FRESNO COUNTY BEHAVIORAL HEALTH BOARD

ANNUAL REPORT

TO
BOARD OF SUPERVISORS

REPORTING ACTIVITIES FROM
JANUARY 2018 THROUGH DECEMBER 2018

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Introduction

The Fresno County Behavioral Health Board (BHB) can report to you that the dedicated staff of Department of Behavioral Health (DBH) provide good quality behavioral health services for Fresno County; however, they are handicapped by the lack of employees at all levels. The Department is unable to hire enough treatment providers to serve their many clients. Hiring and retaining medical staff has been a long-term problem, so DBH has contracted with Central California Faculty Medical Group to provide psychiatric and medical support services. Licensed clinicians often are not available, and when they are, applicants are looking for more favorable working conditions that may not be possible for county employees; perhaps more flexible schedules might make for more successful recruitment. Many programs are contracted out to private agencies, but writing Requests For Proposals (RFP) and managing existing contracts is time-consuming for the limited staff who also have other responsibilities. The Mental Health Services Act (MHSA), which provides funding for many behavioral health programs, requires extensive 3-Year Plans with annual updates to those plans; also required is community input, necessitating meetings and surveys, the results of which must be compiled, distributed, and included in the updates. All the while, the community and BHB are requesting more and more services.

Duties of the Behavioral Health Board

The Fresno County Behavioral Health Board strives to meet its obligations as defined in the California Welfare and Institution Code 5604.2:

- Review and evaluate the community's mental health needs, services, facilities, and special problems
- Review any county agreements entered into pursuant to Section 5650
- Advise the governing body and the local mental health director as to any aspect of the local mental health program
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process
- Submit an annual report to the governing body on the need and performance of the county's mental health system.
- 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.
- Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
- Nothing in this part shall be construed to limit it ability of the governing body to transfer additional duties or authority to a mental health board.

One of those additional duties in Fresno County is to consider all behavioral health programs, including those services for individuals living with substance use disorders.

Work of the Behavioral Health Board

Our BHB has struggled this year with the resignation of several board members. We appreciate those Supervisors who have appointed new members to join us in our work. It is difficult to accomplish those tasks that are deemed important without a robust board. This year we have made efforts to strengthen our board. BHB members gathered for a workshop in March for building trust, respect, and friendship among board members, while deciding on our 2018 Recommendation to your Board of Supervisors. (You previously have received those recommendations, but they are included in this report.) In June our board had a workshop led by a member of the California Behavioral Health Planning Council who trains behavioral health boards throughout the state. Her report also is attached to this Annual Report. The Board is beginning to address some of her concerns and recommendations; we have revised our meeting regulations and bylaws, which were sent to your board for approval. With her help, we also have developed a board evaluation for both self-evaluation and for the community's evaluation. The Board chair attended a meeting of the California Association of Local Behavioral Health Boards and Commissions to glean information about the work of other boards within the state, and to encourage the Association to bring meetings and trainings to the Central Valley, so that all Board members might attend.

To accomplish our tasks, the Board gathers and shares information in various ways. Each month we receive reports from the Director of the Department of Behavioral Health so that we are updated on recent plans, changes, programs, and activities. Included in these reports are Outcome Reports on selected programs. The Board attempts to select programs throughout the spectrum of behavioral health services provided to clients by DBH and its contracted providers; board members usually make site visits to the programs prior to receiving the Outcome Reports. The board has adopted a Site Visit Review form that is completed by one member during each visit, and is filed with both the board secretary and the DBH staff secretary; those reports are attached for your review. The BHB completes an annual Data Notebook provided by the California Mental Health Planning Council that delves into a specific service area; the recent notebook dealt with services for Older Adults, and also is attached to this report. Board members volunteer to sit on review panels for the selection of contractors who provide services to the clients of DBH. The BHB holds a Public Hearing on the Mental Health Services Act (MHSA) 3-Year Plans and Annual Updates. The board holds Community Forums in both the metropolitan area and rural areas to learn of community concerns; we feel that we are your liaisons with those citizens who are interested in behavioral health services. Of course, Board members attend meetings and activities throughout the community that involve behavioral health issues: stakeholder meetings related to MHSA planning, meetings

involving Veterans' Affairs, volunteer positions at behavioral health programs, National Alliance on Mental Health (NAMI) meetings and support groups, Cultural Competency councils and committees, meetings for families dealing with substance use disorders, church groups providing support for living with behavioral health issues, and groups for parents of young children.

Subcommittees

Our board learns significantly about the needs, services, facilities, and special problems, through the work of our subcommittees. These committees identify barriers to services and attempt to find ways in which concerns may be addressed. Attendees include board members, service providers, family and community members, and clients. Often when providers from different agencies and/or departments attend, they have opportunities to work together on methods to improve their services to clients.

The Executive Committee meets to plan the agenda for the monthly board meetings and other possible activities to be recommended to the full board. This committee also deals with issues of membership.

The Adult Services Committee meets 9 times per year, excepting Monday holidays. The Committee began 2018 with follow-up from the meeting ending in 2017, when we received a disappointing report from a representative of the Department of Rehabilitation (DOR) about their lack of supportive service to provide employment opportunities for individuals with serious mental and behavioral health disorders. The committee invited the Deputy Director of DBH to tell about the employment opportunities provided by the Department and its contracted providers. The Supportive Education and Employment Program (SEES) was established by the Department to assists clients by linking them to colleges and by preparing them for competitive employment; unfortunately, most clients of DBH need more support than is available to achieve and succeed in competitive employment. DBH is planning to put out a Request for Proposals (RFP) for a program to provide job development, job placement, and job coaching; our committee, and the full board, is anxious to see the results.

The committee turned to the Social Security Administration (SSA) that has a Ticket-To-Work Program for recipients of disability income, and was dismayed to learn that this program is contracted to DOR, which we already had learned does not have the resources available to serve those with Serious Mental Illnesses (SMI). During the SSA presentation the committee learned more about Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), which are financial safety nets for individuals with behavioral health disorders. A participant from the Department of Social Services (DSS) provided information about their Welfare-to-Work program for individuals with children; those with behavioral health disabilities are referred to Pathways to Recovery, where they are provided services

to help them obtain employment. The committee would like to see a similar program for clients without children.

The committee invited representatives from Central California Legal Services to speak about their services. Attorneys are available to assist low-income people with non-criminal legal issues; not surprisingly, 70% of their cases are related to housing. Clinica Sierra Vista representatives spoke about their new Behavioral Specialty Mental Health Clinics, where clients may receive integrated care for medical and mental health concerns, and even dental care—one-stop shops for all health needs.

Committee participants are concerned about clients with co-occurring mental health and intellectual disabilities receiving the services that they need. The Director of Central Valley Regional Center (CVRC) attended a meeting to explain what services CVRC is able to provide and how to access those services. CVRC does not provide direct services but links clients to appropriate services and pays for those services. To be eligible for services from CVRC, individuals must have been diagnosed with a developmental or intellectual disability prior to age 18. It often is difficult to locate documentation proving an early diagnosis, but with school and medical records and personal interviews, individuals may be found eligible for services. DBH staff meet regularly with CVRC staff to overcome barriers to services for clients with intellectual disabilities and mental illnesses.

While this committee has many interests, this year providing employment opportunities for clients has been a high priority, which reflects one of the Board's 2018 Recommendations: **Establish an employment program with job development, job placement, and job coaching to assist individuals with behavioral health disorders find and keep jobs.**

The Children's Services Committee is a joint committee with the Foster Care Standards and Oversight Commission Behavioral Health Committee. This committee meets bimonthly and focuses on all children, including foster children, with behavioral health disorders. At each meeting the committee receives a report from the DBH Division Manager of Children's Services; the committee also invites speakers on particular topics of concern.

The committee extends its reach to the Transitional Age Youth (TAY) population, which includes young people, ages 16-24 years. There are 2 teams that work with TAY clients—a DBH team that sees young people with less severe conditions and the Full Service Partnership (FSP) program that works with individuals with more barriers to recovery. Most clients of DBH TAY live with their families and have some support; those in the FSP, many of whom are former foster children, do not have as much support and are in desperate need of housing—just like the adult population.

The Child Welfare Mental Health Program was the result of the Katie A. lawsuit and requires that all children who enter the child welfare system be assessed for mental health disorders. The Children's Committee receives periodic reports on the progress of this program, which is a joint DSS and DBH effort. There have been concerns about the length of time it takes for children to receive services. The committee invited staff members from Social Services to provide information about their work, because there seems to be a glitch causing delays and incomplete referrals. There was agreement between DSS and DBH staff to work together to solve issues that were leading to these delays, so that children could receive services more quickly.

As the committee learned more about the Continuum of Care Reform Act (CCR) and its requirements to place foster children in permanent family homes, rather than in group homes, it invited a representative from the non-profit organization City Without Orphans to attend a meeting to tell about its mission to equip and partner with churches, families and service providers to help all children to be placed in a loving homes. This organization supports adoptive and foster families by providing educational classes, support groups, and even occasional respite care. Another area of concern, that transcends children's services to include adult services, as well, is care for individuals with co-occurring intellectual and/or developmental disabilities and behavioral health disorders. The Children's Committee invited the Director of Central Valley Regional Center (CVRC) to educate members about the services that it provides. Case managers at CVRC help families and clients navigate the system of care so that clients receive the services that they need. Committee members especially were concerned about the barriers to services for children in the Foster Care System. It was agreed at this meeting that DBH staff would meet with CVRC staff to overcome these barriers, so that all qualifying children will be served.

In response to an annual External Quality Review, in 2016, DBH began a Performance Improvement Project (PIP) to reduce the readmission rate of children released from inpatient psychiatric hospitals. The Committee received a report on this two-year study. Through some trial-and-error, a plan with improved care coordination, through better communication, with a 7-day follow-up assessment, and short-term therapy until transitioned to ongoing outpatient treatment services, the readmission rate declined *for children not already linked* to outpatient services. The children in the study had been patients in Star Behavioral Health Psychiatric Health Facility (PHF) that serves youth 12-17 years of age. Given the Boards concern about services for younger children, Department staff were asked if younger children released from hospitalization were eligible for services under this project, and replied in the affirmative. This project was so successful that the Department was asked to present the project study to the full Board.

The Justice Committee meets bimonthly and studies different issues related to the care of individuals with behavioral health disorders who are involved in the legal

system. Conservatorship and the client's legal rights were discussed with a Patients' Rights Advocate (PRA), who has responsibility to investigate and resolve complaints from individuals regarding rights violations, and to monitor facilities for compliance with patients' rights laws, regulations and polices. He explained about involuntary psychiatric holds and review hearings, and the Advocate's duty to represent the client's "expressed interest," which may not necessarily be their "best interest"—a frustration to families and service providers.

The Committee learned about the process for those referred by the court to the Misdemeanor Incompetent to Stand Trial (MIST) Program; the county is responsible for restoring these individuals to competency. Currently, Crestwood Healing Center in Kingsburg is certified for a treatment program to serve these clients. It might be noted that restoring the competency of those accused of felonies is not the responsibility of the county, and individuals usually are sent to state facilities until they are deemed competent to stand trial. The Probation Division Director attend a meeting to talk about the work of his department related to AB109/Public Safety Realignment Act, which released lower level offenders from prison to serve their time with supervision in the community. For those individuals with behavioral health disorders The First Street Center was created by Probation Department and DBH to assess and to serve their needs for treatment; for those assessed with Serious Mental Illnesses (SMI) a Full Service Partnership was develop to offer more intense services. The participants in the Justice Committee and members of the Board are pleased that California Forensic Medical Group (CFMG) recently was contracted to provide health services in the Fresno county jail and at the Juvenile Justice Campus. There always has been concern about the quality of care provided to our community members who are incarcerated, especially for those with SMIs. The leadership of CFMG attended a committee meeting so that participants could meet them and learn a bit about their philosophy for the care of inmates. The Board is hopeful that their services will be an improvement over what inmates have experienced in the past. The BHB will invite representatives to attend and report to the full board after they have had more time on the job.

Committee participants learned about the new Friday Court, a specialty court for juveniles who are victims, or at-risk for becoming victims, of human trafficking. At this point the court is focusing on sex trafficking, but might be willing accept victims of labor trafficking. Like other specialty courts, there is collaboration between the judge, District Attorney, Public Defenders, Probation officers, and DBH therapists. It was noted that there needs to be education in the community and training for service providers so that they understand and can work more effectively with these youth. At this meeting DBH staff agreed to plan with court staff the necessary training for staff working with juveniles involved in human trafficking.

Unfortunately, our Substance Use Disorders Services Committee has been suspended due to the lack of leadership to chair that committee. Hopefully, with new additions to the Board, this committee can be revived.

Site Visits

One of the most informative means used to review and evaluate behavioral health services in our county is by conducting site visits to programs. Being on-site often is more telling than oral or written outcome reports. The board generally conducts a site visit each month, and receives the written outcome reports at its monthly meetings.

Crisis Services

Since crisis services always are a top priority of the Community, the BHB began its site visits for the year 2018 at the location where many clients of DBH first obtain behavioral health services—the Exodus Crisis Stabilization Center (contracted with Exodus Recovery, Inc.). The Crisis Center serves both adults and children; of course, the centers are separate to insure safety for all. Most individuals are brought in on involuntary holds (W&I Code 5150). Goals are to stabilize clients through psychological evaluations, medication clinics, and discharge planning for return to the community. Clients are released when they are deemed "stable" and no longer a threat to themselves or others. Ideally, clients have been linked to community services that will help them live successfully in the community without readmission. Most children return home to families, again with linkages to treatment and support systems that assure a successful transition. However, when necessary, clients are referred to inpatient psychiatric health facilities.

After many years Fresno County now has an acute inpatient psychiatric health facility (PHF) for adolescents; the Youth PHF (contracted with Central Stars Behavioral Health Group) is adjacent to the Children's Crisis Stabilization Center on the Kings Canyon Campus. The Board visited this facility in February. The board was impressed with the staff and the program that they provide for children ages 12-17 years. It might be noted that the Central Stars PHF has only 16 beds, is often full, so children of all ages may be sent out of the area for further treatment. Our county still is lacking an inpatient facility for younger children, who, if necessary, must be sent to hospitals elsewhere in the state. This missing piece in our system of care led to the BHB recommendation to your board: **Establish specific services for families with young children (under age 12) who need inpatient services or follow-up to inpatient services.**

The Adult PFH (contracted with Exodus Recovery, Inc.) provides inpatient treatment to individuals who, after mental health crises, need additional care and cannot be released safely into the community. In August your BHB conducted a site

visit at this program; we found that staff there are dedicated to the recovery of their clients and provide the best treatment possible, with education about illnesses and medications, life skills, and community resources. The recidivism rates have declined significantly in the past year indicating a successful program. This facility also has only 16 beds, and often is unable to accommodate the demand for services, so many adults, too, must be sent out of county for treatment. The board learned that during the prior month 161 individuals had been denied admittance due to the lack of capacity. The expansion of the Crestwood Healing Center, a Mental Health Recovery Center (MHRC) in Kingsburg, has provided some relief, as will the new Residential Crisis Unit; however, there still is a need for more inpatient psychiatric beds in Fresno County.

