Overview of the 2017 Project on Behavioral Health Services for Older Adults in California

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The California Behavioral Health Planning Council

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LIST OF ACRONYMS USED IN THIS REPORT

AA	Alcoholics Anonymous
AAA	Area Agencies on Aging, administer certain federal programs under CDA
AB	Assembly Bill
ACA	Affordable Care Act (2010)
APS	Adult Protective Services (protect elders from neglect and/or abuse)
ASIST	Applied Suicide Intervention Skills Training (includes related programs)
BH	Behavioral Health
BHCS	Behavioral Health Care Services (term used by some county departments)
Cal OES	California Office of Emergency Services
CABHB/C	California Association of Behavioral Health Boards and Commissions
CBHDA	County Behavioral Health Directors Association
CBHPC	California Behavioral Health Planning Council ("Planning Council")
CDA	California Department on Aging
CFR	Code of Federal Regulations
CFS	Child and Family Services (also see CFT: Child and Family Team).
CIBHS	CA Institute of Behavioral Health Services
CIT, CRT	Crisis Intervention Teams, or Crisis Response Teams
CSS	Community Services and Supports (category of MHSA programs),
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DCR	Data system used by DHCS for FSP programs
DHCS	CA Department of Health Care Services
DPH, CDPH	CA Department of Public Health
EBP/EBT	Evidence-based Program, Practice, or Treatment
ED or ER	Emergency Department or Emergency Room
EQRO	(California) External Quality Review Organization, www.CALEQRO.com
FEP	First Episode Psychosis program (SAMHSA-sponsored MHBG grant)
FQHC	Federally Qualified Healthcare Center
FSP	Full Service Partnership Program funded by MHSA
FY	Fiscal Year
GENESIS	Geriatric Evaluation Network Encompassing Service Intervention Support
HICAP	Health Insurance Counseling and Advocacy Program
HIPAA	Health Insurance Portability and Accountability Act
HOPE	Helping Older Adults Excel (peer support program for older adults), or: Helping Our Peers Emerge (peer support that includes all ages)
INN (or Inn)	Innovation Project funded by MHSA grant
IHBS	Intensive Home Based Services
LACDMH	Los Angeles County Department of Mental Health
LGBT	Lesbian, Gay, Bisexual, Transgender (or LGBTQ, includes 'Questioning')
MCRT	Mobile Crisis Response Team (aka Mobile Crisis Support Team, MCST)
MH	Mental Health
MHA	Mental Health America (Association)
MHBG	Mental Health Block Grant

MHP	Mental Health Plan; county managed care plans for delivering BH services
MHSA	Mental Health Services Act (Proposition 63), enacted 2004
MHSOAC	Mental Health Services Oversight and Accountability Commission
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding, a type of legal agreement
MST	Mobile Support Team (also called MRT, Mobile Response Team)
OASOC	Older Adult System of Care
ODS	Organized Delivery System for Drug Medi-Cal SUD treatment services
NA	Narcotics Anonymous
NAMI	National Association for Mental Illness
NorCal MHA	Northern California Mental Health Association
NSDUH	National Survey on Drug Use and Health (annual)
NTP	Narcotics Treatment Program
PATH	Projects for Assistance in Transition from Homelessness
PEARLS	Program to Encourage Active and Rewarding Lives for Seniors, an EBT program that helps older adults manage depression-related disorders
PEI	Prevention and Early Intervention
PSA	Public Service Areas designated for services by Area Agencies on Aging
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment (for SUD)
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOS	Signs of Suicide, a prevention program
SUD	Substance Use Disorders
TAY	Transition Age Youth
WET	Workforce Education and Training (funded by MHSA and other sources)
WISE	Wellness Initiative for Senior Education (older adults' prevention program)
WISEWOMEN	Well-Integrated Screening and Evaluation for Women across the Nation
WPC	Whole Person Care, a five-year program under the Medi-Cal 2020 waiver
WRAP	Wellness Recovery Action Plan
YFS	Youth and Family Services

INTRODUCTION: Project Objectives and Data Resources

The purpose of this report is to describe the observations and findings of the California Behavioral Health Planning Council (CBHPC) on the behavioral health (BH) needs and services for older adults who are served by the public mental health (MH) system in California. One key data source for this report includes the responses by local county advisory board members to the 2017 Data Notebook prepared by the CBHPC.

We chose to focus on older adults because of the prevalence of untreated and underdiagnosed mental disorders and substance abuse for this age group. National statistics (2015) estimate that 1.7 million (or 1.6%) of older adults age 50 and over had both a mental illness and substance use disorder (SUD) in the preceding year. Of those, only slightly more than half (57%) received any treatment for their disorders. Most treatment was for mental health issues alone (47%), and only a very small number (7%) of those also received SUD treatment. Only 4% of these older adults (4%) in need of treatment received SUD services without any MH therapy.

These national statistics are expected to be similar to those for California's 8.2 million adults currently aged 60 and over (2018). Based on Medi-Cal paid claims data, older adults (age 60 and over) comprise relatively small percentages of all adults who receive either specialty mental health services (SMHS) or SUD treatment. In addition to the low rates of accessing treatment, there are other data which indicate the likelihood that substantial numbers of older adults in California are living with unmet needs for behavioral health services.

Deaths by accidental drug overdose, diseases arising from alcohol abuse, and deaths by suicide are prevalent and are increasing in both older adults and in late middle age. These trends underscore what some public health officials have described as "diseases of despair," which may be compounded by social isolation, losses of family members or close friends, physical illnesses, lack of resources, financial setbacks, and deep poverty in late life. Statistics for death by suicide show that older adults are at increased risk, and that this risk increases with age (peaking in those age 70-80). This cause of death is more frequent in older men than in older women, and is most frequent in whites and Native Americans compared to other groups of older adults.

Our Council members and other stakeholders expressed concern about the widespread experience of community and individual trauma as a complicating factor for the mental health of older adults. These concerns about accumulated or complex trauma across the lifespan include the recognition that a substantial number of our state residents were born in other countries. Many of these immigrants left countries affected by war, gang violence, natural disasters, or the dire consequences of crushing poverty. All these

circumstances increase the risk of developing anxiety, depression, post-traumatic stress, or other mental health disorders in vulnerable populations.

What is the "Data Notebook" and How Does it Relate to this Report?

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. 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 CBHPC. To provide structure for the report and to make the reporting easier, each year the CBHPC creates a Data Notebook for local mental health boards/commissions to complete. After the Data Notebook reports are submitted to the CBHPC, 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.

The topic for our 2017 Data Notebook reviewed behavioral health services and needs for older adults. In this report, we present data and discussion for review of behavioral health services for older adults, 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 wanted 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 which therefore call for specialized attention and effort by agencies and care providers.

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[1] 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. 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.

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 groups 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 Did We Get the Data?

We obtained data from California Departments of Aging and Health Care Services (DHCS), the California External Quality Review Organization, the American Community Survey and other resources.[2] For some items, statewide data were provided for comparison to the county data. Other issues were highlighted by information from research reports. For important perspectives and background we consulted reports on the Older Adult System of Care by Drs. Janet Frank and Kathryn Keitzman at UCLA for their reports funded bt the Mental Health Oversight and Accountability Commission.[3]

Many questions in the Data Notebook requested input based on the experience and perspectives of local board members. Board members were asked to address related questions about local programs and policies based on information from local county departments of behavioral health or mental health. Those responses represent one major source of information for this report. For the 2017 project cycle, we received 50 Data Notebook reports from local boards representing data from 52 counties[4] that comprised 94% of our state's population.

