattern is consistent with a number of studies that similarly cite both the graying of the homeless population but also the clear underrepresentation of individuals in their 60's living on the streets. This pattern may be due in part to safety net programs targeting older adults that commence at age 65 (e.g., Social Security and Medicare), which improve an individual's ability to transition to secure housing (Baiocchi et al, 2019). Table 1 below shows the concentration of unsheltered homeless older adults in the 50-54, 55-59, and 60-64 age groups.

Table 1: Age Distribution of Unsheltered Adults 40 and Older in 2019



Source: 2019 Sacramento County Point-in-Time Count

An estimated 700 older adults were experiencing unsheltered homelessness (65%), while a total of 376 (35%) older adults were staying in shelters. The demographics of unsheltered older adults 55+ are provided in Table 2 below.

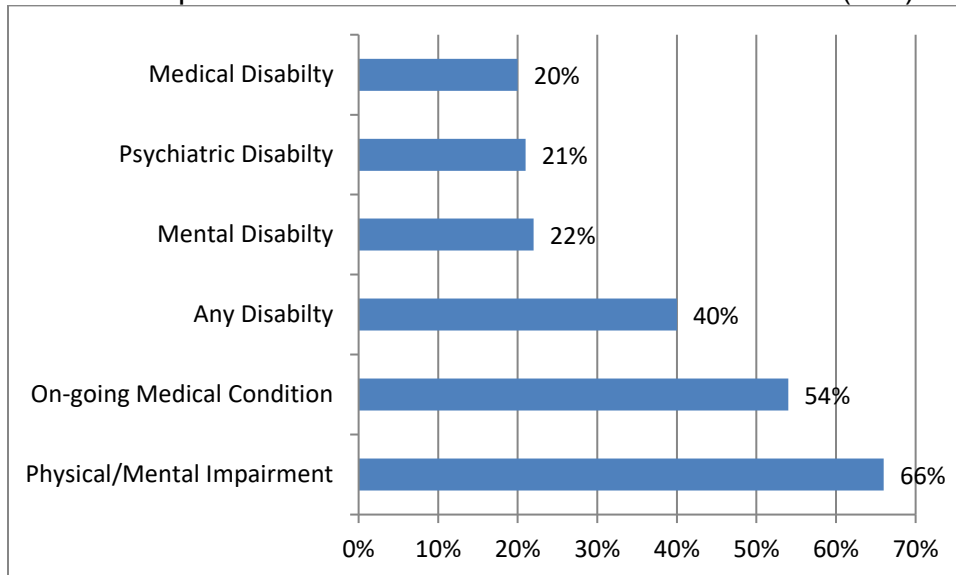
Table 2: Demographic Characteristics of Unsheltered Older Adults 55+

Demographic Characteristic	Percent
Gender	
Male	68%
Female	32%
Transgender	0%
Ethnicity	
Hispanic	8%
Non-Hispanic	92%
Race	
White	55%
Black	32%
Asian	0%
American Indian	4%
Native Hawaiian	2%
Multiracial	7%
Sexual Orientation	
Straight	89%
Gay or Lesbian	5%
Bisexual	1%
Other	4%
Refuse	2%

Source: 2019 Sacramento County Point-in-Time Count

Among older adults, overall 66% report some type of physical or mental impairment as reported in Table 3 below. Broken down more specifically, 21% report being affected by a psychiatric disability, which is consistent with national estimates of mental illness among homeless persons at 25% (Mental Illness Policy Org). At a rate of 21% of the homeless older adults reporting a psychiatric disability, that would total approximately 225 persons in the Point in Time Count.

Table 3: Reported Conditions of Unsheltered Older Adults (55+)



Source: 2019 Sacramento County Point-in-Time Count

In terms of solutions, older adults were adamant that affordable housing is a critical issue that needs to be addressed in the county (65%). Older adults were three times more likely to raise this issue than any other age group. For some respondents, this was the only issue that they raised. Older adults also discussed the need for rental assistance (18%) as well as better access to mental health programs (17%) (Baiocchi, A. et al 2019).

The DBHS has just received two awards for permanent supported housing from No Place Like Home grant funds. These projects will fund 87 beds for persons with serious mental illness served by the Mental Health Services Act.

Recommendations

The DBHS should allocate some of the new 87 units funded by the No Place Like Home grant for older adults with serious mental illness experiencing homelessness.

Sacramento County's Homeless Initiatives and the DBHS Homeless Services should increase outreach to older adults with serious mental illness experiencing homelessness.

Appendix A

Ad Hoc Children and Youth Committee

Tanya Kilpatrick, Chair
Dmitri Godamunne
Mike Nguy
Caroline Lucas
Dan Niccum
Ann Arneill, ex officio

Ad Hoc Adult Committee

Christopher Barton
Laura Bemis
Mike Nguy
Silvia Rodriguez
Mia Vivone
Ann Arneill, ex officio

Ad Hoc Older Adult Committee

Maria Padillo Castro, Chair
Mark Rodgers
Bryan Richter
Ann Arneill, ex officio

Appendix B

Total cost of not treating a depressed mother and her child

Cost of not treating mothers with depression	Amount
Lost income of mothers	\$7,211
Cost due to lost productivity	\$945
	\$6,223
Costs associated with a child born to a depressed mother	\$15,323
Cost of treating low birth weight (LBW) babies	\$6,283
Cost of pre-term deliveries	\$1,130
Loss of future income of babies due to LBW	\$3,522
Loss of future income of babies due to delayed brain development	\$2,465
Loss of future income of babies due to death of LBW child	\$1,577
Cost to the juvenile justice system	\$120
Loss in tax revenues (mother and child)	\$383

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