It might be pointed out that these three programs all are located on the Kings Canyon Campus, at Kings Canyon Road and Cedar Avenue, in an antiquated building that needs renovation and repair. Outpatient services also are located on this campus in similar buildings. If these essential behavioral health programs are to remain at this location, there needs to be a financial investment in improving these facilities.

Outpatient Services

Once discharged from inpatient services, adults may be referred to DBH Outpatient Services, which provides psychiatric care, medication, therapy, case management, and peer support. Many adult services are at the Kings Canyon (Metro) location. Recently the Transitional Age Youth (TAY) and the First Onset Teams have moved to the Heritage Center, located at Millbrook and Shields Avenues. The Older Adult Team is located at the Senior Resource Center, adjacent to other services for senior citizens at 2025 E. Dakota. Clients who have greater needs are referred to Full Service Partnerships (FSP) for intense, 24/7 wrap around services. FSPs, including those for individuals with co-occurring substance use disorders, are contracted out to service providers in the community. Contracted providers also provide outpatient behavioral health services in the rural areas of Fresno County.

The California Behavioral Health Planning Council asks behavioral/mental health boards throughout the state to study particular aspects of local behavioral health care, to answer questions, and to complete a Data Notebook. The Board received the 2017 Data Notebook in early 2018 and began to study the year's topic—Older Adult System of Care. The board, with the help of Department staff and a site visit to the Older Adult Team, completed the Data Notebook, which is attached to this report. During our site visit we determined that our older adults are receiving good behavioral health care, including access to a geriatric psychiatrist, via telemedicine. The goals for the program are to prevent hospitalization and incarceration, to reduce isolation by connection to family and to community programs, to link to primary care physicians for medical issues, and to build self-sufficiency. However, the program is limited by lack of staff and space; at the time of the board's visit, the program was at capacity. Of particular concern was the safety issue of being located

on the second floor of the building; in case of an emergency, it would be difficult to move all clients down the stairwell. The BHB has recommended that the Older Adult Team be relocated to first floor space.

Housing

Housing for individuals with behavioral health disorders is a major concern, not only in Fresno County, but also throughout California and the entire county. The BHB has focused on permanent supportive housing as one of its priorities, as indicated by its 2018 Recommendation to your board: **Move forward with a permanent supportive housing project available to all clients of Department of Behavioral Health.** However, recognizing that all housing is important, the Board has requested quarterly reports from the Department on the progress towards improving the supply of all types of housing. When community members think of housing, they may think only of homeless individuals, but families and clients of behavioral health services think of housing to meet their particular needs, too. No type of housing meets the needs of all, so DBH organized a Housing Workgroup to focus on both the quantity and quality of housing for their clients at all levels of need. A BHB member attends these quarterly meetings.

There are plans and programs for emergency and temporary housing for those vulnerable individuals and for those awaiting housing availability. Board and Care (B&C) Homes provide the highest level of housing for individuals living in the community. While these homes are licensed, many do not provide the level of care that their residents need and deserve. DBH is meeting with B&C providers to support the expansion of services and to increase the number of available, high-quality homes. Many clients who are more independent live in Room and Board (R&B) Homes, where generally management provides meals and some support for their residents. R&B Homes are not licensed, which allows poor-quality homes to exist. DBH has contract with Independent Living Association (ILA) to work with R&B providers, on a voluntary basis, to improve the quality of their homes. Providers that agree to participate in the program must adhere to quality standards and best practices. Homes that are members of ILA will be given priority for placement of DBH clients.

Permanent Supportive Housing is the goal for many individuals with behavioral health disorders who are able to live independently. Having a permanent home with support staff available when needed is a dream for clients and their families. There are few units designated for DBH clients, thus the push for additional inventory. Years ago MHSA, along with the Housing Authority, funded the Renaissance developments at Trinity, Alta Monte, and Santa Clara, but those provide only 69 homes to homeless individuals, or those at-risk of homelessness. To expand the numbers, MHSA funds a contracted master-leasing program recently increased to 75 units. These programs meet only a small fraction of the need. DBH has received a grant for technical assistance to plan, design, and strategize for the

development of permanent supportive housing under the No Place Like Home Initiative (NPLH). Homes developed and funded under this initiative will use a "housing first" approach for individuals, both homeless and at-risk of homelessness, living with mental illnesses.

DBH contracted with Corporation for Supportive Housing (CSH) to assess and evaluate the existing supportive housing projects in Fresno County. While CSH only visited two sites, they did talk with staff and residents at other properties. They found that well-meaning staff did not understand the concept of the "housing first" model and were unsure of their responsibilities. Training on service delivery for on-site staff was highly recommended. Additionally, a breakdown in communication between the Housing Team and Clinical Team has resulted in the lack of timely referrals, and therefore, lost opportunities for housing for DBH clients; the Housing Team and the Clinical Team must work together to clarify the procedures to secure housing for as many clients as possible. The MHSA Annual Update creates the Housing Access and Resource Team (HART) that should solve some of the difficulties in communication.

The Renaissance at Santa Clara housing program was of major concern to CSH, as it has been to BHB since its inception. Santa Clara has the challenge of being in a neighborhood inundated with homeless individuals with multiple health and social issues, located directly across the street from Poverello House. (It might be pointed out that the Mental Health Board (MHB) recommended against building in this location.) The MHB and, more recently, the BHB have visited and expressed concerns about the safety of residents. Currently, on-site DBH staff are available five days per week, 8:00 am-5:00 pm, with a Housing Authority manager available 40 hours per week. Security staff is on-site from 4:00 pm-8:00 am, and all day on Friday. CSH recommended 24 hour/day staffing to protect residents from drug trafficking and violence, stating: "Overnight and evening staff would serve to mitigate inter-personal conflicts, limit unwanted visitors to the building, provide crisis intervention and general milieu management, and offer informal counseling to tenants." In response to this report, in September the BHB conducted a site visit to this location. Renaissance at Santa Clara is an oasis surrounded by a myriad of social problems that often spill over into the apartment complex. The biggest obstacle to the program, identified by staff, is substance use disorders of residents and the resulting behaviors; it is hard for many to avoid using substances when their use and availability surround their home. Prior to living at Santa Clara, most residents were homeless or at-risk of homelessness. The goal of the supportive housing staff is to help residents maintain their housing, offering whatever services and support are needed to achieve that goal. Though on-site staff say that many former problems at the site have been resolved, the BHB supports the recommendation of CSH for 24/7 support staff, as well as security, to assure the safety and success of the residents.

Substance Use Disorder (SUD) Services

Since the creation of the new board that united the Mental Health Board and Alcohol and Drug Advisory Board (ADAB), the BHB's responsibilities have include those services for individuals living with substance use disorders. DBH has overseen SUD services for many years. Most SUD services are contracted out to community providers. During the last two years the Department has been in the process of planning a reorganization of SUD services under a new Drug Medi-Cal-Organized Delivery System (DMC-ODS). The California Department of Healthcare Services has approved Fresno County's plan, but has not finalized its own system, so implementation plans already developed have been delayed. Once operational the redesigned plan will expand services, providing more support to both clients and service providers. Programs will be developed for individuals with co-occurring mental health and SUD. The Board is excited by the expanded services that will be available to DBH clients.

To learn more about existing SUD services, the Board made a site visit to West Care Substance Use Disorders Residential Treatment Program. DBH contracts with West Care California to provide residential treatment for men and women with substance use disorders. Stays vary from 30 days up to a year. The program allows both women and men with children to be in residence. Goals are to develop abstention skills, get health care under control, become medication compliant, and develop vocational skills. Clients must be able to care for themselves and to participate in the program, so some individuals with SMI are not accepted into the program. There is a waiting list for DBH clients, but individuals may participate in the outpatient program until a spot is available. The completion rate is approximately 45%, which is high for SUD treatment programs.

The BHB also visited Pathways to Recovery, which is the one SUD program operated by DBH. The program is located on the Kings Canyon Campus. In the past this program served Cal-Works clients from the Department of Social Services (DSS) who had mental health and substance use disorders. Clients were required to complete a 6-month program in order to qualify for General Relief. With the Drug MediCal redesign, DBH plans to transition this program into a co-occurring program for its own SMI clients with SUDs. The Memorandum of Understanding (MOU) with DSS has ended; DSS is contracting elsewhere for services for clients with mild to moderate mental health disorders, and the Pathways program is accepting only clients with SMIs, most of whom are clients of DBH. An interesting aspect of the program is the Family Development Center, which includes a nursery and pre-school. This Center not only provides childcare while parents are in programing, but also serves as an early intervention program for children and teaches parenting skills to mothers and fathers. It will be interesting to see how the new program develops to serve the needs of those individuals with co-occurring conditions.

Children's Outpatient Behavioral Health Services

Much information regarding Children's behavioral health services is gleaned from presentations and from regular updates by the Division Manager of Children's Services at the Children's Services Committee. In addition, the Director of DBH gives periodic updates on children's services at BHB meetings. Most DBH outpatient services are provided to children at the Heritage Center. Many contracted programs provide services to children in the community—at schools, in homes, or at other locations. Contracted programs also provide behavioral health services to children in rural areas of Fresno County. The Board conducted a site visit to Children's Outpatient Behavioral Health Services at the Heritage Center during this calendar year. This program is housed in the old Valley Children's Hospital, along with DBH offices and administrative staff, and other county programs. It is a maze of hallways and offices; however, staff is making it work for their clients.

The Board learned that DBH offers a variety of outpatient mental health services for children ages 0-18 years. The Youth Wellness Center is a walk-in service for children to be assessed and seen, as quickly as possible, depending on need, by clinicians and psychiatrists; no one is turned away. The Child Welfare Team (Katie A.) works with those involved with Child Protective Services (CPS), the foster care system, probation, and other court referred children. Expansive day treatment for youth ages 12-18 years offers intensive mental health services in a structured setting. Childcare for ages 0-12 years is available for families who need this service during appointments. DBH provides outpatient infant mental health for ages 0-5 years. Some school-based services for local and rural students also work out of this site. The biggest challenge for Children's Services is the lack of qualified staff, which is a problem throughout the Department.

The Perinatal Wellness Center helps mothers and fathers who are experiencing symptoms of Perinatal Mood and Anxiety Disorders or Post-Partum Depression. The Board had a site visit to the Center, located at the West Fresno Regional Center. The dedicated staff provide services in the office, in the home, or at any other location in the community. The goal is to reduce symptoms and shorten the recovery period, by teaching coping skills and self-management for wellness and recovery. Obstacles to treatment and recovery include, substance use, transportation, and stigma, in addition to lack of commitment by clients. Staff was happy to report that there have been no suicides by parents or harm to infants by those clients active in this program.

Community Collaboration

The Board is concerned about housing for all residents with behavioral health disorders, but the homeless population is a critical concern for the citizens of Fresno County. To address this concern The Multi-Agency Access Program (MAP) was formed. MAP is a joint venture, including several community agencies; DBH has been a leader in this project. MAP serves individuals with mental illnesses,

substance use disorders, or physical illnesses who need help in meeting their needs. Most clients are homeless or at-risk of homelessness, and lack the services that they need to live successfully in the community. Individuals may go to a MAP point for assessment and meet with a navigator who guides and links them to the services that they need and offers support, including accompanying clients to appointments and helping with necessary paperwork. Once linked, a case manager from the appropriate agency continues to assist until the individuals obtain the services to meet their needs.

Housing is often a major need, so the program works on a "housing first" model, while connecting individuals to other health and social services that are needed; many are referred to DBH. Of course, there is not enough housing to meet the need, so agencies work with a vulnerability scale to determine which individuals to house first. This is where temporary housing, including motel vouchers, is useful. The MAP project has been extremely successful, and has expanded from its original location at Poverello House, to consist of ten "points," including a mobile food truck that travels through parts of the rural areas in Fresno County.

Recently a coalition was formed between the City and County of Fresno to address homelessness systematically in our county. Street2Home is an attempt to share leadership for the solution of the complex issue of homelessness. DBH will be a partner in this new collective to share experience and knowledge, and to work towards addressing the housing needs of its clients.

Another collaborative effort by DBH is its partnership with Fresno County Superintendent of Schools (FCSS). Joint leadership is through DBH-FCSS Partnership Steering Committee. This integrated plan will expand behavioral health services for youth ages 0-22 years. It is based on a Hub and Spokes model with clinical staff, who serve a region, located at the Hub; the Spokes are the satellite sites surrounding the Hub. Services can take place in schools, in homes, or in the community. The first two Hubs will be in downtown Fresno and in Firebaugh. This innovative partnership has been approved and is in the organizational and hiring stages. Service delivery is expected to begin in early 2019.

After a number of teen suicides shocked the community, DBH was instrumental in organizing the Fresno County Suicide Prevention Collaborative. This dedicated group of individuals representing law enforcement, schools, hospitals, and public, private, and non-profit agencies came together to draft an action plan to reduce and prevent suicides in our county. The plan includes public outreach, understanding, education, training, early intervention, treatment, and stigma reduction throughout the community.

Cultural Diversity

Though your BHB is lacking in cultural diversity, it strives to represent all residents of Fresno County. Board members serve on the DBH Cultural Competency Committee and the Advisory Council for the Holistic Cultural and Educational Wellness Center (Holistic Center). Members often attend cultural events, such as the Hmong New Year, the Lao New Year, and Sikh festivals. In April the Board did a site visit to the Holistic Center. Members were impressed by the wide-range of services that it provides to culturally diverse residents in our county. When this program began, as an MHSA Innovations project, there were concerns that it would be unable to incorporate mental health education into a program for diverse populations who were reluctant to accept traditional services. The Holistic Center aids in participants' recovery by complementing traditional mental health care with cultural practices that support the whole person—mind, body, and spirit. Cultural Brokers are individuals with diverse backgrounds who represent traditionally unserved and underserved cultural groups. Every class or program has an intentional theme related to mental health; brokers explain and discuss the importance of mental health care. When needed, brokers refer clients to outside agencies for help with day-to-day issues, as well as to traditional physical and mental health services. This program that struggled in the beginning, has come into its own and is recognized for its effective means of sharing behavioral health care with the community that it serves.

Each year BHB receives a report from DBH on Cultural and Linguistically Appropriate Services (CLAS.) When the Board received the report in October, DBH reported that staff are working on the Cultural Competence Plan encompassing the entire system of care—SUD and mental health, in both county operated and contracted programs. DBH is working to ensure access to services in the threshold languages of Spanish and Hmong, and to recruit and certify additional bilingual staff. BHB will continue to support the efforts to provide behavioral health services for all clients.