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

[1] Biological development here loosely refers to the stages of physical, cognitive and emotional growth and aging.
[2] Web site links for these and other data resources are listed in the table in Appendix I.
[3] 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
[4] **See list of participating counties for 2017 on the 'Acknowledgements' page at the end of this report.**

These services are vital to mental health and sustaining recovery, as well as physical health and helping individuals to maintain 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), 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 stakeholders suggest 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

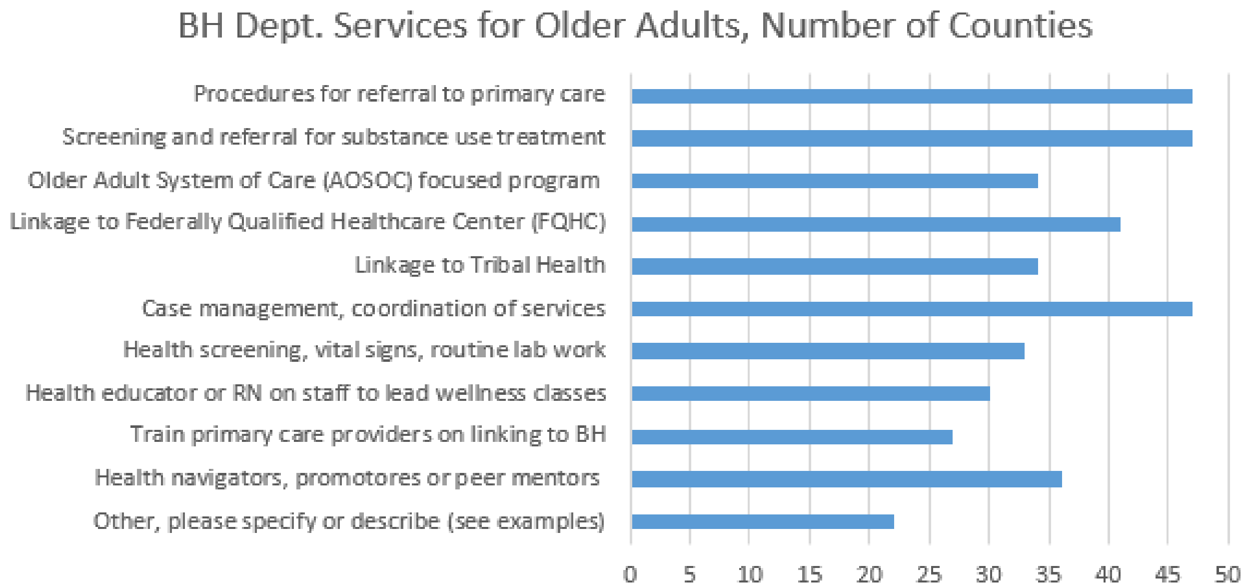
The CA Department of Health Care Services has implemented the Whole Person Care (WPC) Pilot Program. WPC is a five-year program authorized under the Medi-Cal 2020 waiver. This program coordinates services for physical health, behavioral health, and social welfare in a patient-centered manner, with the 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. One important goal is to coordinate care in a more effective and efficient manner by reaching individuals with high rates of multi-system service utilization. In late 2016, 18 counties were approved to participate and by March 2017, additional counties[5] had applied.

We want stakeholders in the MH community to be knowledgeable about the WPC programs because of their importance to overall health and outcomes. Therefore we asked local advisory boards: "Has your county applied or been approved to participate in the Whole Person Care Pilot Program? And if so, will older adults be served in your county's program?" Twenty-four counties responded "yes" and twenty-six said "no." All of the WPC participant counties stated that older adults will indeed be served by their WPC pilot program. However, four counties stated that their program eligibility is limited to age 64 and below, and does not include Medicare recipients.

In a prior Data Notebook (2014), counties provided examples of efforts to ensure integrated delivery of physical health care with behavioral health care. Based on those results and some additional research, we provided an updated list (below) of the most common services or activities. We asked local advisory boards to identify the services provided by their county for <u>older adults</u>. Responses from fifty counties are summarized below, and show the number of counties that provide specific services to older adults.

[5] The data shown above are likely underestimates of total counties participating in the WPC Pilot Program due to those counties which did not submit a Data Notebook for the 2017 project cycle.

Figure 1. Availability and Types of Behavioral Health Services for Older Adults, by Number of Counties



Some counties noted that their behavioral health department does not have a designated 'older adult system of care,' but that their providers and services are sensitive to the needs of older adults. Examples of 'other' services that promote coordinated care for older adults include the following.

- Targeted outreach and preventive health services for older adults, nurse-provided health screenings and assessments, and a senior volunteer outreach program that may include 'Senior Peer companions' or 'Senior Peer Counselors' available for older clients.

- Geriatric-trained psychiatrist or a neuropsychologist who serve as consultants for other therapists and primary care providers.

- MHSA-funded programs for Prevention and Early Intervention (PEI) designed for older adults. These programs may also have Full Service Partnerships (FSP) that include older adults with a history of serious mental illness who are either homeless or at risk of becoming homeless.

- Referrals to programs for employment services and independent living skills for older adults who are still able to, and desire to, work.

- Referrals for older adults experiencing memory loss to Adult Day Healthcare Centers or to ‘Lifelong’ and ‘Day Programs’/social clubs.

- Coordination with Area Agencies on Aging help serve specific language or cultural communities such as Hmong, Lao, Tagalog/Filipino, Chinese, or Latino.

- Mental wellness is promoted in outreach and engagement presentations that educate the community on MH issues and work to reduce stigma. Topics include: Good Sleep, Managing Your Medication, Depression and Anxiety, Emotional Well-being, Holiday Blues, Hoarding, Resiliency, Preserving Your Memory, Senior Bullying, Late-life Transitions, and Grief and Loss.

- Los Angeles County Department of Mental Health (DMH) is implementing chronic disease self-management programs at some clinic sites and partnering with the county’s Department of Public Health (DPH). One example of this collaboration is the Geriatric Evaluation Network Encompassing Service Intervention support (GENESIS), which is a unique program to increase access for older adults to both mental health and health care services, and will serve seniors countywide as it is 100% field-based. The goal of this partnership is to help older adults accept and access MH treatment in spite of life experience or stigma associated with MH issues. Interdisciplinary teams of social workers and registered nurses collaborate to provide MH services that are packaged with medical, case management, and resource linkage services. Desired outcomes, among others, include continued collaboration with primary health care providers, linkage to community resources to promote independent living, and successful navigation of public systems (or agencies) to maintain an adequate standard of living.

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.[6]

Of those, "approximately 1.6 million (30 per cent of California's total older adult population) was foreign-born." [7]

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.[7]

Table 1. 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[8], 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 %

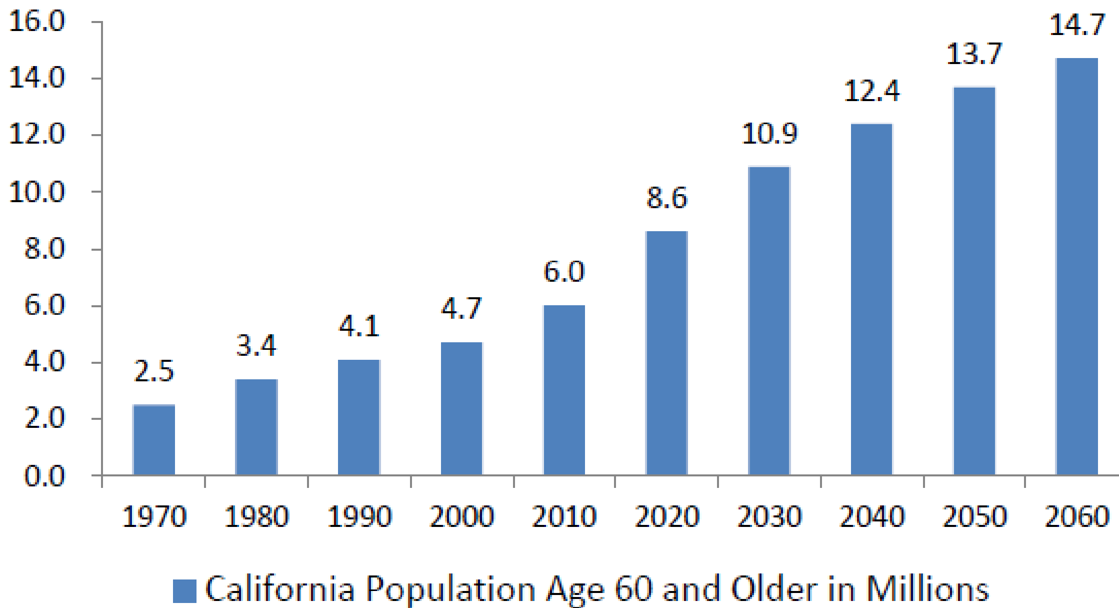
"California's older adults will continue to grow more racially, ethnically, and culturally diverse. While 62 percent of older adults were White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities." [7] These trends gave rise to the descriptive term 'majority-minority.'