Mental Health Service Act (MHSA)

As noted earlier many behavioral health services are funded by MHSA funds. The Board reviews these programs, as well. The board hears periodic sustainability and reversion reports regarding MHSA funds. Each year board members participate in the stakeholder process that collects information from the public about services provided, needs, and gaps in the system of care. After the annual update has been posted for 30 days for public comment, the BHB conducts a Public Hearing where members of the public may express their interests, concerns, and requests for changes and additions to the plan. Following the Public Hearing, at its regularly scheduled meeting, the Board comments, makes suggestions, and makes recommendations to your Board of Supervisors. This year the Public Hearing was

held on October 17, 2018, with the recommendation by the BHB that the Board of Supervisors approve the MHSA Annual Update 17-18.

Community Forums and Community Concerns

During the year the BHB hosted two Community Forums to hear directly from the public about their concerns. The first was held in central Fresno and was well attended by family members, interested community residents, and service providers. Their concerns are enumerated below.

The second forum was held in Selma. Residents and providers spoke about the lack of services in the rural areas. The number one concern was the lack of housing—all types: emergency, permanent supportive housing, housing vouchers, Room and Board homes, and Board and Care homes. Individuals often must move to Fresno to find housing, which separates them from their support systems, including familiar service providers, families, and friends. SUD services are lacking in the rural areas, forcing residents to look elsewhere for the help that they need. Homelessness also is an issue in the rural areas. Selma is fortunate to have a MAP Point located there, which has helped to reduce the homeless population significantly; this year the Point-in-Time Count indicated a 50% reduction in homelessness in Selma. The Rural Triage Team (contracted with Kings View Behavioral Health) serves Selma with clinicians to assist law enforcement officers with behavioral health related calls; the Selma Chief of Police, in attendance, was very grateful for these services. Additionally, a behavioral health clinic (contracted with Turning Point of Central California) is located in Selma to provide treatment for those who need services. Though still lacking services, Selma may be the best served rural area in Fresno County. The Board would like to see an expansion of services in Selma, and into other rural communities.

At these community forums, at other community meetings, and by personal contact, Board members repeatedly hear from the community about the lack of information concerning behavioral health services in our county. As a result of this community concern, the BHB made it the number one priority in its 2018 Recommendations to your Board: **Create a system to educate and inform families of behavioral health services that are available and how to access those services.** Whether to begin services before a crisis develops or to obtain treatment after a crisis, individuals, their families and friends, need help in finding the appropriate services and in navigating the system of care. Though the BHB has advocated for a method to disperse information to the community, efforts have been piece-meal, with no solid plan for providing information or roadmaps for navigating the system of care. There was a family advocate on staff for a number of years, but that position now is vacant, leaving community members without that important resource. DBH is making efforts to improve the situation; a new public information project described in the MHSA Annual Update is very promising. DBH also is planning once again to contract for one or more family advocates to assist families with obtaining care for

loved ones. Once linked to services, case managers are able to assist clients with their needs.

Another major concern of our community is the response of law enforcement officers during behavioral health crises. Citizens of our county are worried about their own safety and that of their loved ones who are in crisis. Law enforcement spends much of its time responding to crisis calls related to individuals with brain disorders. As a result, law enforcement agencies throughout the county have become committed to training to develop the skills to cope with behavioral health situations. We applaud their efforts. DBH established a pilot program to pair Fresno police officers with mental health clinicians to respond to calls relating to behavioral health. Soon they will be expanding this program by securing a contracted provider to supply clinicians to work with a team of police officers and sheriff deputies throughout the metropolitan area. Already there are is a similar program working in the rural areas of Fresno County. While no one wants to call law enforcement to respond to these crises, families often have no alternative in order to obtain services for their loved ones who are experiencing mental health episodes. Laws that were put in place to protect individual rights now often prevent the care and treatment that people need and deserve, so it is necessary to involve law enforcement in crisis situations.

Due to their mental illnesses, some individuals become involved in the criminal justice system; families and care providers are concerned about their care while in jail. When incarcerated in the Fresno County jail, individuals often receive inadequate care. The BHB is hopeful that the new provider (CFMG) of medical care in the jail will be more successful in providing appropriate care for those with behavioral health disorders, especially those inmates with Serious Mental Illnesses (SMI). A new Intensive Transition Team is being created to work with those individuals prior to and after release from jail to connect them to appropriate services in order to avoid recidivism. Additionally, a new MHSA Innovation plan will create a MAP Point specifically for the justice population to address the barriers to accessing behavioral health services for individuals involved in the justice system. DBH also participates in Collaborative Treatment Courts, including Adult Behavioral Health Court, Veterans Court, Family Behavioral Health Court (for juveniles involved in the criminal justice system), Adult Drug Court, Family Dependency Treatment Court (for those at risk of losing parental rights), and the new Friday Court that deals with juveniles involved in human trafficking.

There continues to be interest in the community for the implementation of Assisted Outpatient Treatment (AOT), otherwise known as Laura's Law. To qualify for AOT, an individual must have a serious mental illness, plus a history of psychiatric hospitalizations and an unwillingness to accept mental health treatment; in such case, a judge could require the individual to comply with outpatient treatment or risk being hospitalized. State law requires that each county Board of Supervisors authorize local implementation of AOT. Fresno County DBH has not made that request; however, there is a placeholder in the current MHSA plan for possible implementation at a later date.

Advocacy

Though "advocacy" is not listed among the responsibilities of the BHB, it is one of the most important services that the Board performs. Through our work on the board, members engage in advocacy at the local level and in the wider community. Our board has sent letters to Fresno City Council and to your Board of Supervisors, discouraging the approval of liquor licenses in areas already exceeding the recommendations of Alcohol Beverage Control Board. Letters have gone to pharmacies encouraging their support of the Lock-It-Up project that provides information on storage, including lockboxes, for prescription medication, and for the proper disposal of those medications. Our board has sent letters to state legislators in support of SB 906, and made support of its passage one of our 2018 Recommendations to your board: **Support SB 906 regarding certification for peer providers of mental health and substance use disorder services; when this legislation is passed, establish Certified Peer Support Specialist positions.** Unfortunately, the governor vetoed this legislation, so counties will need to establish some sort of training program for their Peer Support Specialists (PSS) until the state develops a certification program. Recently DBH provided an 80-hour training program for twenty-one PSS to hone their skills in working with clients. However, without a certification process, providers will not be able to bill MediCal for services that PSS provide. Through various activities outside of board meetings, members advocate for better services, and fight against stigma by participating in community activities, such as the NAMI Walk and SoberStock.

Conclusion

The Behavioral Health Board is an active group of individuals who represent the residents of Fresno County and help to ensure that they receive the best possible behavioral health services. Each year we make a few specific recommendations directed to your BOS and to DBH; these recommendations have been highlighted in this report. In conclusion, it should be noted that work has begun on each of the board's recommendations, but none have been completed at this time. The BHB will be anxious to see the progress on these particular items:

1. Create a system to educate and inform families of behavioral health services that are available and how to access those services.
The MHSA Annual Update 17-18 includes a new communication division to improve the dispersion of information about services and access to services to the community.

2. Establish specific services for families with young children (prior to age 12) who need inpatient services or follow-up to inpatient services.
Locally there is no inpatient hospital for young children. Parents still have few resources for their young children with serious mental illnesses.

3. Move forward with a permanent supportive housing project available to all clients of Department of Behavioral Health.
DBH continues to struggle with logistics for development of permanent supportive housing projects. Current supportive housing projects have been evaluated, and soon a Supportive Housing Institute will be formed to help develop, plan, and budget a supportive housing project. Regrettably this is a slow process when housing is needed now.

4. Establish an employment program with job development, job placement, and job coaching to assist individuals with behavioral health disorders find and keep jobs.
The current MHSA Annual Update includes a plan for an RFP seeking a contractor to provide employment opportunities for DBH clients. Still little has been accomplished in this area during the calendar year.

5. Support SB 906 regarding certification for peer providers of mental health and substance use disorder services. When this legislation is passed, establish Certified Peer Support Specialist positions.
As mentioned earlier, the Governor vetoed this bill. However, there is some hope that a new governor might be more willing to recognize and support the expertise of those with lived experience, and approve a bill for a certification process, as have 40 other states. The Board will continue to advocate for the approval of a certification process for Peer Support Specialists.

Your Behavioral Health Board supports and appreciates the work done by the Department of Behavioral Health, and though our priorities may differ slightly, our goals are the same in meeting the behavioral health needs of those living in Fresno County.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD

REPORT ON FRESNO COUNTY BEHAVIORAL HEALTH BOARD TRAINING

JUNE 2, 2018

BY SUSAN WILSON

MEMBER, CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL

LIAISON TO CALIFORNIA ASSOCIATION OF LOCAL BEHAVIORAL HEALTH BOARDS AND COMMISSION

SMW

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June 3, 2018

Carolyn Evans, Chair, Fresno Behavioral Health Board
By email
AND
Dawan Utecht, Director/Public Guardian, Fresno County Behavioral Health Department
By email to Christina Young, Executive Assistant

Carolyn and Dawan:

Attached is a report from our training of the Fresno Behavioral Health Board.

The Behavioral Health Board met on 6/2/2018 for a 4 to 5-hour training. The Board requested training in five specific areas:

- Duties of a local mental health board as defined in WIC Section 5604.2
- Development of an Action Plan
- Advocacy methods for delivering a message to a group or the public
- Board evaluation: introduction to a possible methodology for self-evaluation
- Recruitment of new board members.

In addition, I received a request via Christina Young from the Department of Behavioral Health Executive Team for a summary of the training to include an analysis of the Behavioral Health Board (BHB) response to the content areas, my overall assessment of their integration of the knowledge in each of the key content areas, and a summary/analysis of the effectiveness of the BHB.

My trainings are based on the foundation of effective partnership between the Board of Supervisors, the Department/Director, and the Board. Very early in our training Board members began to discuss issues in working with the Behavioral Health Department and asking for assistance in addressing those issues to form a productive partnership. The tone of the group was positive, the discussion was thoughtful and robust, and I think the training was effective and every person learned new information and participated fully. At the end, one person indicated that (s)he had not wanted to attend the training doubting the value of it and invited me back anytime for training because the training/time had been so effective and provided lots of opportunity for participation and discussion. Overall, you have a very hardworking board that really wants to do their job well. They feel very responsible for mental health services to the community. They worry that, as volunteers, they are not valued for the work that they do.

I have provided training to about 15-20 individual mental/behavioral health boards/ commissions in California over the past few years. I have reached many more in group trainings that I do every three months (northern CA, Bay Area, Los Angeles, southern CA). As a result I have seen and learned a lot about the Boards in CA. The report I attached is directed to the Board. I also have some thoughts for the Department:

- The Board needs more support from the Department staff. I know that is difficult in these times. The Board members should have assistance in developing agendas and in taking minutes for their standing committees, at a minimum. They indicated that they had told the Department that they would do those things because the Department does not have the manpower. The Board members are volunteers, and some have skills, others do not. A few people are carrying the load. They need support. I hope that you can work out a way to provide that support. This is the only Board I have seen that tries to do their own work.
- The Board needs support in their membership recruitment effort; they are down 7 members. I understand that the Board of Supervisors is the appointing body. Many Boards throughout CA have a partnership with the Board of Supervisors: the Behavioral Health Board recruits, interviews and makes recommendations to the Board of Supervisors. The Board of Supervisors appoints. I think the Department could be instrumental in helping that process develop effectively.
- The Board also needs support in "orienting" new members. They have developed an extensive manual full of necessary information. It would be great if the Department would copy about 10 of those manuals (7 for the members-to-be, and 3 for current members who do not have the manual).
- I feel that the Director needs to participate in the Executive Committee meetings even though I understand that you have been told by the Board Chair that you don't have to attend. Your guidance is crucial in agenda development and providing direction because the Director is a partner. In addition, I understand that minutes are not kept of the Executive Committee meetings and as a standing committee they must have minutes.

Thank you. I am available for further discussion by phone, email, text if you want to talk further or have questions.

Susan Morris Wilson

REPORT:

Every board member was present for the training although 2 members were not able to stay for the whole period: one individual was recording a program for Univision, and the other individual had a very brief appointment to attend. One board applicant was present and one person who is a client was present.

Every board member participated in the training and there was consensus on most of the issues. The group was in session from 9:00 a.m. to 1:30 p.m. and worked right through lunch. The discussion was positive, constructive, interested, and anxious to address what is perceived as a very strained relationship with the Director and Department. Some of the issues were several years old (some members have been on the Board for years) and some were based on the expectations/decisions made by the Board Chair last year and this year.

I have framed the goals developed by the Board earlier this year in terms of their roles and responsibilities pursuant to WIC Section 5604.2 to help focus on those roles and responsibilities. I also developed an Action Plan with the group to help them limit their attempt "to be all things to all people all the time", pointing out that currently there are 8 volunteers to accomplish all the tasks they have set out.

During the reflection period following the training and discussion, the following items were mentioned:

- The relationship with the Department of Behavioral Health is strained: most indicated that the relationship is not what it should be, and they want to do what it takes to make it better and to work closely with the Dept. to meet the needs of the clients of the Dept. and the community. Some indicated that they are volunteers and do not feel appreciated by the Dept.
- The action planning was good and really focused their attention on issues that need to be addressed, and about limiting the number of items to deal with each year. The Board has a page of goals that are important to them and need to be considered as well.
- It was great to hear different opinions from people and to learn more about other board members during the discussion.
- Need to explore using Rosenberg's Rules (League of Cities) as an alternative to Robert's Rules (too formal?).
- We need help from a staff person to support the Board and to take minutes for the standing committees. It is possible that some people resigned from the Board because of the workload?

I suggested to the Board that they establish a position of liaison to the California Association of Local Behavioral Health Boards and Commissions (also known as CALBHBC) and obtain funding for additional training (at no cost, includes hotel, food, travel, etc.) for one person quarterly through the CA Institute for Behavioral Health Solutions (also known as CIBHS). That training includes much of what I presented to them. It would provide Board members a chance to get to know other Board members from all over CA.

FRESNO BEHAVIORAL HEALTH BOARD GOALS (2017/2018 prepared in 2/2018):

WIC Section 5604.2 defines the role and responsibilities of the mental health board. The Board had a current list of goals they want to meet, and we discussed them in terms of their roles and responsibilities as one way of checking their current direction.

(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.