[6] California Department of Finance, Demographic Reports and Projections, 2017. www.dof.ca.gov.
[7] California State Plan on Aging – 2013-2017, California Department of Aging, www.aging.ca.gov.
[8] Due to statistical reasons regarding sampling, data from the above 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 2. Projected Increases in Population Age 60 and over in California. [9]



We requested that local board members examine data provided for their county and to compare those predicted changes in population numbers with those for the state (below).

	2010 Population age 60+	2030 Population age 60+	Change in 20 years
California	**6,016,871**	**10,879,098**	**81 %**

Then, we asked local boards: "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? If yes, please describe." Responses from 30 counties indicated "yes," and 20 said "no." This question appeared to have been interpreted in two different ways by local counties and their boards. Based on the population trends depicted in Figure 2

[9] State of California Department of Finance (January 2017), 2016 population data and projections: www.dof.ca.gov. See also some Census data about diversity in CA, shown in Appendix II from the American Community Survey.

and the county data we supplied, some of the local boards clearly understood that we intended to ask about longer-term planning. The twenty counties that said “No,” a few of those indicated they do have plans to begin this process with their partners in other county agencies. Interestingly, a number of county staff members expressed appreciation that these data trends had been brought to their attention.

However, many of the 30 counties (or their boards) that answered “yes” appeared to assume that the question asked about current planning processes and therefore they provided details about plans for the current year or the next one-to-three years. Examples of such plans included: the MHSA 3-year plans for Community Services and Supports, MHSA housing-related services, Cultural Competence Advisory Committees, coordinated planning with the Area Agendas on Aging, and multi-disciplinary planning with county alcohol and drug programs. Some local BH advisory boards have an adult services committee which addresses the needs of older adults. A few counties with rural populations in outlying geographic areas mentioned plans to open more clinics or to link with other local providers so that more of these residents, including older adults, could access services more readily.

A few counties described longer-term plans and/or processes for county inter-agency planning, including consulting with the Area Agency on Aging. Examples included:

- Marin County has an Innovation project to plan for increased numbers of older adults with a “recovery-oriented, community-based response by providing services as alternatives to hospitalization for…older adults experiencing psychiatric crises.”

- Another example, Placer County, has developed a 5-year plan to address areas of concern for the growing older adult population, including (1) communication and information about available services, (2) transportation needs, (3) housing, (4) community and health services, (5) social inclusion and respect, (6) civic participation and employment, (7) outdoor spaces and buildings.

- San Diego identified twelve priorities in their planning document “The Ten Year Road Map for FY 2016-2026”. Major priorities include the aging population and ensuring that older adults with serious mental illness (SMI) have access to “integrated, age-appropriate services to meet their complex needs.” This county includes SUD treatment services for older adults (age 60 and above) in their implementation of the Drug Medi-Cal ODS program.

- Santa Cruz and San Bernardino counties echoed similar statements about providing services to older adults in planning for Drug Medi-Cal ODS services.

Los Angeles County (LAC) now has one-quarter of all the state's older adult population who are aged 60 and older, and expects their increasing numbers to roughly parallel those predicted for the state as a whole in coming years. Therefore, LAC Department of Mental Health (DMH) has taken an especially robust approach to their long term planning, a collaborative process involving the Systems Leadership Team, Older Adult Provider meetings, Older Adult System of Care forums, and Executive Leadership. Planned strategies include: (1) develop workforce skills for treating older adults with mental illness and co-morbidities, (2) expand clinic and field-based services for older adults, (3) increase Full Service Partnerships (FSP) for justice-involved, homeless and Intensive Service Recipient older adults by 40%, and (4) implement evidence-based prevention practices for older adults. In addition, LAC-DMH has launched an Older Adult Innovations Project targeted for homeless older adults with (or at risk of) mental illness, many of whom have chronic health conditions and/or substance use disorders. Some project strategies are to provide a safe and supportive day shelter, educate the community around engaging older adults with mental illness, and provide linkage to MH services.

Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

In the United States (2014), national data[10] reported that about one-third (36%) of people aged 65 and over had either a physical or cognitive disability. A disability was defined as difficulty in hearing, vision, cognition, ambulation, self-care, or independent living. "The percentages for individual disabilities ranged from almost one quarter (23 percent) having an ambulatory disability to 7 percent having a vision difficulty."…"Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs." About 8% had impairments in their ability to care for themselves, and 15% were not able to perform the functions of daily living that would enable them to live independently.

Compare those numbers to data for California, below. Statewide, in 2011, there were more than 4.3 million people age 65 years and older. Of those, the number with a disability was nearly 1.6 million.

Thus, in California, about 40% of adults age 65 or over have a physical or cognitive disability. These numbers change dramatically with increasing age. Disability affected 24% of those aged 65-74, but affected slightly more than half of all persons age 75 and older, who had one or more disabilities. The data further show that both the types and degree of total disability in this population also increase as people age.

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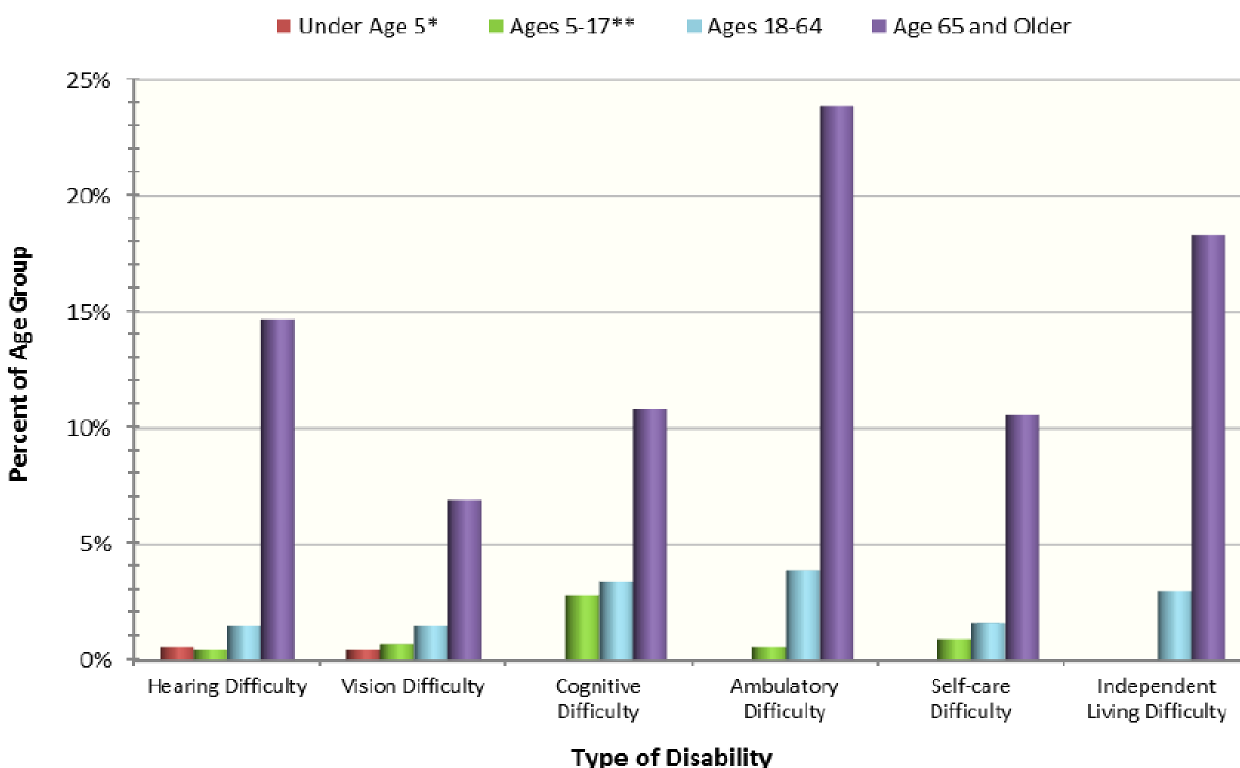
[10] See Appendix II, and U.S. Census Bureau, American Community Survey. Data for 2014, as presented in the 2015 California report: www.aging.ca.gov/docs/DataAndStatistics/Statistics/OtherStatistics/2015-Profile.pdf.

Table 2. **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%**

Figure 3. **Type of Disability in Different Age Groups in California (2011), below.**



*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.

The data above shows specific types of disability, but 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. Disability statistics tell only a part of the story about barriers to BH access.