- Evaluate, review, and receive input on services within the county Behavioral Health system.
  - Receive *brief or written* reports at Behavioral Health Board (BHB) meeting on Behavioral Health Department (BHD) programs from the Director.
  - Participate in the development of Mental Health Services Act (MHSA) Annual Plan and Update.
  - Receive semi-annual reports on the MHSA sustainability/reversion
  - Visit programs and services in both rural and urban communities
- Develop and implement a plan for interactive exchanges with clients, family members and other interested community members:
  - Hold at least three community forums: (1) forum prior to BHB meeting; (2) forum at a metropolitan community location (TBA); and (3) forum at a rural community location (TBA). *Further discussion included the possibility of the forum being topic oriented and/or providing education on some pertinent issue to forum participants*
  - Act as a conduit of resources for clients, family members, caretakers and community member. *Further discussion included making the restart of the family advocacy program an urgent priority and assuring that the program is not diluted by having other activities assigned to it.*
- Encourage BHB representation on other community committees which deal with behavioral health issues.
- Support community events related to mental health and substance use disorders
- Encourage collaboration with community providers through BHB committees

(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.

- Contact the Board of Supervisors (BOS) annually via small groups and personal contacts
  - Submit an annual Report to the BOS
  - Attend BOS meetings on a regular basis
  - Recruit and recommend new members for the BHB to the BOS for appointment, emphasizing diverse representation, including clients and family members.

CONSIDER:

- Increase the visibility of the Behavioral Health Board by presenting the Annual Report in person as a presentation (versus a consent agenda item).
- Increase the visibility of the Behavioral Health Board by presenting the results of the Data Notebook in person as a presentation.

(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.

- (see 3 above) Contact the Board of Supervisors (BOS) annually via small groups and personal contacts
  - Submit an annual Report to the BOS
  - Attend BOS meetings on a regular basis
  - Recruit and recommend new members for the BHB to the BOS for appointment, emphasizing diverse representation, including clients and family members *(see Action Plan that follows)*.

(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.
CONSIDER:

- Cooperate with the appropriate staff of the Behavioral Health Department to complete the Data Notebook in an ad hoc committee of the Board. Present the final draft to the Behavioral Health Board for acceptance. Use the document for outreach to the Board of Supervisors and to other organizations/service providers in the community, for example the Data Notebook 2016/Youth and Transition Aged Youth could be presented to the Fresno County Board of Education.

(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.

OTHER GOALS:

- Conduct an annual BHB retreat annually for team building, setting goals etc.
- Provide an orientation and mentoring process for new board members
- Adopt a standing agenda for the coming year

CONSIDER:

- **Identify one meeting of the Board annually as the Annual Meeting.** Use that meeting to confirm the goals of the organization, review the bylaws of the organization and amend as appropriate, confirm the action plan for the Board for the coming year, evaluate the Board's performance during the past year and make recommendations for any appropriate changes, and set the Board's meeting schedule and locations, etc. *The Board indicated that they are interested in evaluating if the current time of the board meeting is best for members, staff, community.*

- **Develop an orientation process for new board members** that includes mentorship. The Board has a manual with good information in it but not everyone has the manual. Every member should have the updated manual.
- **REVISE the Fresno County Behavioral Health Board Meeting Regulations (effective 5/20/2018).** Nowhere on the document does it indicate that the Behavioral Health Board must meet all the requirements of the Brown Act. That is the basic document that they need to refer to. One specific area that requires clarification is the first paragraph that indicates that a meeting will be held without a quorum. Arguably, the Brown Act would indicate you must have a quorum to hold a meeting.
- **REVISE the Bylaws (undated).**
  - Specifically Article V Section 2 (a) needs to include the language of 5604 (d)(2) to reflect the exception for consumers. The reference is not adequate.
  - Specifically Article V Section 2 (b) might include what "recuse" means, i.e. that the member leaves the room during the discussion and vote as required by the Brown Act.
  - Specifically Article VIII Section 3 should be corrected to comply with the Brown Act. The Chair/Executive Committee cannot appoint members to the ad hoc committee. The board may wish to include a description/definition of the requirements of standing committees and the requirements of ad hoc committees. Many bylaws list their standing committees.
  - It common practice for Bylaws to indicate the date they were ratified/amended by the Board and the signature of the Secretary.

ACTION PLAN FOR 2018:

1. **In cooperation with the Board of Supervisors, fill vacant positions on the Fresno Behavioral Health Board as soon as possible.**
   Currently there are 8 of 15 positions on the Behavioral Health Board filled. The method for filling vacancies is for each of 5 Supervisors to appoint 2 members and the whole board to appoint to appoint 5 members at large.
   a. Meet with the Director of the Department of Behavioral Health to strategize about filling vacant board positions
   b. Meet with Sal Quintero to strategize about filling vacant board positions
   c. Meet with County Jean Rousseau to strategize about filling vacant board positions
   d. Develop a proposal to the Board of Supervisors for Behavioral Health Board involvement in the selection of members for the Board including the possibility of recruiting, interviewing and making recommendations to the Board of Supervisors on membership.

2. **In cooperation with the Department of Behavioral Health and the Director, schedule presentations by community-based service providers at least 4 times annually at the monthly Behavioral Health Board meetings.**
   Currently the Director of the Department of Behavioral Health makes all the reports on both services provided by her department and services provided in the community. The Board indicated that this reporting methodology was developed after an antagonistic interaction between the Board and a staff member reporting to the Board at a meeting. The Board would like to build their relationship with community providers by inviting them to present.
   a. Develop guidelines for community-based service provider presentations..

b. Develop an annual list of community-based service providers to make presentations based on the current interests of the Board.
c. Coordinate these agenda items with the Director and/or staff as necessary

3. **Develop strategies to work more closely with the Director of the Department of Behavioral Health and the Department.**
Currently the Director does not attend the Executive Committee Meeting of the Behavioral Health Board based on a request from the Chair. The Director provides all reports to the Behavioral Health Board due to an incident that occurred several years ago. The Chair of the Behavioral Health Board meets with the Director for about one hour monthly. The relationship between the Department and the Board is described by the Board as very strained. In addition, some Board Committees complete all their own work including developing agendas, writing minutes, etc. with minimal support from the Department as the Board has heard that the Department is not able to support them.
   a. Consider including the Director in the Executive Committee meetings that set the agenda for the Board meetings.
   b. Consider requesting reports from Behavioral Health Department staff on their specific responsibilities rather than receiving all the reports from the Director.
   c. Consider requesting assistance from the Director for staff for standing committees (currently the Executive Committee, the Adult Committee, the Children's Committee, the Justice Committee (has some support).

FRESNO COUNTY BEHAVIORAL HEALTH BOARD

REPORTS ON SITE VISITS TO VARIOUS BEHAVIORAL HEALTH PROGRAMS BY MEMBERS OF FRESNO COUNTY BEHAVIORAL HEALTH BOARD

JANUARY 2018 TO NOVEMBER 2018

Fresno County Behavioral Health Board Facility/Program Report

By: Brandy Dickey
Date: January 11, 2018
Facility: Exodus Crisis Stabilization Center
Address: 4141 E. Kings Canyon Ave. Fresno, CA
Program Supervisor: Ana Monreal

1 The staff: Nurses, Administration, Psychiatrists, Mental Health Workers take vitals, do assessments for crises, administer medication. Providers see patients for medicine
2 The individual Grievance Procedures are posted in the hallway along with the Patient's Rights Advocate number.
3 The typical treatment goal is to stabilize clients through psychological evaluations, medication clinics, group discharge planning for the return home or to an inpatient facility. The average length of stay is 18 hours.
4 The obstacles faced by this facility that make it difficult to achieve these goals are not enough chairs, treatment not given to patients, and communication between programs.
5 The agencies Board of Directors does include consumer members, and Exodus CEO is in recovery himself. They do not discriminate between MH or SUD.
6 They know when a consumer no longer needs services when the provider assessment clears them to leave. Consumers should have a support system in place either family or social workers or case managers. Consumers are released with a plan of care for future.
7 It has been undefined how many people were turned away because of lack of capacity (diversion). The exclusion criteria (doesn't meet criteria) is 1.978% a month. It has increased 3% in 2017.
8 The Medication Clinic allows staff to fill medications based on treatment and medical history. They can give 1-2 week up to 1 month of prescriptions based on need.
They do not like to place people on 51/50 hold because they like for consumers to walk in for help. The staff seems committed to "doing whatever it takes," to help a patient find their wellness.

1. My overall impression was that the staff at Exodus are concerned with the welfare and safety of the consumer, family members, and staff. I enjoyed the newly painted green walls that added color. Appreciated staff attention to safety and wellness. Impressed that the CEO was in recovery himself and has a personal connection to the facility and clients. This is a stabilization center, not a treatment center.
2. The following recommendations were made by the BHB:
A) Brandy Dickey- Consider enlarging this facility or moving it to accommodate the needs of our population. Further the use of information sharing, accountability, and responsibility between departments and providers. Consider using MHSA money to extend these services also.
B) Renee Stiltson- Liked the "whatever it takes attitude," suggested landscaping improvements.

C) Katie Rice- Appreciates the incorporation of family members. Asks that there would be more activities for younger youth.
D) Curt Thornton- Likes that staff adjusts to needs and not stuck in "that's the way it's always been done," concerned the youth side is inadequate and needs a better facility.
E) David Weber- Thank you to staff of the crisis center for their hard work and the respect they show to everyone including consumers and family.
F) Francine Farber- Recommended landscaping by local nurseries who can help.
G) Don Vanderheyden- Really well managed, complimented the security, and assessments done.

#2

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Don Vanderheyden
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: 2/2/18 10:00 Am.

PROGRAM/FACILITY NAME: Childrens PHF
Central Star, 4411 Kings Canyon Rd Bldg 319

LOCATION:
STREET ADDRESS:

PROGRAM SUPERVISOR/CONTACT (NAME & PHONE #): Debora Tobias Gatewood LMFT
Senior Administrator Central Star
2140 Merced Street, Suite 101
Fresno, CA. 93721
559-840-4937

SERVATIONS (STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS) 12-18 Yo

1. * HOW DOES THE STAFF INTERACT WITH CLIENTS? THIS MAY NOT BE KNOWN
All levels - Administration, professional, Semi professional, Family Partners, youth counselors
PMD \ MD \ NP \ SW \ Care Staff Rehab Therapist.

2. ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N Initial entrance, older patient open area, office areas. Rules published & family enforced.

3. WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?
Good ADLS, Community meetings, Life Skills, Expressive Arts on week, Wellness Groups, Problem Solving, Family / Support Person Education
* activity Schedule - Time Scheduled.

4. WHAT ARE TWO OR THREE ONE OR TWO OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS? Security, Safety, Family involvement, Recovery issues, Care resolution (Second-parent effect) no cell phones, no weapons, [illegible] Teens Dynamics multi age level, developmental, multi DX's or

5. DOES YOUR AGENCY'S BOARD OF DIRECTORS INCLUDE ANY BEHAVIORAL HEALTH CONSUMER MEMBERS? YES / NO (No) Awareness yes

6. HOW DO YOU KNOW WHEN AN INDIVIDUAL NO LONGER NEEDS THE SERVICES YOU PROVIDE?
PMD evaluation/Assessments, staff consensus/observation, Stabilized on meds / behaviors, [illegible]

5. HOW MANY PEOPLE SEEKING SERVICES DID YOUR ORGANIZATION TURN AWAY BECAUSE THE PERSON DID NOT QUALIFY FOR THE PROGRAM OR BECAUSE OF LACK OF CAPACITY? Fairly often due to excess demand to # of beds authorized. Helps Fresno Co. [illegible] other local counties and some private entities

6. IS THERE ANY OTHER ASPECT OF THE PROGRAM YOU'D LIKE TO SHARE WITH US TODAY?
Recreational outside area was excellent, exercise, organized games, personal time
Video coverage of activities in most areas, especially plus for safety, security and review of activities or incidents
Quiet rooms and use available if need for acting out behaviors. Good D/C preparation [illegible] improvements
Good Family program handbook.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM
6 members present. Multiple questions asked by FCBHB members about Star Program facts.

1. WHAT IS YOUR OVERALL IMPRESSION OF THE FACILITY/PROGRAM, INCLUDING STRENGTHS AND LIMITATIONS?
"Multifaceted children's program, create flexible needs met in a positive comprehensive way!
Willing to change and adjust program to better serve children's PHF patients & family [illegible] parents needs
Excellent Family handbook handout. Good interagency agencies contacts of cooperation.

ANY RECOMMENDATIONS FOR THIS FACILITY OR PROGRAM FOR THE BEHAVIORIAL HEALTH BOARD TO CONSIDER?
Enlarge program to allow more available beds as per population needs in the Central Valley.
o. Capital investments in facility; not updated since about 1976. Repaint in colors / heat & air conditioning / update / better lighting / music therapy?
Retention / outcomes / most needs of content

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Carolyn Evans
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members
Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: MARCH 16, 2018

PROGRAM/FACILITY NAME: OLDER ADULT PROGRAM, DEPARTMENT OF BEHAVIORIAL HEALTH

LOCATION:
STREET ADDRESS: 2025 E. DAKOTA AVENUE, FRESNO, CA 93726

PROGRAM SUPERVISOR/CONTACT
(NAME & PHONE #): TREVOR BIRKHOLZ, CLINICAL SUPERVISOR
559-600-5755

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. * HOW DOES THE STAFF INTERACT WITH CLIENTS? NO OBSERVATION

2. ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N
YES. BOTH ARE POSTED AND FORMS ARE AVAILABLE.

3. WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?
GOALS INCLUDE STABILIZATION AND INDEPENDENCE BY CONECTING TO COMMUNITY RESOURCES, CREATING SOCIAL NETWORKS, AND IMPROVING FAMILY RELATIONSHIPS; ALL OF WHICH REDUCE ISOLATION.

4. WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS? STAFFING INADEQUATE. SERIOUS MENTAL ILLNESSES AND HOMELESSNESS. HOUSING SPECIALIST TO CONNECT TO APPROPRIATE HOMES. FACILITIEDS TO TREAT THOSE WITH COOCCURRING MEDICAL ISSUES.

5. Does Your Agency's Board Of Directors Include Any Behavioral Health Consumer Members?
Yes / No Peer Support Specialist on staff.

How Do You Know When An Individual No Longer Needs The Services You Provide? When clients have met their individualized goals, have had no hospitalizations or incarcerations, have become self-sufficient, and have built a social network in the community, they generally no longer need the services provided by the Older Adult Program.

7. How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity? Currently the program is capped, accepting no new clients due to lack of staff. Since the program is for those 60+ years, some individuals are turned away because of their age; (a few 55+ are accepted.) Some individuals are excluded from service due to their insurance coverage.

8. Is There Any Other Aspect Of The Program You'd Like To Share With Us Today? Staff does community outreach to educate agencies and service providers about the needs of older adults. CIT training for law enforcement includes presentations on dealing with older adults.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations? The older adult program seems to do a good job providing for the behavioral health needs of seniors. Strengths include: 1) linkage of clients to community programs to build relationships and reduce isolation. 2) access to a geriatric psychiatrist via telemed. 3) linkage to primary care physicians to care for their medical issues, including cognitive decline. The space is small to serve 350+ clients.

2. Any Recommendations For This Facility Or Program for the Behavioral Health Board to consider? 1) The program needs to be fully staffed; not only are slots vacant, but several individuals are on medical leave. 2) The Program needs more space, and needs to be moved to first floor space, as a safety issue. 3) Treatment facilities and housing need to developed to care for individuals with both mental illness and other medical issues.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Carolyn Evans
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: APRIL 11, 2018

PROGRAM/FACILITY NAME: HOLISTIC CULTURAL & EDUCATION WELLNESS CENTER

LOCATION:
STREET ADDRESS: 4867 E. KINGS CANYON ROAD, FRESNO, CA 93727

PROGRAM SUPERVISOR/CONTACT
(NAME & PHONE #): CHRISTINA ALEJO; 559-255-8395

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. *** HOW DOES THE STAFF INTERACT WITH CLIENTS?** CULTURAL BROKERS WORK WELL WITH THEIR IDENTIFIED CULTURAL GROUP AND ARE WILLING TO INCLUDE AND SERVE OTHERS.

2. **ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N**
   N/A

3. **WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?** NOT A TREATMENT PROGRAM.

4. **WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS?** EVEN WITH RECENT EXPANSION THE PROGRAM HAS LIMITED SPACE. TRANSPORTATION FOR CLIENTS IS A CHALLENGE. CHILD CARE NEEDED FOR CLIENTS TO PARTICIPATE IN PROGRAM.
5. **DOES YOUR AGENCY'S BOARD OF DIRECTORS INCLUDE ANY BEHAVIORAL HEALTH CONSUMER MEMBERS?** YES. THE ADVISORY COUNCIL DOES INCLUDE CLIENTS WHO USE SERVICES.

6. **HOW DO YOU KNOW WHEN AN INDIVIDUAL NO LONGER NEEDS THE SERVICES YOU PROVIDE?** CLIENTS ARE INVITED TO CONTINUE SO LONG AS INTERESTED AND FEEL THAT PROGRAM IS HELPFUL.

7. **How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity?** None are turned away, though some programs and classes may be full on some days.

8. **Is There Any Other Aspect Of The Program You'd Like To Share With Us Today?** Program has been expanded with satellite locations in Fresno and Parlier. HCEWC brokers attend cultural events in the community. Clients are empowered to work with the community and on site; several have been hired by the HCEWC.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. **What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations?** HCEWC is working to expand its reach to others in the community, including veterans---both US and SE Asian. Few programs for men but making efforts to engage. All programs have an intentional mental health component that is explained and clarified for clients. When needed referrals are made to service providrs. Congratulations to a once-marginal program that has become strong and effective in supporting individuals who are reluctant to seek out and accept traditional services.

2. **Any Recommendations For This Facility Or Program for the Behaviorial Health Board to consider?** HCEWC needs more space for its programs. Other cultural groups could be included. Programs for men needed. Specific programs for new moms lacking. Transportation services could help more individuals attend programs.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD

FACILITY/PROGRAM OBSERVATION REPORT:

By: Francine Farber

Date of Site Visit: May 14, 2018 – 1 p.m. -- 2:15 p.m.

PROGRAM NAME: West Care Substance Use Disorders

Location 2772 S. Martin Luther King Blvd., Fresno, Phone 265-4800

Program Supervisor: Lynn Pimental (not present) Gary Knepper, Res. Director (not present)

Rob Evans, Program Coordinator, Giovanna, clinician

OBSERVATIONS

1. **How does the staff interact with clients:**
   We did not see much interaction in this setting. There were a few casual contacts in the hallways which were unremarkable. During discussion they verbalized awareness of differences and respect/concern.

2. **Are individual grievance procedures posted?** Yes Are Grievance forms readily available? DK; Is the current patient advocate's contact information posted D/K

3. **What are the typical treatment goals for individuals in this program?**
   - There are three programs but only two types of programs
   - The first is the Residential Multiservice program for individuals on parole. Their ultimate goal is to prepare for employment.
   - The second is men's and women's programs for individuals with substance use disorders. Their goals are to develop abstention skills, get health care under control, become medication compliant and develop some vocational skills.

4. **Obstacles which program, staff and individuals face**
   - Some individuals in RMS have outside unsupervised visits. It takes them away from in-house training groups; make give them an opportunity to leave; or be in contact with others who may undermine their recovery.
   - There are some recruitment problems because staff have to be registered/certified. New Medical waiver may increase salaries which should help recruiting.

5. **Doe the agency's board of directors include behavioral health consumers?**
   Not known. The board of directors is at corporate headquarters in Las Vegas. Previous client can return as unpaid interns after one year out, or may be employed after two successful years out.

6. **How do you know when an individual no longer needs the services you provide?**
When the goals are met – see #3

7. **How many people did your organization turn away for not qualifying for the program or lack of capacity?**
   - Prospective clients with psychosis or highly delusional or other severe mental health problems may not be accepted. Have to be able to selfcare, attend groups, don't accept peple with history of arson
   -
   - There is a small waiting list from time to time mostly because some clients accept and then decide not to come. They may be referred to another facility.

8. **Is there any other aspect of the program you'd like to share with us?**
   - The program includes men with their children, which is unique. They don't know of another program which incudes fathers/children. Since 2002 there have been 290 births, including one last week.
   - The program holds graduation ceremonies twice yearly; usually there are about 60 people who have completed the inpatient program, completed outpatient work, and may have been in another program as well.
   - The Living Room program has monthly alumni dinners featuring movie night and other events which act as continual support.

OTHER INFORMATION

- Residential Multi Services has capacity for 70; currently 56 men with 3 children, 9 women
- Parole officer visits 2x per week.
- Women's program has 60 women, 14 children, 80 capacity
- Men's program has 56 men, 3 children, 68 capacity
- Stays vary from 60 to 90 days to 6 months or up to a year.
- Generally rate of completion of programs is about 45%
- Clinician runs 4 groups for co-occurring disorders, also individual sessions and follow-up linkages
- Medical Director Psychiatrist, oversee meds and emergencies
- Children mostly infants and toddlers; child care worker, not preschool teacher
- Families can visit in outdoor courtyard on Sat and Sun, family groups (no children) Tues and Thurs night
- Everyone in men's and women's programs has inside job like dishwasher, cook, etc.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Katie Rice
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: 06/08/2018

PROGRAM/FACILITY NAME:
DBH OUTPATIENT CHILDREN'S MENTAL HEALTH SERVICES

LOCATION:
STREET ADDRESS: 3133 N. MILLBROOK AVENUE FRESNO

PROGRAM SUPERVISOR/CONTACT
(NAME & PHONE #): LESBY CASTRO-FLORES (CLINICAL SUPERVISOR/DIVISION MANAGER), BECKY RODRIQUEZ (ADMINISTRATIVE ASSISTANT)

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. * HOW DOES THE STAFF INTERACT WITH CLIENTS? WE DID NOT SEE ANY STAFF/CLIENT INTERACTION AS CLIENTS WERE IN SESSION. WE DID SIT IN THE WAITING ROOM AREA AND SAW CLIENTS WAITING FOR THEIR SESSION.

2. ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N
   YES BOTH WERE POSTED IN PLAIN VIEW. GLASS CASE CONTAINING INFORMATION WAS DIRECTLY IN THE ENTRANCE AND THE OTHER NEXT TO CHECK IN DESK.

3. WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?
   OUTPATIENT SERVICES ARE BASED ON GOALS THAT ARE DETURMINED BASED ON AREA OF NEED. (INPUT FROM CLIENT, FAMILY, SCHOOL, OTHER HEALTH CARE PROFESSIONALS. ARE ALL TAKEN INTO CONSIDERATION WHEN DECIDING GOALS.)

   SCHOOL BASED SERVICES- TREATMENT GOALS ARE INDIVIDULAIZED AND CAN INCLUDE GOALS THAT WILL HELP REDUCE ABSENCES, DECREASE IN BEHAVIORS AND SELF HARM, DEVLOPING COPING SKILLS, ADDRESSING ANY TRAUMA OR SUICIDE RISKS.

4. WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS?
   OUTPATIENT SERVICES: REPORTED NOT HAVING ENOUGH STAFF AS THEIR BIGGEST OBSTACLE.
   SCHOOL BASED SERVICES: REPORTED NOT HAVING ENOUGH STAFF & LACK OF SCHOOL OFFICE SPACE AS THEIR BIGGEST OBSTACLES.
5. DOES YOUR AGENCY'S BOARD OF DIRECTORS INCLUDE ANY BEHAVIORAL HEALTH CONSUMER MEMBERS? YES / NO

It was reported that in the past, Yes. Currently there is a vacancy for a Parent Partner. Currently interviewing.

6. How Do You Know When An Individual No Longer Needs The Services You Provide?

Outpaient Services: Communication with client and family on progress and reduction in areas of need.
School Based Services: Goals are met at home, school and in the community.

7. How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity?

Outpatient Services: No body is turned away.
School Based Services: If clinician(s) are at maxed caseloads upon the time of referral, they will send client to outpatient services and make sure linkages to additional services are provided.

8. Is There Any Other Aspect Of The Program You'd Like To Share With Us Today?

Trauma Informed Yoga will be offered in the near future. Staff was very excited about this.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations? The facility is very clean and has beautiful artwork throughout. Initial and ongoing training for staff is provided in a dedicated training room. (workforce Education Training, Avatar Traning/Billing for staff) It was nice to see so many staff working on a Friday after 3pm. White Boards on doors and in intake area indicating who is in/out.(good communication) 2 Fully padded rooms for clients that may be escalated or need a quiet area to go.

Walk-in crisis situations can be assesed immediately. There are 3 admitting interviews available. Front desk staff is trained to pre screen aplications for urgency. If admitting interviewrs are not available, a supervisor is always avaialable to conduct an assessment. Staff is trained in NCI (non-violent crisis intervention) Upon assessment, if needed, client can be referred to Exodus or ER. Doors close at 5pm.

Facility offers:Outpatient Mental health Services for ages 0-18
Expansive Day Treatment for ages 12-18
Outpatient Infant Mental health Ages 0-5
Daycare for ages 0-12 for individuals that don't have childcare.
School Based Services in Rural areas: Colinga, Selma, foothills, sanger, organge cove
*working on Partnership with FCSS to expand services in the school setting.
Child welfare Worker available for those involved with CPS, Probation, DCSS, court.
*Same day goal for referrals
Currently have 3 psychiatrists (2 on staff at all times) Hired a 4TH who will work about 16 hours a week.
1 Nurse Practioner
LVN/RN
7 Telemed Rooms
Vitals Room/ Wellness Embedded into Programs
Therapy Rooms (Individual/group)
Medication/Dr. App scheduling Room
Clinicans/ Clinican Support Staff

2. Any Recommendations For This Facility Or Program for the Behaviorial Health Board to consider?

They currently do not offer PCIT.
They currently do not have an infant Mental Health Developmental Pediatrician.
They only have person currently that handles all the medication referrals.
Ongoing issues with CVRC linkages. Why???
Additonal staff needed to ensure ALL clients needs are met

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Carolyn Evans
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: AUGUST 21, 2018

PROGRAM/FACILITY NAME: EXODUS ADULT PSYCHIATRIC HEALTH FACILITY

LOCATION: 4411 E. KINGS CANYON ROAD, FRESNO

PROGRAM SUPERVISOR/CONTACT: ZIA V. XIONG, CLINICAL DIRECTOR, 559-600-7180

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. * HOW DOES THE STAFF INTERACT WITH CLIENTS? STAFF SEEMS COMFORTABLE AND FRIENDLY WITH CLIENTS. THEY SEEM TO RELATE WELL.

2. ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? YES IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? YES

3. WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM? MENTALLY AND PHYSICALLY STABLE. WILLINGNESS TO PARTICIPATE IN WELLNESS ACTIVITIES, INCLUDING GROUPS. PARTICIPATION IN EDUCATION AND UNDERSTANDING OF MEDICATION. KNOWLEDGE OF COMMUNITY RESOURCES. ACCEPTANCE OF DISCHARGE PLAN. DEVELOPMENT OF SAFETY PLAN.

4. WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS? LACK OF COMMUNITY RESOURCES. FULL SERVICE PARTNERSHIP PROGRAMS AT CAPACITY. LONG WAITS FOR STATE HOSPITAL PLACEMENT. LACK OF HOUSING.
5. DOES YOUR AGENCY'S BOARD OF DIRECTORS INCLUDE ANY BEHAVIORAL HEALTH CONSUMER MEMBERS? EXODUS BOARD OF DIRECTORS DOES INCLUDE CONSUMER MEMBERS.

5. HOW DO YOU KNOW WHEN AN INDIVIDUAL NO LONGER NEEDS THE SERVICES YOU PROVIDE? MENTALLY STABLE. ACCEPTIVE OF COMMUNITY SERVICES. COOPERATIVE. RECEPTIVE TO MEDICATION EDUCATION. ABLE TO CREATE A WELLNESS PLAN.

7. **How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity?** Because they have only 16 beds, many are turned away. During the month of July alone 161 individuals were turned away due to lack of capacity. Priority list are for those needing conservatorship and those coming from Exodus Crisis Stabilization Unit.

8. **Is There Any Other Aspect Of The Program You'd Like To Share With Us Today?** Exodus encourages family engagement; holds family potlucks and holiday dinners; willing to adjust or extend visitation hours. Psychiatrist on-site, full-time (40 hrs). Social services team links to community services, including housing.

SITE VISIT SUMMARY

Behaviorial Health Board Members to complete these questions after visiting the program

1. **What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations?** The staff at Exodus Adult PHF are committed to the best care possible for their clients. Staff adapts to the old, outdated facilities; they are looking forward to much needed rennovations. They have a strong recovery-focused program, and adequate staff to carry it out. Outside area is a nice size for leisure and recreation. Including families in the wellness program is a positive. Since they have only 16 beds, they must turn away many individuals. Long wait times for other placements further impacts their capacity to serve. Readmissions have declined which indicates success.

2. **Any Recommendations For This Facility Or Program for the Behaviorial Health Board to consider?** Major rennovations are needed. The facility is sterile and institutional, rather than the friendly, home-y environment that one would like to see. Furniture arrangement could reduce some of the institutonal feel. Outside areas also need fresh paint. The Uniformed security guard patrolling inside the facility is *not* friendly or comforting for clients. If it is necessary for security to be inside the living and treatment area, they should be in less intimidating clothing.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Carolyn Evans
Board Member Name

This Report is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: SEPTEMBER 14, 2018

PROGRAM/FACILITY NAME: RENAISSANCE AT SANTA CLARA

LOCATION: 1555 SANTA CLARA STREET, FRESNO
STREET ADDRESS:

PROGRAM SUPERVISOR/CONTACT : SONIA SAHAI-BAINS; 559-233-2054
(NAME & PHONE #):

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. * **HOW DOES THE STAFF INTERACT WITH CLIENTS?** NO RESIDENTS PRESENT.