Limited English Proficiency is often a Barrier to 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 its historical origins and the large inflow of immigrants, California "is one of the most language-diverse states in the nation,"[11] with more than 100 languages spoken.

Statewide, a language other than English is spoken at home by one-quarter of the population age 5 years and over. But fully one-third of adults over age 65 speaks a language other than English at home, and half of these older adults speak English "less than well," (as shown below). This lack of proficiency could impair communication about one's healthcare and other sensitive personal matters.

Table 3. Language Spoken at Home and Ability to Speak English by Age. Data set: California population age 5 years and over.

		Speaks a Language Other than English at Home			
Age Group	Total	Number	Percent of Age	Speaks English Less than "Well"	Percent of Age
5-17	6,736,128	3,058,109	45.4%	161,828	2.4%
18-24	3,976,778	1,872,784	47.1%	180,178	4.5%
25-64	20,053,913	8,945,108	44.6%	2,774,311	13.8%
65+	4,397,806	1,517,026	34.5%	704,671	16.0%
Total	**35,164,625**	**15,393,027**	**43.8%**	**3,820,988**	**10.9%**

Several counties historically have had especially 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.

Many counties have difficulty finding behavioral health staff who speak Spanish, the language spoken most frequently in California after English. Efforts are made to hire staff who speak other languages in areas of the state with an especially high need. However, the most-commonly used alternative is the telephone-based translation service, which at times can be awkward for addressing highly personal issues in mental health and substance use treatment. To illustrate the type and prevalence of language needs by residents of California, we show the top ten languages spoken at home (other than English) in the table below.

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

<u>Table 4.</u> Top Ten Languages Spoken at Home Other than English by Ability to Speak English. Data set: California population age 5 years and over who speak a language other than English at home.

Language	Speaks a Language Other than English at Home			
	Number	Percent	Speaks English Less than "Well"	Percent Speaks English Less than "Well"
All Languages	**15,393,027**	**100.0%**	**3,820,988**	**24.8%**
Spanish	10,105,866	65.7%	2,753,552	27.2%
Tagalog	763,121	5.0%	59,274	7.8%
Chinese	579,808	3.8%	194,186	33.5%
Vietnamese	526,747	3.4%	173,367	32.9%
Korean	371,273	2.4%	123,299	33.2%
Cantonese	222,565	1.4%	82,584	37.1%
Mandarin	215,708	1.4%	46,212	21.4%
Persian	205,196	1.3%	34,533	16.8%
Armenian	199,503	1.3%	53,966	27.1%
Arabic	157,871	1.0%	27,873	17.7%

Local boards identify needs of the cultural groups in their community and become knowledgeable about those groups most likely to need cultural outreach and language assistance. Therefore, we asked the local boards: "are there groups in your county who are at significant risk of being unserved or underserved due to limited English proficiency?" Of those counties that responded, forty boards answered "yes." Only ten counties answered "no," and all but one of those were small population counties in the far northern (Superior) or Sierra mountain regions of the state. Interestingly, one such small county (who had answered "no") noted that their county had a bilingual staff member who spoke Hmong in addition to English.

In addition, we asked those boards that had answered in the affirmative to list the top three major language groups[12] or communities in their county in greatest need of outreach for behavioral health services. At least 40 counties listed Spanish-speaking communities in their top three cultural groups potentially in need of outreach, translation services, and/or bicultural service providers. A few counties also noted that LGBTQ older adults and Deaf and Hard of Hearing communities were in need of outreach by people who understand their needs and cultures. Overall, the responses were very informative,

[12] The range of responses received from counties in the 2017 Data Notebook are qualitatively similar to the more rigorous data of Table 4 above. However, our questions were not designed to capture a detailed statistical survey.

and reinforce the picture of our state's cultural and language diversity, while further illustrating the concomitant challenges for healthcare access.

- Some county BH clients who were not fluent in English included native speakers of Russian, Portuguese, and other Indo-European languages.

- Some clients spoke languages such as Mixteco (found in some villages in Mexico) and other indigenous languages from Central and South America.

- County BH departments have served clients who spoke Asian or Pacific Island-origin languages such as: Mandarin, Cantonese, Japanese, Korean, Filipino/Tagalog, Thai, Vietnamese, Hmong, Laotian, Mien, Lahu, Burmese, and Cambodian (Khmer). Some clients from the Indian subcontinent spoke Punjabi, Hindi, or Urdu, as the most common of several dozen primary language groups possible in people from that region.

- Languages of clients from the Middle East and south Asia included Assyrian (Syria), Farsi (Iran), languages of Afghanistan (Dari, Pashto, and others), and Arabic (Iraq, Palestine, and many other countries).

- Other clients had emigrated from African countries, including Ethiopia, Somalia, and Eritrea, and spoke one of several languages indigenous to those regions.

- Los Angeles County had a notable number of clients with Asian or Pacific Islander origin who were in need of service providers and/or translators proficient in Cambodian, Vietnamese, and Korean, as well as other languages such as Chinese, Tagalog, Laotian, Japanese, Hindi, Burmese, in addition to Spanish. This variety and the total numbers of non-English speaking clients further illustrate the challenges faced by BH departments.

As a follow-up question, we asked the local advisory boards to describe one or more strategies that their counties employ to reach and serve various cultural and/or race-ethnicity groups within their population of older adults. One of the most frequent responses identified the importance of using telephone-based translator services to assist client and family interviews and having good availability of translators for the county access lines. Also, nearly all counties have prepared written materials in multiple languages to provide information about services and mental health issues. Some boards noted that there were increased difficulties due to recent immigration laws and enforcement activities. Perceptions and fears resulted in many individuals (especially in the Hispanic population) 'keeping a low profile' and actively avoiding help of any kind from

government agencies. These reality-based fears are difficult barriers to overcome in our effort to reach those who may be in need of BH or other health services.

We received responses from a substantial number of counties that discussed the specific role played by *promotoras* in assisting clients and their family members who are predominantly Spanish-speaking. *Promotoras* act in a peer-specific role to conduct outreach to Spanish-speaking communities to link individuals to BH services (or other health services), assist clinicians with language barriers and coordinate family team meetings, work with FSP case managers who provide intensive MH services to the SMI population including older adult Spanish monolingual persons. Although this form of assistance is available to all age groups, it is most needed by the older adult population who have the largest numbers that are not proficient in English.

The types of population-specific clinical and outreach programs used by California counties comprise a rich array of services and strategies, and vary across counties. As an aid to informing local boards and stakeholders, we have prepared a detailed listing of county BH programs for older adult services and strategies for outreach, arranged mainly by cultural and language groupings, in a detailed report addendum[13] which is available upon request.

[13]Report Addendum, pages i—xx: "County Behavioral Health Outreach and Service Strategies for Older Adults in the Community and those Designed for Members of Specific Cultural Groups." Available upon request from: DataNotebook@CMHPC.ca.gov.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

The next goal of our discussion is to present an overall picture based on several different types of data for older adults, including the disability and language issues already presented. Additional data from the California Department of Aging describe demographic circumstances that can challenge mental health and well-being in addition to presenting obstacles to service access. These items 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 the person communicates primarily in a language other than English. These conditions affect quality of life, the ability to participate in one's community, and the access to services. Our health care systems need to be ready to assist the growing numbers of older individuals that experience one or more of these challenges, as illustrated below.

Table 5. Demographic Projections[14] for Older Adults (60+) in California (2018).

Age 60+: 8,221,985	Age 75+: 2,481,797
Nonminority: 4,563,242	Minority:[15] 3,658,743
Low income:[16] 988,559	Non-English proficient: 432,451
Medi-Cal: 1,708,471	SSI/SSP (65+): 574,857
Lives alone (60+): 1,406,405	Geographic isolation (60+): 438,984

These demographic circumstances affect a large number of older adults, many of whom contend with several of these challenges simultaneously. We want to understand how these, and other potential issues, created barriers to service access in local communities. Therefore, we asked local boards whether there were other significant barriers to obtaining BH services for older adults in their county. And if so, to please identify all those applicable from a list of common barriers that we had compiled from prior reports.