2. **ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL?** Y/N **IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED?** Y/N N/A

3. **WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?** NOT A TREATMENT PROGRAM. THE GOAL IS FOR RESIDENTS TO MAINTAIN THEIR HOUSING. QUARTERLY INSPECTIONS PROVIDE AN OPPORTUNITY TO EDUCATE ABOUT EXPECTATIONS AND TEACH LIFE SKILLS AS NEEDED.

4. **WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS?** LOCATION, WITH LARGE HOMELESS POPULATION OUTSIDE THE FENCE. SUBSTANCE USE DISORDERS OF RESIDENTS AND RESULTING BEHAVIORS. TRANSPORTATION FOR RESIDENTS.

5. **Does Your Agency's Board Of Directors Include Any Behavioral Health Consumer Members?** Peer Support Specialist works on site. Tenent Council no longer active.

6. **How Do You Know When An Individual No Longer Needs The Services You Provide?** Most residents move when they receive a housing voucher for another apartment or move in with family. Some residents are unable to live independently and move to a more supportive environment. Very few are evicted.

7. **How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity?** Santa Clara has only 69 apartments, with 25 funded by MHSA and designated for DBH clients. When apartments become available, the DBH Housing Team uses the Coordinated Entry System to determine who is next on the waiting list.

8. **Is There Any Other Aspect Of The Program You'd Like To Share With Us Today?** Staff may accompany residents to treatment programs and/or train them to use the bus system. Groups are held on site most days. Occasionally there are outings or joint events with residents in the other Renaissannce housing projects—Trinity and Alta Monte. Residents have formed a community and enjoy each others' company. Security is on duty from 4 PM-8 AM every night, and all day on Friday when some staff often is away. A few residents are employed; 4 provide in home support services for their neighbors. 10% of residents have cars.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. **What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations?** There is a lot of staff on site, including those from the Housing Authority and DBH. Recently there have been trainings on the Housing First Model, so that staff will understand what is expected of them---active engagement with residents and support to help residents maintain their housing. Meetings with staff from other housing project has been beneficial to those at Santa Clara. Staff indicated that some problems from the past, such as unwelcome guests from the neighborhood and loitering have decreased. No residents were available to express their thoughts about their housing and the supportive services provided. Having security staff on site when staff is not present is essential for this housing site. Proximity to MAP Point and Poverello House provide some services for residents.

2. **Any Recommendations For This Facility Or Program for the Behavioral Health Board to consider?** There should be a Tenent Council or regular scheduled meetings where residents could come together to discuss concerns and solutions. Training and Support for staff should continue, especially since they are isolated from other DBH staff. The dead grass should be watered and a lawn maintained for a better appearance and to provide an attractive outdoors area for residents because there is not much that is aesthetically pleasing outside the fence. Transportation services would be helpful for individuals going to treatment programs.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Carolyn Evans
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: OCTOBER 2, 2018

PROGRAM/FACILITY NAME: PATHWAYS TO RECOVERY

LOCATION:
STREET ADDRESS: 515 S. CEDAR AVENUE

PROGRAM SUPERVISOR/CONTACT
(NAME & PHONE #): JULIE APPERSON; 559-600-6075

OBSERVATIONS ***(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)***

1. *** HOW DOES THE STAFF INTERACT WITH CLIENTS?** NO CLIENTS WERE PRESENT; HOWEVER FRONT OFFICE STAFF DEALT WELL WITH INDIVIDUALS WHO CAME IN, AND ALSO SPENT TIME LISTENING AND OFFERING REFERRALS TO THOSE WHO CALLED .

2. **ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE *CURRENT* PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N** YES/YES

3. **WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?** THIS IS A PROGRAM IN TRANSITION. IN THE PAST CAL-WORKS CLIENTS WERE REFERRED BY DEPARTMENT OF SOCIAL SERVICES (DSS); CLIENTS WITH BEHAVIORAL HEALTH DISORDERS WERE REQUIRED TO COMPLETE A 6-MONTH PROGRAM IN ORDER TO QUALIFY FOR GENERAL RELIEF. A NEW CO-OCCURRING PROGRAM WILL HAVE INDIVIDUALIZED TREATMENT PLANS DEVELOPED WITH AND BY DEPARTMENT OF BEHAVIORAL HEALTH CLIENTS. HARM REDUCTION AND DECREASED USE OF SUBSTANCES WILL BE AN IMPORTANT ELEMENT IN ALL TREATMENT PLANS, ALONG WITH MENTAL HEALTH TREATMENT AND CARE. THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) ASSESSMENT TOOL WILL BE USED AND CASE MANAGERS WILL EVALUATE CLIENT'S PROGRESS. THE NEW DRUG MEDI-CAL REDESIGN WILL MAKE THIS TRANSITION AND THE NEW SERVICES POSSIBLE.

4. **WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS?** FINANCIAL INTEGRATION OF SERVICES AND FUNDING SOURCES. LACK OF STAFF. STIGMA ASSOCIATED WITH SUBSTANCE USE DISORDERS AND MENTAL ILLNESSES.

5. **Does Your Agency's Board Of Directors Include Any Behavioral Health Consumer Members?** Currently there are no Peer Support Specialists on staff. Clients do serve as Mentors to new participants. Peer Support Specialists will be employed in the new Co-occurring Program.

6. **How Do You Know When An Individual No Longer Needs The Services You Provide?** Currently, Cal--Works clients must complete a 6-month program. With the new Co-occurring program, progress in meeting treatment goals will be measured by assessments and evaluations of staff. When client no longer meets medical necessity, the client will be stepped down to a less intensive outpatient program. Aftercare and reapse prevention are available.

7. **How Many People Seeking Services Did Your Organization Turn Away Because The Person Did Not Qualify For The Program or because of lack of capacity?** DSS clients with mild to moderate mental health disorders are no longer accepted into the program. No clients with Serious Mental Illnesses are turned away; if they do not meet the criteria for the program , staff will help clients find appropriate services.

8. **Is There Any Other Aspect Of The Program You'd Like To Share With Us Today?** The Family Development Center is on-site to serve clients and their children. A nursery and a pre-school program are available, offering early intervention for children and teaching parenting skills to parents.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. **What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations?** Since the program is in the midst of change, it is difficult to gage its strengths and limitations. While the program was successful working with DSS clients, its resources will be better used in providing services for co-occurring individuals with SMI and SUDs. The Family Development Center is a big plus, and will continue to give children and parents opportunities for development and growth in a positive environment.

2. **Any Recommendations For This Facility Or Program for the Behaviorial Health Board to consider?** BHB should revisit the program after the transition is complete to learn about its progress.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

BY: Curt Thornton
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Fresno County Behavioral Health Board

DATE OF SITE VISIT: OCTOBER 30, 2018

PROGRAM/FACILITY NAME: PERINATAL WELLNESS CENTER

LOCATION:
WEST FRESNO REGIONAL CENTER,
142. E. CALIFORNIA AVENUE, FRESNO, CA 93706

PROGRAM SUPERVISOR/CONTACT
LORI JAMES, 559-600-1033

OBSERVATIONS *(STARRED (*) ITEMS MAY NOT APPLY TO SOME PROGRAMS)*

1. * HOW DOES THE STAFF INTERACT WITH CLIENTS? WE DID NOT OBSERVE THE CENTER STAFF INTERACTING WITH CLIENTS, BUT WE HEARD A LOT ABOUT THEIR PHILOPSOPHY WHICH IS MEANT TO BUILD RELATIONSHIPS WITH CLIENTS. THEY CHANGED THEIR NAME TO "PERINATAL WELLNESS CENTER" TO EMPHASIZE THEIR FOCUS ON WELLNESS. THEY TRY TO DO THIS WITH AN INTITIAL PHONE CALL OR VISIT TO THE OFFICE. THEY WORK HARD TO HAVE CLIENTS SEE THEIR CENTER AS A SAFE PLACE. THEY FEEL THEY HAVE A STAFF THAT IS PASSIONATE ABOUT THEIR WORK. THEY TAKE A LOT OF SATISFACTION KNOWING THEY HAVE NOT LOST A SINGLE MOTHER CLIENT TO SUICIDE SINCE THE INCEPTION.

2. ARE INDIVIDUAL GRIEVANCE PROCEDURES PROMINENTLY POSTED? ARE GRIEVANCE FORMS READILY AVAILABLE TO THE INDIVIDUAL? Y/N IS THE CURRENT PATIENTS' RIGHTS ADVOCATE'S CONTACT INFORMATION POSTED? Y/N
YES AND YES.

3. WHAT ARE THE TYPICAL TREATMENT GOALS FOR INDIVIDUALS IN THIS PROGRAM?
TREATMENT GOALS VARY DEPENDING ON THE DIAGNOSIS OF THE INDIVIDUAL. THEY ENCOURAGE MEDICATION WHERE IT SEEMS APPROPRIATE, BUT THEY TRY TO AVOID BEING SEEN AS FORCING IT. THEY TRY TO TEACH THEIR CLIENTS TO "MANAGE" THEIR SYMPTOMS. WRAP – THE WELLNESS RECOVERY ACTION PLAN IS UTILIZED.

4. WHAT ARE TWO OR THREE OBSTACLES YOUR PROGRAM, STAFF, AND INDIVIDUALS FACE WHICH MAY MAKE IT DIFFICULT TO ACHIEVE THESE GOALS?
THE CENTER HAS ACHIEVED A SIGNIFICANT INCREASE IN PATINENTS HAVING A SUBSTANCE ABUSE PROBLEM SINCE THE LEGALIZATION OF MARIJUNA IN CALFORNIA.

TRANSPORTATION IS A PROBLEM FOR MANY CLIENTS, DESPITE EFFORTS THAT ARE MADE TO ASSIST CLIENTS WITH THEIR TRANSPORTATION NEEDS. HEIR SEEMS TO BE A LACK OF COMMITMENT FOR THE POPULATION BEING SERVED, AS EXHIBITED BY THE WORST PERCENTAGE OF CANCELLED APPOINTMENTS WITHIN DBH.
STIGMA IS A SIGNIFICANT PROBLEM IN GETTING INDIVIDUALS INTO TREATMENT AND CONTINUING. WHEN ASKED IF THERE IS A PARTICULAR POPULATION SEGMENT THAT IS MORE DIFFICULT IN THAT REGARD, WE WERE TOLD IT IS SIGNIFICANT FOR ALL SEGMENTS. HOWEVER, IT WAS NOTED THAT THE AFRICAN-AMERICAN POPULATION IS ESPECIALLY RELUCTANT TO SEEK TREATMENT.

5. DOES YOUR AGENCY'S BOARD OF DIRECTORS INCLUDE ANY BEHAVIORAL HEALTH CONSUMER MEMBERS? YES / NO

NOT APPLICABLE.

6. HOW DO YOU KNOW WHEN AN INDIVIDUAL NO LONGER NEEDS THE SERVICES YOU PROVIDE?

TYPICALLY THIS IS ASSESSED WHEN THE BABY TURNS 12 MONTHS OLD, BUT THAT IS NOT AUTOMATIC. THEY WANT TO SEE THE CLIENT HAVING MET THEIR TREATMENT GOALS AND BEING STABLE.

7. HOW MANY PEOPLE SEEKING SERVICES DID YOUR ORGANIZATION TURN AWAY BECAUSE THE PERSON DID NOT QUALIFY FOR THE PROGRAM OR BECAUSE OF LACK OF CAPACITY?

AT THIS POINT THEY HAVE NOT HAD TO TURN PEOPLE AWAY. BUT IT WAS CURIOUS THAT THEY FEEL THEY COULD DO MORE WITH THE ADDITION OF A COUPLE OF STAFF MEMBERS

8. IS THERE ANY OTHER ASPECT OF THE PROGRAM YOU'D LIKE TO SHARE WITH US TODAY?

THEY DO UTILIZE A PEER SUPPORT SPECIALIST WHO CONTRIBUTES WELL TO THE CENTER. MOST OF THEIR REFERRALS COME FROM OB OFFICES, AND FROM GROUP HOMES. THEY UTILIZE A TELE-PSYCHIATRIST AND NURSE PRACTIONER, AND THEY HAVE THEIR OWN NURSE PRACTIONER ON STAFF. THEY ARE WORKING ON SCHEDULING THINGS BETTER TO HAVE AVAILIBILITY ON MORE DAYS/TIMES.

SITE VISIT SUMMARY

BEHAVIORIAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. WHAT IS YOUR OVERALL IMPRESSION OF THE FACILITY/PROGRAM, INCLUDING STRENGTHS AND LIMITATIONS?

THE OVERALL IMPRESSION WAS VERY GOOD. WE DID NOT GET TO INTERACT WITH CLIENTS WHICH WOULD HAVE BEEN HELPFUL. OUR QUESTIONS WERE ANSWERED VERY WELL.

2. ANY RECOMMENDATIONS FOR THIS FACILITY OR PROGRAM FOR THE BEHAVIORIAL HEALTH BOARD TO CONSIDER?

THE DESIRE TO HAVE AN BILINGUAL CLINICIAN WAS MENTIONED SEVERAL TIMES, AS WAS A NEED FOR A SUBSTANCE ABUSE SPECIALIST. WHEN ASKED IF THE PROPLEM GETTING THESE SPOTS FILLED WAS A BUDGETARY PROBLEM OR A PROBLEM FINDING QUALIFIED INDIVIDUALS, WE WERE TOLD IT WAS THE ABILITY TO HIRE THE RIGHT INDIVIDUALS. THEY HAVE SOME INTERVIEWS COMING UP AND ARE HOPEFUL. IT SEEMS THAT IT IS ALMOST UNIVERSAL, WHETHER CAUSED BY THE COUNTY NOT BEING ATTRACTIVE ENOUGH WITH WAGES OR WHATEVER, OR THE CURRENT LOW UNEMPLOYMENT RATE. IT'S HARD TO STAFF OUR VITAL PROGRAMS.