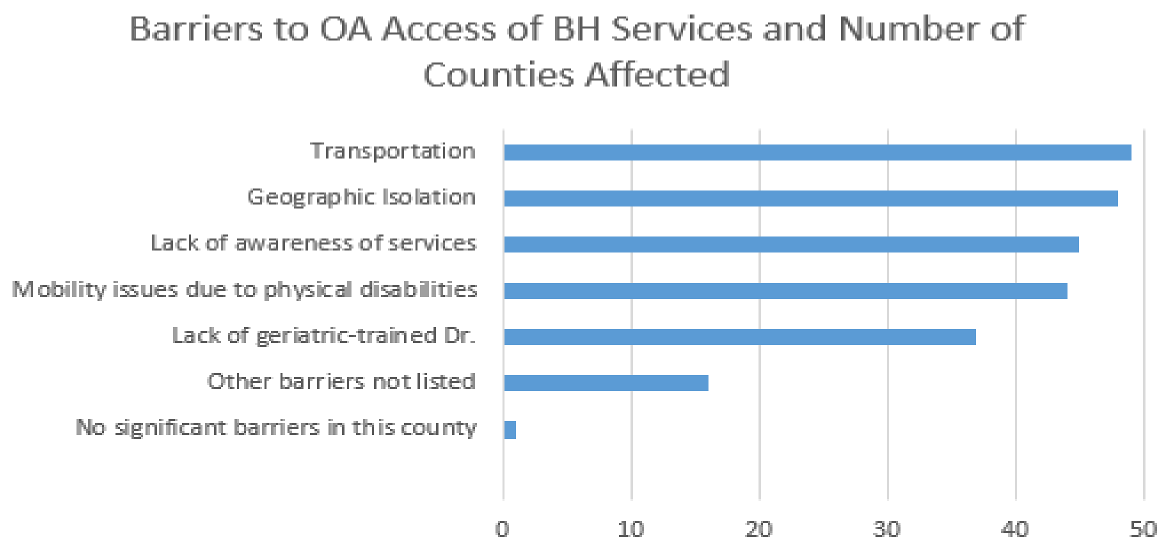
[14] CA Department of Aging, www.aging.ca.gov. 2018 CDA Population Demographic Projections by County and PSA, (used for Intrastate Funding Formula, IFF). PSA = Public Service Area designated for programs for the elderly. www.aging.ca.gov/docs/DataAndStatistics/Statistics/IFF/2018%20Population%20Demographic%20Projections.pdf

[15] The federal data guidelines used by the CA Department on Aging define defines "nonminority" as non-Hispanic Whites, and "minority" as everyone else, that is, all race/ethnicities that are not Caucasian and are not Hispanic.

[16] Low income is considered 80% of the median income for an area; very low income is considered 50% of median income, and extremely low income is 30% of median income or the FPL, whichever is greater. Rent and housing costs, along with number of family members, affect the income values to meet these definitions. Data shown are based on the census's American Community Survey.

Only one county indicated "no significant barriers." The other 49 responding counties answered "yes," and identified their most important barriers, as illustrated below.

Figure 4. Prevalence and Types of Barriers for Older Adults Seeking Behavioral Health Services, by Number of Counties



Nearly all of the 50 counties reported that the first four factors above are significant barriers to service access for older adults in their community. About 75% of these counties also identified "lack of geriatric-trained practitioner" as a barrier. Sixteen local boards volunteered other barriers to care, as listed below.

- Lack of safe, affordable housing; more and different levels of housing are needed, including independent or assisted living facilities.
- Medical and/or MH issues can preclude older adults from certain housing or assisted care facilities, especially if the client has physical mobility issues, or if they display problematic behaviors.
- Lack of affordable health insurance and/or high co-payments.
- Co-occurring physical and mental health conditions, each of which can complicate the other condition.
- Unclear or inadequate facility signage is a problem to those with changes in vision and/or their ability to identify a specific feature in a complex visual environment, especially if the place is unfamiliar to the client.

- Lack of culturally relevant targeted activities for seniors, especially the senior LGBT population.

- Stigma also prevents many older adults from accessing both MH and SUD treatment services.

- Difficulties navigating the health system and confusion with the complexities of paperwork give rise to a perception that “there is no one centralized entry point where people can get help with one phone call.’

- Transportation issues can cause a ripple effect on seniors upon loss of driver’s license, including loss of independence, increased loneliness and isolation, any of which may lead to medication non-compliance (or inability to get refills), risk of injury by falls, substance abuse, worsening depression, among other sequelae.

- Lack of services in outlying rural areas, especially in mountainous areas or the “vast high desert region,” or those living remotely or ‘off the grid.’

- In many counties there is a large homeless population, some of which includes older adults in rural areas, which creates a difficult environment to identify and reach those in need.

In summary, the most significant barriers for older adults are transportation, geographic isolation, and affordable housing. Respondents also noted that accessing BH services may be complicated by cultural stigma, lack of insight regarding one’s own need for such services, lack of motivation, and a sense of hopelessness or chronic depression.

BEHAVIORAL HEALTH: OLDER ADULTS' CONTINUUM OF CARE

Substance Use Treatment for Older Adults: Barriers and Stigma

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." 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 by accident, or mix them with alcohol, or may become "accidental addicts." Depression and anxiety in older adults may lead to inappropriate "self-medication."[17]

Stigma, denial, lack of awareness, and nominally acceptable social use (e.g. alcohol, marijuana, prescription drugs) all play some role in both creating 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 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. The need for integrated treatment of both MH and SUD is even greater for those with co-occurring disorders.

In the U.S. (2015),[18] there were at least 1.7 million adults aged 50 or older who had both mental illness and SUDs in the prior year. That number corresponds to 1.6 percent of all adults 50 and older. Of those with co-occurring disorders, 57 percent had received mental health care or SUD treatment at a specialty facility. Mental health care only was received by 47 percent of this group. Both mental health care and SUD treatment were received by 7 percent. However, a few of those with co-occurring disorders (4%) were only able to access SUD treatment without MH services. These national trends lead us to consider some related data for older adults in California.

Focus on Fifty-five (and over) in California:

The following information applies only to publically-monitored SUD treatment data that has been submitted to DHCS, most of which is paid by Drug Medi-Cal and federal block

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[17] 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

[18] 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.

grant funds. There is no public data available for other SUD treatment that is funded by private insurance or private payment, so their information is not included in our report. Analyses[19] of data for clients in California age 55 and over who were admitted for SUD treatment in FY 2014-2015 yielded these findings:

- About 11,000 unique clients ages 55 and over participated in 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 of these clients age 55 and over were enrolled in the Outpatient Narcotic Treatment Program (NTP) -- maintenance service type (30%), or to the Outpatient Drug Free service type (28%). Residential Detoxification was next at 25%, and then Residential Treatment at about 17%.

- About 47% of these older clients reported problems with drugs alone (other than alcohol), about 24% reported problems with alcohol alone, and 29% reported both alcohol and drug use.

- 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.

- In contrast, for clients under 55, methamphetamine is the most commonly-reported drug, followed by the other major drugs of abuse listed above.

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 any MH services received in the 30 days prior to entering treatment, including whether they had been prescribed psychiatric drugs. Certain responses were taken as indicators suggesting that the SUD client likely had MH issues within the prior 30 days.

- A relatively small percentage (about 3-4% combined) of newly enrolled SUD clients reported past month episodes of emergency MH/ER visit or admission to 24 hours or more psychiatric facility days.

- About 24% of newly enrolled SUD clients reported psychiatric drug use (as prescribed by their physician) within the past month. This metric is taken as one

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[19] 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. NTP= Narcotic Treatment Program.

indicator of having a MH condition. These data represent a minimum estimate of how many individuals likely had co-occurring MH and SUD conditions.

- These findings for California are in line with the SAMHSA estimates that about 24% of all adults nationally (not just older adults) had a MH disorder that needed treatment in the past year.

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 after treatment. These outcome measures included primary drug abstinence, employment, stable housing, and participation in social support recovery days in groups such as ten-step programs. Those with co-occurring disorders were also more likely to have been arrested than other SUD clients.

In our analysis of statewide data, the age break for older adults was lowered to 55 because their SUD problems often have roots in late middle age, with increasing impairment in subsequent years. The data below show how many older adults (age 55+) received different types of SUD treatment services relative to other age groups in our state. Column percentages are shown to emphasize age group differences and the limited numbers of seniors who received SUD services.

Table 6. State of California: Availability of Different Types of SUD Treatment, Analyzed by Age Group and Type of Treatment Received (FY 2015-16)

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	3,005 13.4 %	3,674 16.9 %	3,363 5.7 %	2061 7.3 %	12,103 9.2 %
Age 37-54	8,395 37.5 %	7,340 33.8 %	16,475 28.2 %	9,148 32.2 %	41,358 31.6 %
Age 26-36	7,442 33.2 %	7,719 35.6 %	20,216 34.5 %	11,170 39.3 %	46,547 35.5 %
Age 15-25	3,555 15.9 %	2,974 13.7 %	18,467 31.6 %	6,014 21.2 %	31,010 23.7 %
Column TOTALS:	22,397 100 %	21,707 100 %	58,521 100 %	28,393 100 %	131,018 100 %

For comparison to the statewide data above, we provide examples of data from three counties of markedly different population sizes in Appendix III. Examination of data from many counties results in two key findings (among other possible conclusions):

- 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. This is a pattern seen in many counties, regardless of population size. Some typical examples of data for individual counties (large, medium and small population counties) are presented in Appendix III.

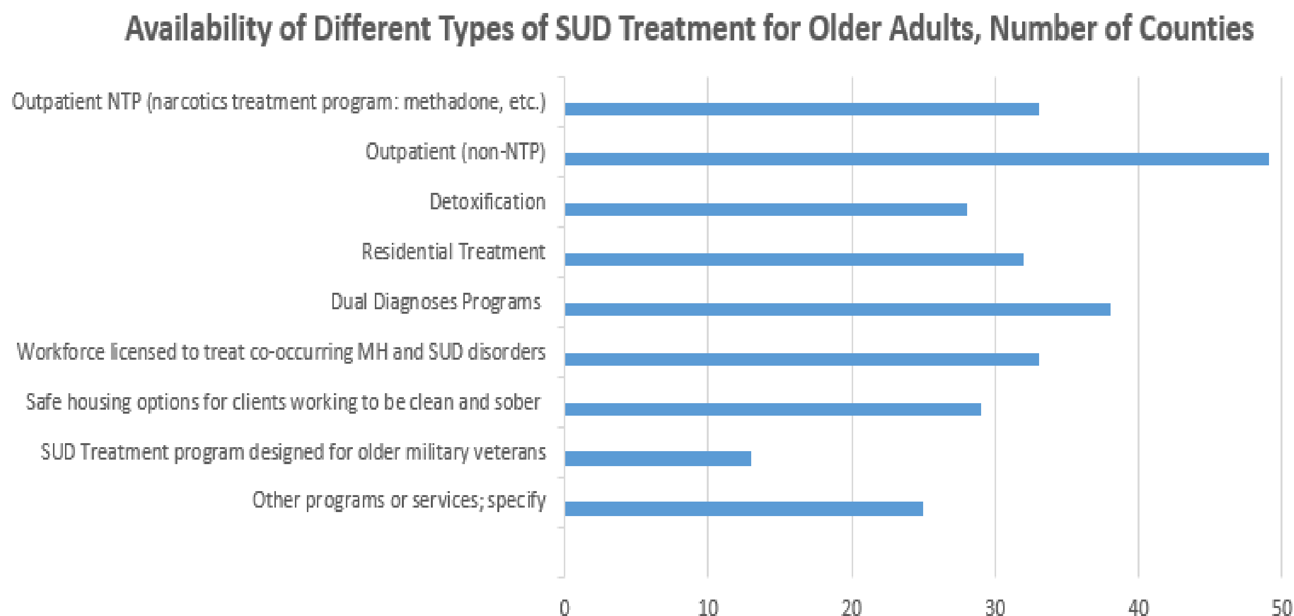
- In the majority of small counties with populations <100,000, there are relatively few options for different types of SUD treatment besides outpatient treatment (e.g., non-NTP), as illustrated in Appendix III. Most small county SUD data tables show a large number of "zeroes" for numbers of clients who received specific types of treatment, a pattern which suggests that there is a substantial geographic disparity in access to a full range of SUD services.

The issue of limited availability of a full range of SUD treatment types is being addressed over time. This year we are seeing more reports of regional treatment resources that are able to serve clients in nearby counties. However, limited transportation options and long travel distances continue to present barriers to service access, especially for seniors who are homebound or who live in isolated areas.

One of our project goals is to identify unmet needs for substance use treatment in older adults in different counties and regions of the state, based on local community needs assessments. Or, an alternative way to address this issue is to tabulate what services are available and where, and then identify any gaps.

Counties offer a variety of services as part their implementation of Medi-Cal funded SUD programs. We hoped to highlight those services that are specifically designed for the unique needs and culture of older adults. Therefore, we asked the local boards to identify the substance use treatment services that are available in their counties for older adults. The responses from fifty counties are summarized below.

Figure 5. **Types of SUD Treatment and Availability to Older Adults in Counties**



Although many counties offer several types of SUD treatment programs and services, none of the responding counties identified programs designated specifically for (or only for) older adults. Most services are available to all age groups. Providers try to be sensitive to the specific issues and needs of older adults, including concerns about alcohol, prescription drug misuse, and cultural/peer influences or social isolation as factors in substance abuse. Many counties schedule discussion and therapy groups for older adults within their standard array of SUD treatment services. In addition to the services listed in above, many county reports described a variety of "other" types of SUD programs that are available to both older adults and all eligible adults, as follows.

Medication Assisted Treatment (MAT) is provided by Butte County. MAT is a program that administers the drugs Suboxone and/or Vivitrol as a treatment coupled with counseling and behavioral therapies. The goal is to provide a 'whole person' approach to the treatment of SUD that involve CNS depressants such as opioids or alcohol.

Dual diagnosis programs may be found in many large population counties. One example of a small population county, Calaveras County, has a dual diagnosis program serving all age groups. By comparison, Shasta County has "dually-trained" staff, but no formal program specific to dual diagnosis. Sonoma County offers both SUD and specialty MH services to clients as part of a coordinated care program that includes age 65 and over. Other small population counties, such as Tuolumne, also provide outpatient NTP and non-NTP services that include "12 Steps" programs, "Celebrate Recovery," and local groups at community centers, church sites, or the Salvation Army.

Sober living housing options continue to be a matter of considerable importance, especially in a state facing major challenges due to very limited options for all types and levels of affordable housing. Counties employ a variety of strategies to provide sober living options for their BH clients, including those who are older adults, as follows:

- Siskiyou County has no sober living residences of their own, but instead they contract with providers in Shasta County to serve Siskiyou County residents.

- Yolo County has safe housing options for clients working to be clean and sober, and these options are also available to dual-diagnosis clients.

- El Dorado County provides safe housing options for clients working to be clean and sober, but these resources do NOT apply to dual diagnosis clients.

- San Francisco: has a designated Homeless Outreach Team (HOT) to get eligible clients into supportive housing appropriate to the client's BH needs. Their target population includes older adults with SMI or SUD, many of whom may have other disabilities or physical health conditions that are worsened by 'life on the street.'

Veteran's resources were specifically mentioned for Mariposa County, Napa County, Sonoma County, and out-of-county for Mendocino residents. Humboldt County has both a V.A. Clinic and the North Coast Veteran's Resource Center. San Bernardino also has a large V.A. facility that provides BH services for veterans, but they may also receive SUD and recovery services through the county BH department's system of care. Santa Clara County noted that there were no services specifically designed for older military veterans, but that they may access standard services in their BH department.

At least 12 counties identified SUD treatment programs that are either designed or are available for older military veterans. However, that number is likely to be an underestimate due to both question design and response rates for the 2017 Data Notebook. Whether there is adequate availability of BH services appropriate to needs of military veterans in all areas of the state is an open question that deserves further investigation. Some veterans may benefit from a more specialized, trauma-informed approach due to issues such as PTSD arising from events or injuries encountered in military service. Also, they may be more comfortable in groups of people with similar experiences and who share a background in military culture.

One important concern is ensuring that BH providers are dual-diagnosis qualified. Therapists and other providers need the expertise to work effectively with, and treat, older adults diagnosed with co-occurring MH and SU disorders. Such workforce

training may be provided by professional associations, universities, CIBHS, and some of the larger counties. Los Angeles County is one example of a county with a strong initiative that provides an array of trainings on these topics, for example:

- SBIRT-Screening, Brief Intervention, and Referral to Treatment
- Seeking Safety (a trauma-informed approach to SUD treatment)
- Advanced Motivational Interviewing
- Application of Motivation Interviewing Techniques for Older Adult Clients
- Substance Abuse in the Older Adult Population.