FRESNO COUNTY BEHAVIORAL HEALTH BOARD

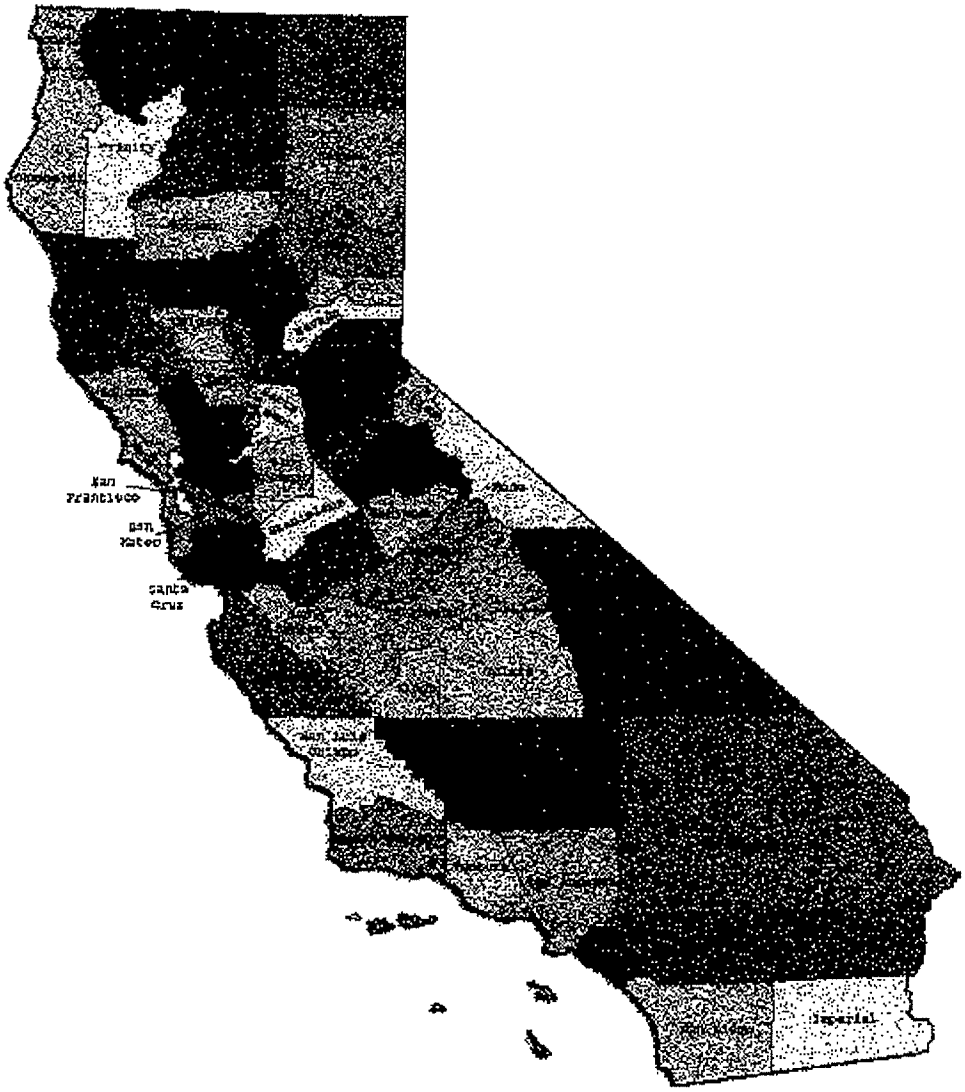
DATA NOTEBOOK 2017

FOR
CALIFORNIA BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

FRESNO 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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FRESNO COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2017): 999,902

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

http://www.co.fresno.ca.us/Departments.aspx?id=120

Website for Local County MH Data and Reports:

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

http://www.co.fresno.ca.us/DepartmentPage.aspx?id=384

Specialty Mental Health Data[1] from calendar year (CY) 2014: Table 1. Race/ethnicity detail for total Medi-Cal beneficiaries who received Specialty Mental Health services.

Table 1—Fresno MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	50,543	3,590
Hispanic	223,189	6,168
African-American	24,609	1,641
Asian/Pacific Islander	41,787	1,020
Native American	2,175	121
Other	27,598	1,621
Total	369,898	14,161

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

[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.

Supplemental County Data Page

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

Population (2010): 930,517

Adult population over 18: 652,637

Civilian veterans: 44,149 (6.8% of the adult population)

Total civilian noninstitutionalized population: 918,579

With a disability, all ages: 106,447 (11.6%)

Under 18 years with disability: 9,509 (3.4% of those within this age group)

Age 18-64 years with a disability: 58,499 (10.6% of those in this age group)

Total population age 65 years and older: 92,029 (9.9 % of total population).

Age 65 and older with a disability: 38,439 (41.8% of those in this age group)

Total households: 287,082 (100%) Population in households: 911,941 (98.5%)

Households with a member 65 years or over: 66,939 (23.3%)

Householder living alone, age 65 years and over: 23,391

Grandparents living with own grandchildren under 18 years: 29,060

Responsible for grandchildren: 8,659 (29.8% of those living with grandchildren)

Grandparents who are female: 5,412 (62.5%)

Grandparents who are married: 6,318 (73.0%)

Percentage of all families whose prior year income was below poverty level: 20.0%

Percentage of all persons living under the federal poverty level: 24.8%

Percentage of aged 65 and over with prior year income under poverty level: 11.4%

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

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[2] All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 930,517 in the year of the last U.S. census, 2010.

[3] http://www.labormarketinfo.ca.gov/File/census2012/fresndp2012.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_

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

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

   __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
   ____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
   ____Other, please specify. _____

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

DEMOGRAPHIC TRENDS : CHALLENGES FOR SERVICE ACCESS

Who are California's Older Adults?

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

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

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

Race/Ethnicity	Age 65 to 74	Age 75 and Older	Total # of All Adults ≥ 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]

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

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

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

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

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

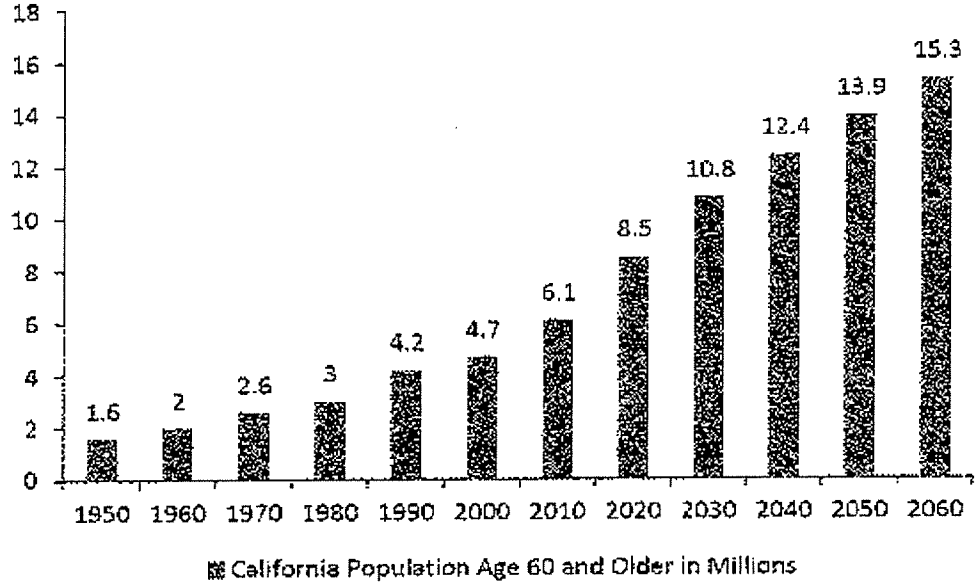


Figure 1. Projected Increases in Population Age 60 and over in California. [13]

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

	2010 Population age 60+	2030 Population age 60+	Per Cent Change over 20 years
Fresno County	**134,523**	**243,111**	**81 %**
California	**6,016,871**	**10,879,098**	**81 %**

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

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

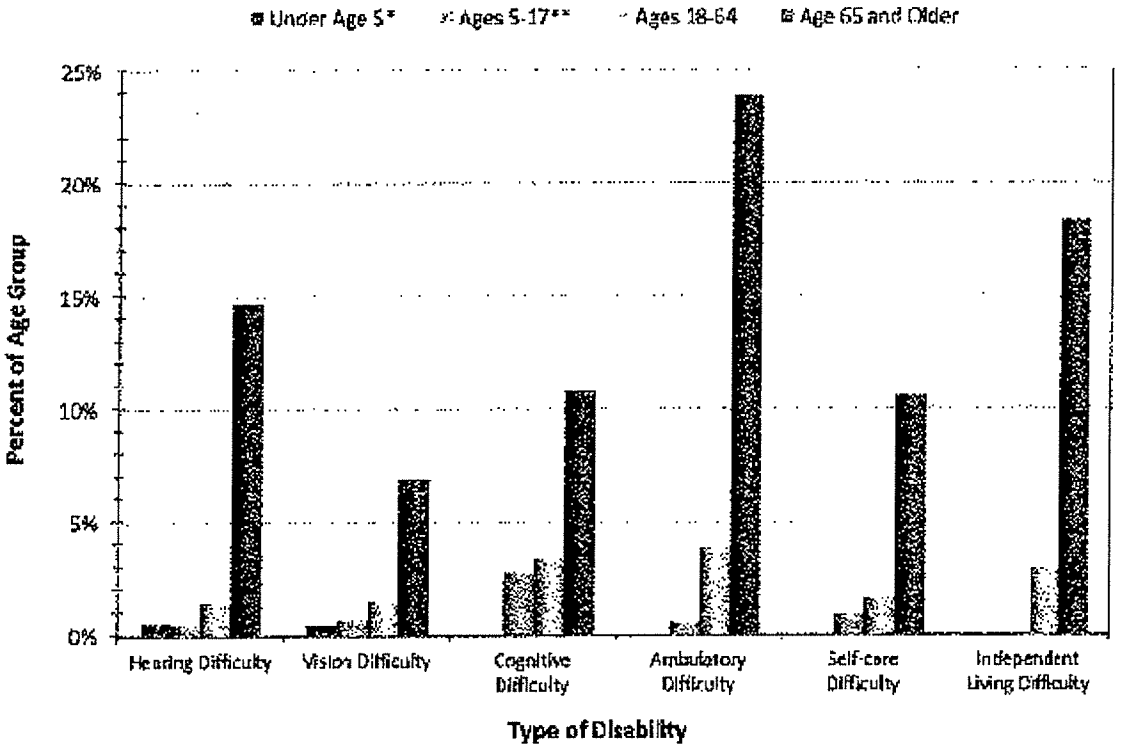
Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

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

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

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



*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.

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:

Fresno County (2011): There were 92,029 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 38,439. That number represents 42 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

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

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

Fresno County (2016):

Age 60+: 164,643	Age 75+:
Nonminority:[15] 88,019	Minority:[16] 76,624
Low income: 24,000	Non-English proficient: 10,920
Medi-Cal: 40,877	SSI/SSP (65+): 16,007
Lives alone (60+): 30,030	Geo-isolation (60+): 18,289

[14] California Department of Aging, 2015, www.aging.ca.gov.

[15] Using federal data guidelines, the Department on Aging defines "nonminority" as non-Hispanic Whites.

[16] The federal data guidelines used by the Department on Aging define "minority" as everyone else, that is, all race/ethnicities that are not Caucasian and are not Hispanic.

Limited English Proficiency is a Barrier for Behavioral Health Access

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

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

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

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

   Yes_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.

   Spanish, Hmong, Vietnamese

5. Describe one strategy that your county employs to reach and serve various cultural and/or race-ethnicity groups within your population of older adults?
   Contract with Fresno Center (Living Well Program &
   Holistic Cultural and Education Wellness Center). Cultural Based Access Navigation System (CBANS)—contracts with Fresno American Indian Health Project, Centro La Familia, Fresno Interdenominational Refugee Ministries, West Fresno Family Resource Center, & Sarbat Bhala (Punjabi). These providers may serve all clients, including Older Adults.
6. Are there other significant barriers to obtaining services for older adults in your county? Yes_X__ No ___ If yes, please check all that apply.

   __X_Transportation
   _X__Geographic Isolation

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

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

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

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

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

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

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

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

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

[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: FRESNO

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	61 13.71 %	188 42.25 %	127 28.54 %	69 15.51 %	445
Age 37-54	185 11.11 %	309 18.56 %	835 50.15 %	336 20.18 %	1665
Age 26-36	194 9.21 %	298 14.15 %	1083 51.42 %	531 25.21 %	2106
Age 15-25	82 4.27 %	109 5.67 %	1527 79.49 %	203 10.57 %	1921

CALIFORNIA: Statewide

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

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

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

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

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

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

   Please check all that apply.

   _X__Outpatient NTP (narcotics treatment program (methadone, etc)

   _X_Outpatient (non-NTP)

   _X_Detoxification

   _X_Residential Treatment

   _X__Dual Diagnoses Programs

   ___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)

   __X_SUD Treatment program designed for older military veterans Referrals to Veterans Administration SUD Treatment program

   ___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.

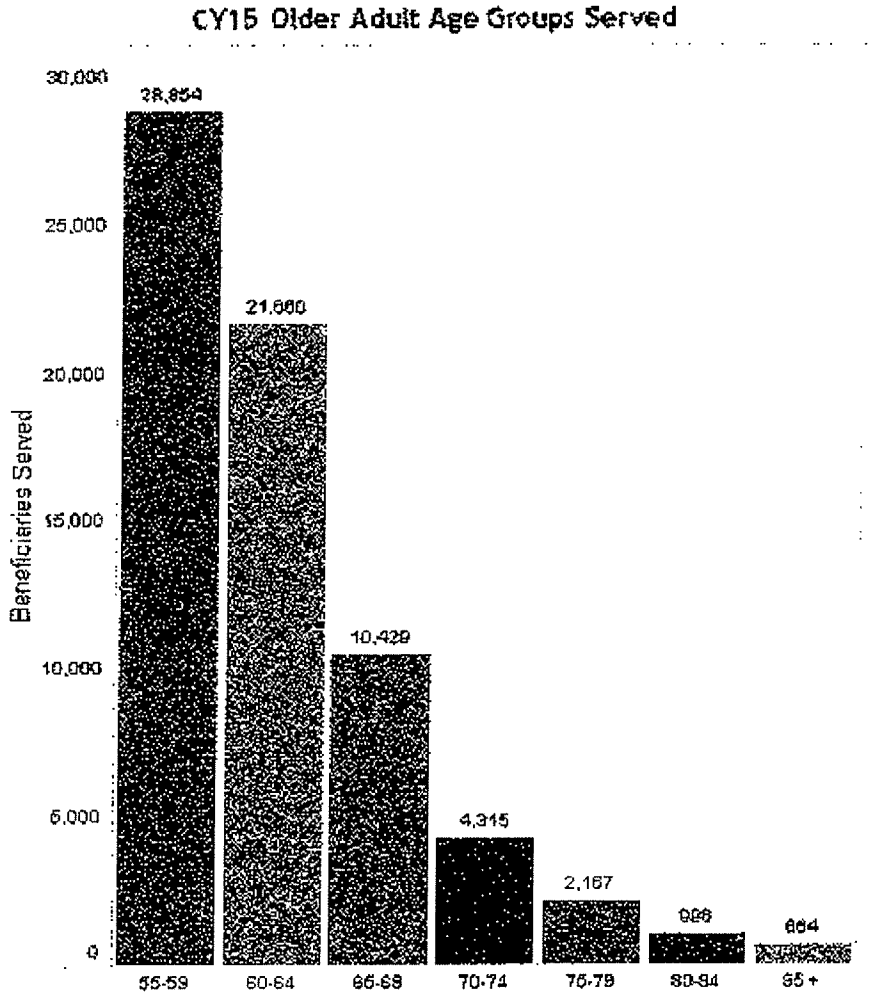


Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).