Mental Health Services for Older Adults[20]

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.[21] About 15-20 percent of older adults have experienced depression at some point.[22] 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.[23] 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.[24] 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. Major depression also shortens lives due to interactions with medical conditions and due to suicide. Untreated depression in older adults also increases the risk for developing dementia.

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. Large changes occurred in the total population eligible for Medi-Cal services as a result of the passage of the Affordable Care Act (2010) and its implementation beginning in 2011. In our recent report on BH services for children and youth, we examined the effects of the ACA which substantially increased the numbers of children and youth who are eligible for Medi-Cal funded BH services. There were similar challenges placed on county BH departments in the systems that serve adults and older adults. The problems presented considerable resource challenges to county staff in meeting the increased needs for SMHS for adults and older adults who became eligible as a result of the Medi-Cal

[20] 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.

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

[22] Geriatric Mental Health Foundation, 2008.

[23] 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.

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

expansion. This phenomenon may have increased the likelihood that some individuals are not able to get needed services. We are concerned that these constraints may have further impacted older adults, as there have been indications that older adults were underserved both on the basis of their share of the Medi-Cal eligible population and as a share of the overall population. Therefore, we will briefly examine a short overview of the data for all adults age 21 and over, followed by an in-depth look at data for those age 65 and over. More details of the SMHS data can be found in Appendix IV and Appendix V for those who are interested in further research.

We cannot effectively discuss data for older adults in isolation, without the context of the total population of which they are a part. We would not have any clear idea about whether older adults are being underserved or relatively unserved, compared to their percentage of the population as a whole. We also need the larger data context in order to assess how well the system is performing in reaching older adults within various cultural or race-ethnicity subgroups.

The table below summarizes data for all California Medi-Cal certified eligible adults (including older adults) who also received specialty mental health services (SMHS).

Table 7. Challenges to County Resources and Workloads: Rapid Changes Year-over-Year in Medi-Cal Population and those who received Specialty MH Services.

Demographics Report: Unique Count of Adults Receiving SMHS by Fiscal Year

Statewide as of March 22, 2018

SFY	Unique Count Receiving SMHS*	Year-Over-Year Percentage Change	Unique Count of Medi-Cal Eligibles	Year-Over-Year Percentage Change
FY 13-14	297,369		5,753,705	
FY 14-15	341,797	14.9%	7,189,144	24.9%
FY 15-16	346,669	1.4%	7,882,474	9.6%
FY 16-17	341,362	-1.5%	8,220,974	4.3%
Compound Annual Growth Rate SFY**		**4.7%**		**12.6%**

**SMHS = Specialty Mental Health Services. See Measures Catalog for more detailed information.*

***SFY = State Fiscal Year which is July 1 through June 30.*

Next, we show an extract of that data which suggest that adults over the age of 65 receive far fewer specialty MH services, compared to other adults, using either

measures of access or engagement. The table at top shows data for those adults who received at least one specialty MH service (one measure of "access"). The lower part of the table shows how many adults engaged in five or more services during the year.

Table 8: Adults and Older Adults: Access and Engagement in SMHS

Top: One measure of access to SMHS is provided by data for the service penetration rates shown for adults who received one or more SMHS services per year, by ages.

	FY 16-17		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	341,362	8,220,974	4.2%
Adults 21-44	173,087	4,305,488	4.0%
Adults 45-64	145,546	2,602,031	5.6%
Adults 65+	22,729	1,313,455	1.7%

Below: One measure of client engagement in SMHS is indicated by penetration rates for those adults who received five or more services during the year, by age group.

	FY 16-17		
	Adults and Older Adults with 5 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	209,648	8,220,974	2.6%
Adults 21-44	100,028	4,305,488	2.3%
Adults 45-64	95,053	2,602,031	3.7%
Adults 65+	14,567	1,313,455	1.1%

Take special note of the data for "Adults 65+." We observe that adults over age 65 received far fewer specialty MH services in both cases compared to other age groups.

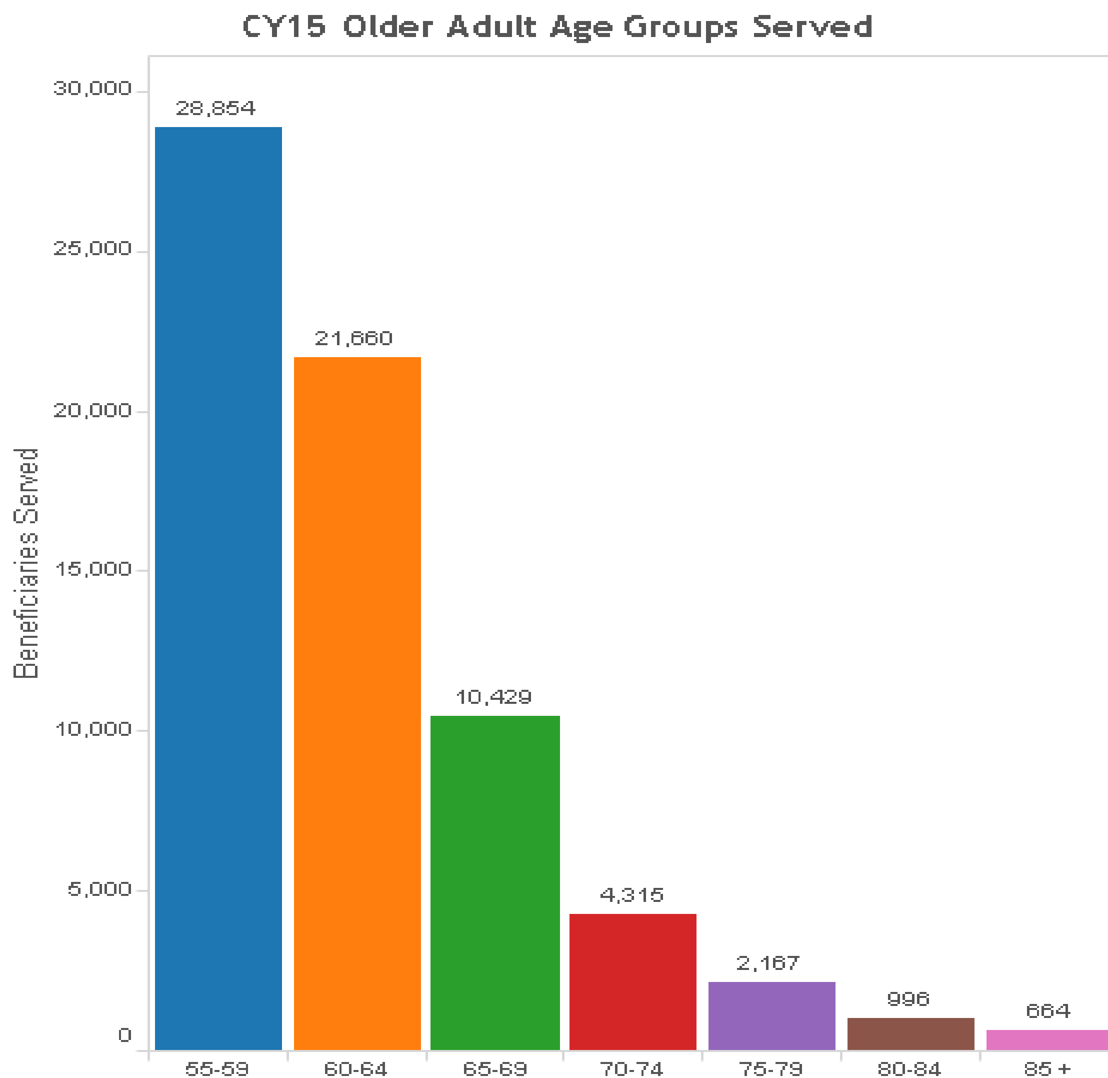
Next, we examine the information in more detail for older adults, based on a special analysis of Medi-Cal claims data that was performed by the California EQRO for a presentation at one of our Planning Council committee meetings.[25]

[25] "Older Adult Population Served by California's Medi-Cal Specialty Mental Health Services," presented by Saumitra SenGupta, Ph.D., and Rachel Phillips, M.S., of BHC-CalEQRO, at the California Mental Health Planning Council Quarterly Meeting, San Jose, CA, April 20, 2017. For additional details see the following:

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. Of these older adults, 88% were aged 55-69. Only 12% were aged 70 and older. In particular, the Affordable Care Act (ACA) enabled 28% of these older adults (total 19,376) to access mental health services, who had not received services before.