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.

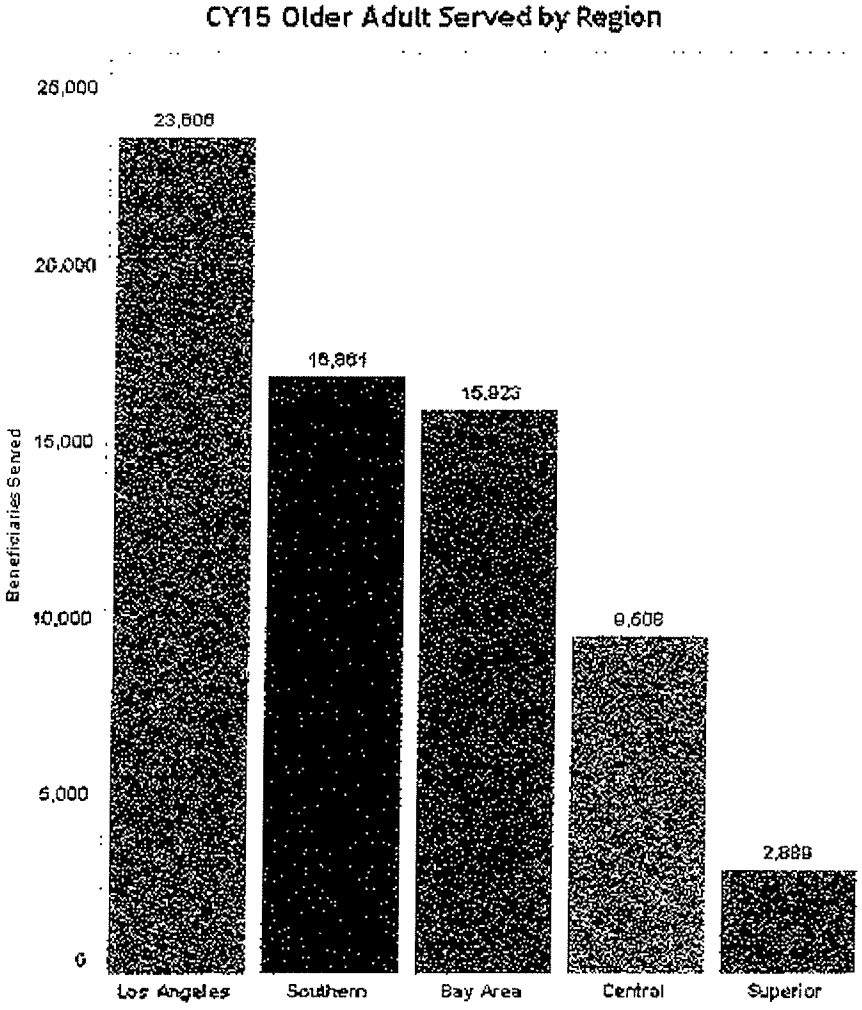


Figure 4. The numbers of persons in each region who received Specialty Mental Health Services ("beneficiaries", CY 2015). Los Angeles County is taken to be its own region.

[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.

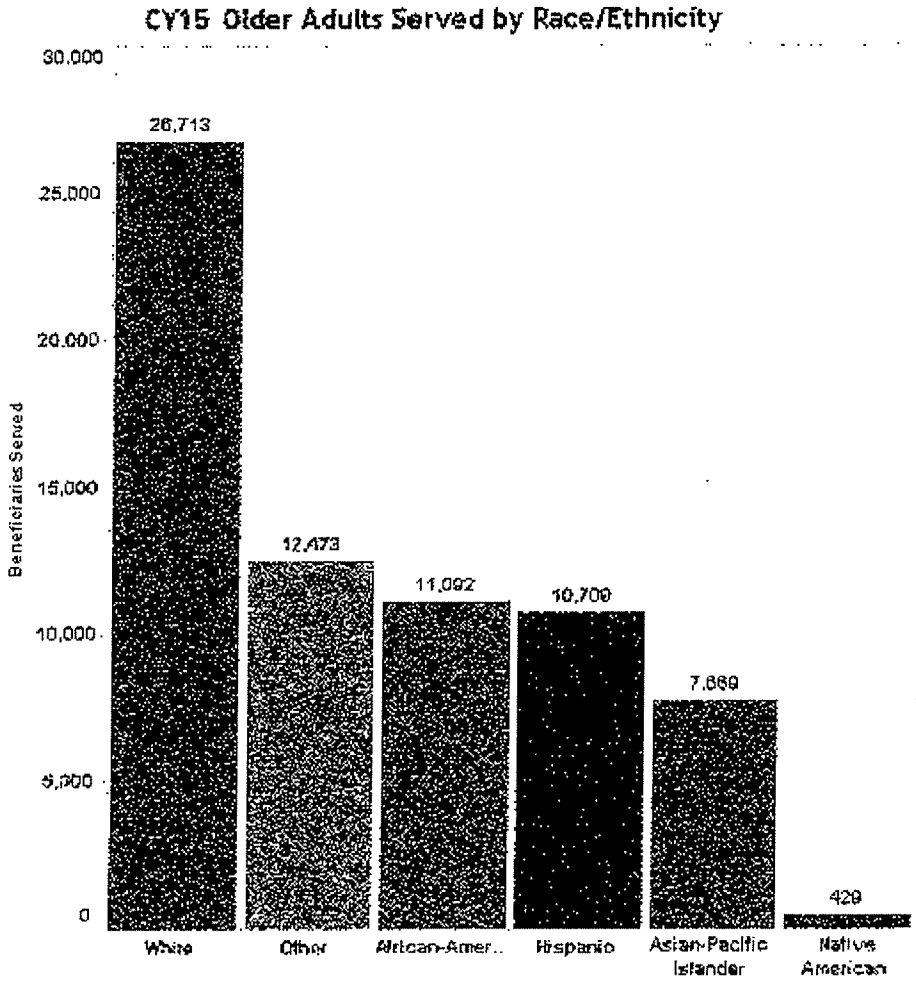


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group ("beneficiaries served").

[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.

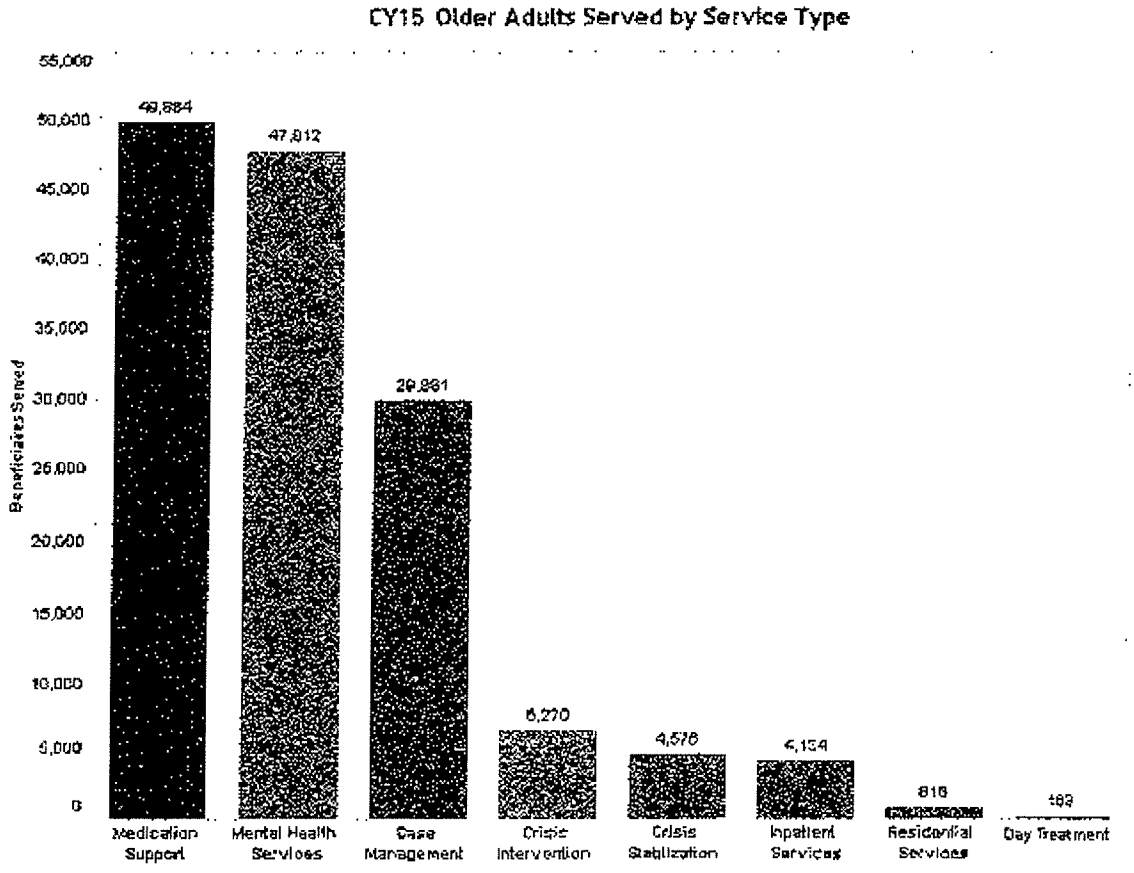
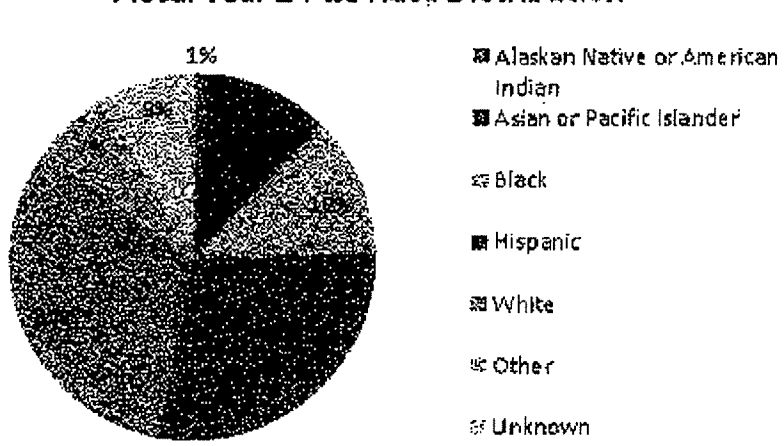


Figure 6. The most frequently used specialty mental health services are shown by the total number of older adults ("beneficiaries served") who received each type of service.

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: Fresno (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.

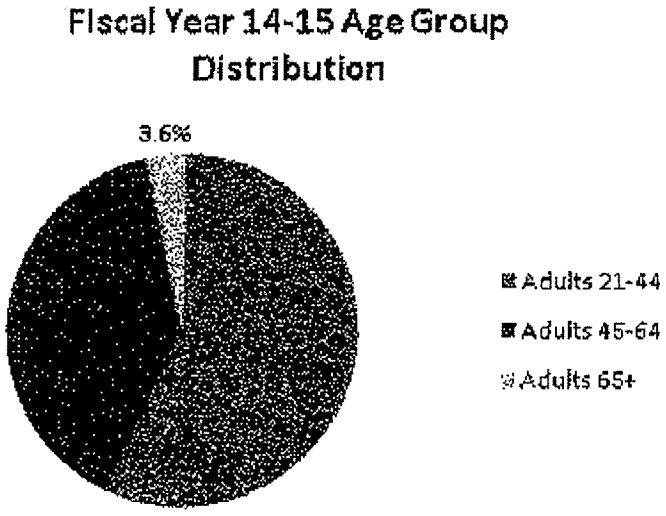


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).[28]

[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: Fresno (FY 2014-2015)
Specialty Mental Health Service Visits (SMHS) and Service Penetration Rates

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

	Adults with 1 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	**10,586**	**235,632**	**4.5%**
Adults 21-44	6,047	133,173	4.5%
Adults 45-64	4,155	71,925	5.8%
Adults 65+	384	30,534	1.3%
Alaskan Native or American Indian	119	1,807	6.6%
Asian or Pacific Islander	1,178	44,293	2.7%
Black	1,305	16,719	7.8%
Hispanic	3,018	95,167	3.2%
White	3,367	46,831	7.2%
Other	695	16,517	4.2%
Unknown	904	14,298	6.3%
Female	5,868	130,766	4.5%
Male	4,718	104,866	4.5%

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	**6,782**	**235,632**	**2.8%**
Adults 21-44	3,616	133,173	2.7%
Adults 45-64	2,843	71,925	4.0%
Adults 65+	243	30,534	0.8%
Alaskan Native or American Indian	73	1,807	4.0%
Asian or Pacific Islander	792	44,293	1.8%
Black	781	16,719	4.7%
Hispanic	1,909	95,167	2.0%
White	2,128	46,831	4.5%
Other	400	16,517	2.4%
Unknown	625	14,298	4.4%
Female	3,732	130,766	2.9%
Male	2,970	104,866	2.8%

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

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

   Yes___ No_X__

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

   In the Metropolitan area Fresno County is meeting the needs of Older Adults who are aware of the services that are available. The problem is the lack of knowledge in the community about services provided. This is an issue among all age groups in Fresno County; DBH needs more outreach to the community—both urban and rural.

Community Supports for Mental Health Emergencies and Crisis Services

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

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

   Yes__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 on Behavioral Health in California, December 2015. http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

___Crisis residential treatment for older adults

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

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:

Fresno County (2011):
Total persons age 65 years and older: 92,029 (10 % of total population).
Grandparents living with own grandchildren under 18 years: 29,060.
Grandparents responsible for grandchildren: 8,659 (which is 30 % 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.

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

If yes, please check all that apply below.

___Group therapy or support groups

___Counseling/parenting strategies

___Respite care services

___In-home supportive services (IHSS)

___Stress management program

___Mental health therapy, individual

___Other, please specify: _____.

Significant Changes in Behavioral/Cognitive Function in Older Adults

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

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

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

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

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

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

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

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

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

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

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

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

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

    If yes, please provide one example. Older Adult Team

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

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

12. Does your community train and/or utilize the skills and knowledge of <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.
    Peer Support Specialist employed in Older Adult Team.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

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

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

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

____MH Board completed majority of the Data Notebook

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

__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: Executive Assistant to Department of Behavioral Health Director.

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

Name and County: Christina Young, Fresno County

Email: christinayoung@co.fresno.ca.us

Phone #: 559-600-9193

Signature: _____

Other (optional): _____

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

Name and County: Carolyn Evans (2018), Fresno County

Email: evansalca@comcast.net

Phone #: 559-355-0962

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