Nearly all of those clients who received SMHS fell into the age group 55-69, as shown in the data below. Of those, the age group 55-59 had the largest number of individuals who received services. Age 80 and over received the fewest services.

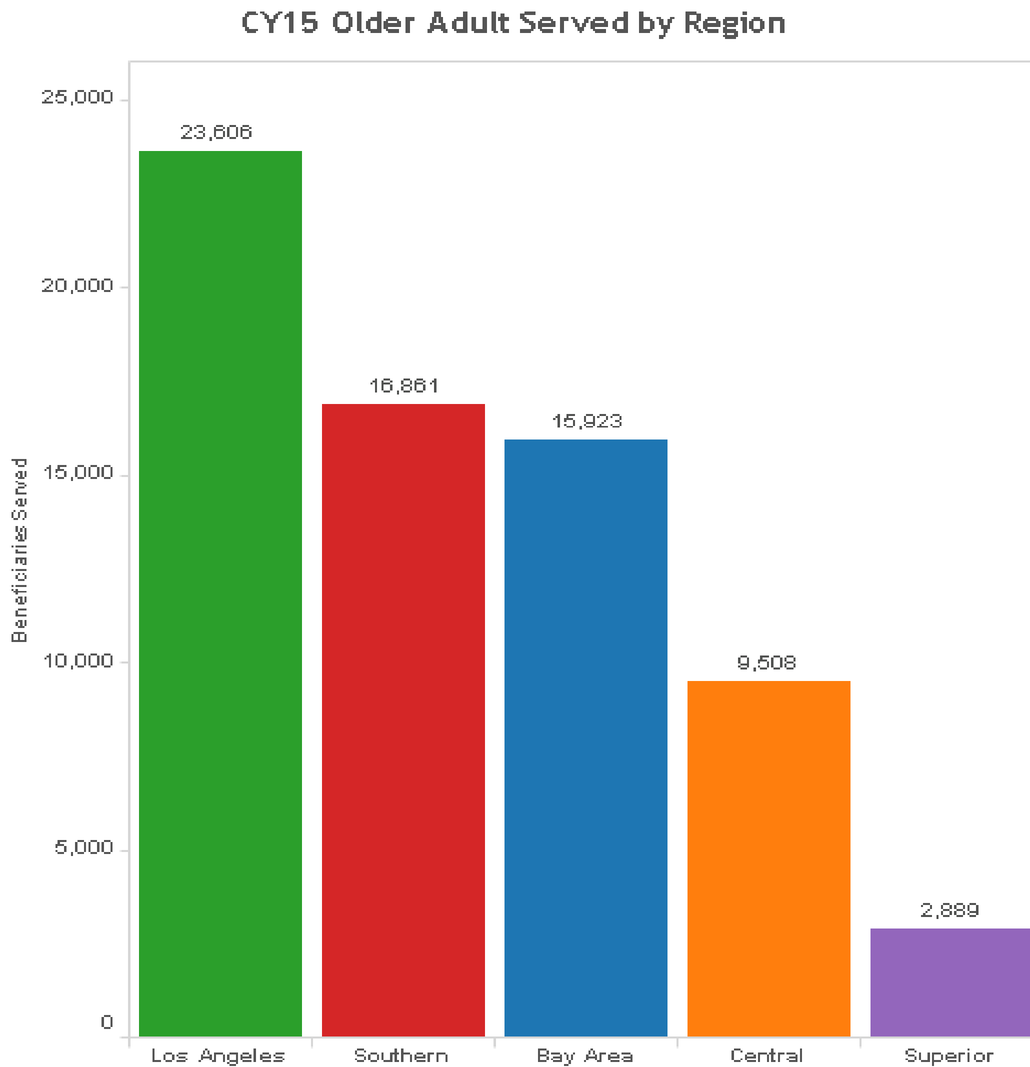
Figure 6. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).



https://www.caleqro.com/data/MH/Presentations%20and%20Trainings/CA%20MH%20Planning%20Council%20Presentation%20on%20Older%20Adults%20Served.pdf.

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 7. 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.



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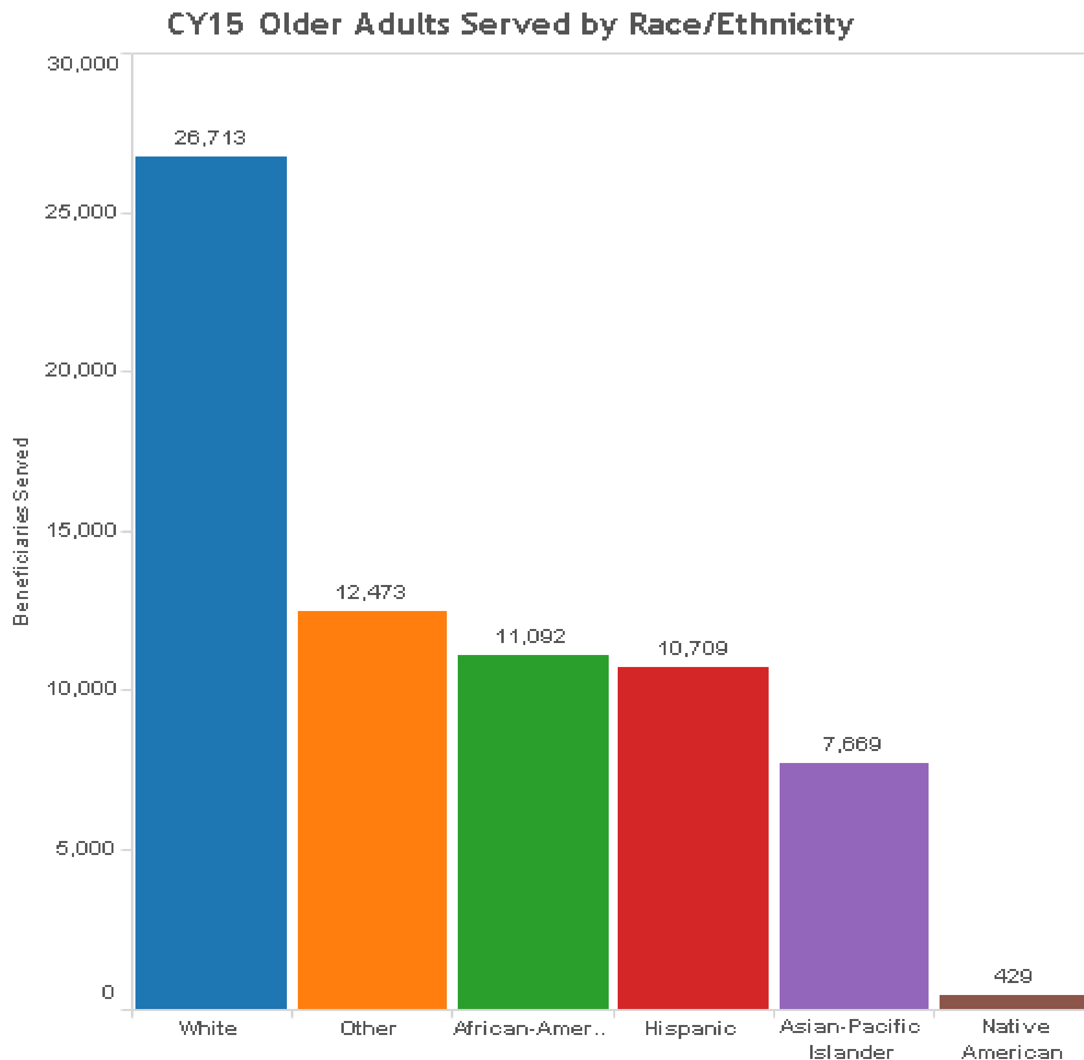
[26] Bay Area: Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma counties.
Central region: Amador, Alpine, Calaveras, El Dorado, Fresno, Inyo, Kings, , Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Sierra, Stanislaus, 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.

<u>Figure 8.</u> The major demographic groups of older adults who received Specialty Mental Health Services (CY 2015), by race/Ethnicity, shown with the number of persons in each group ("beneficiaries served").



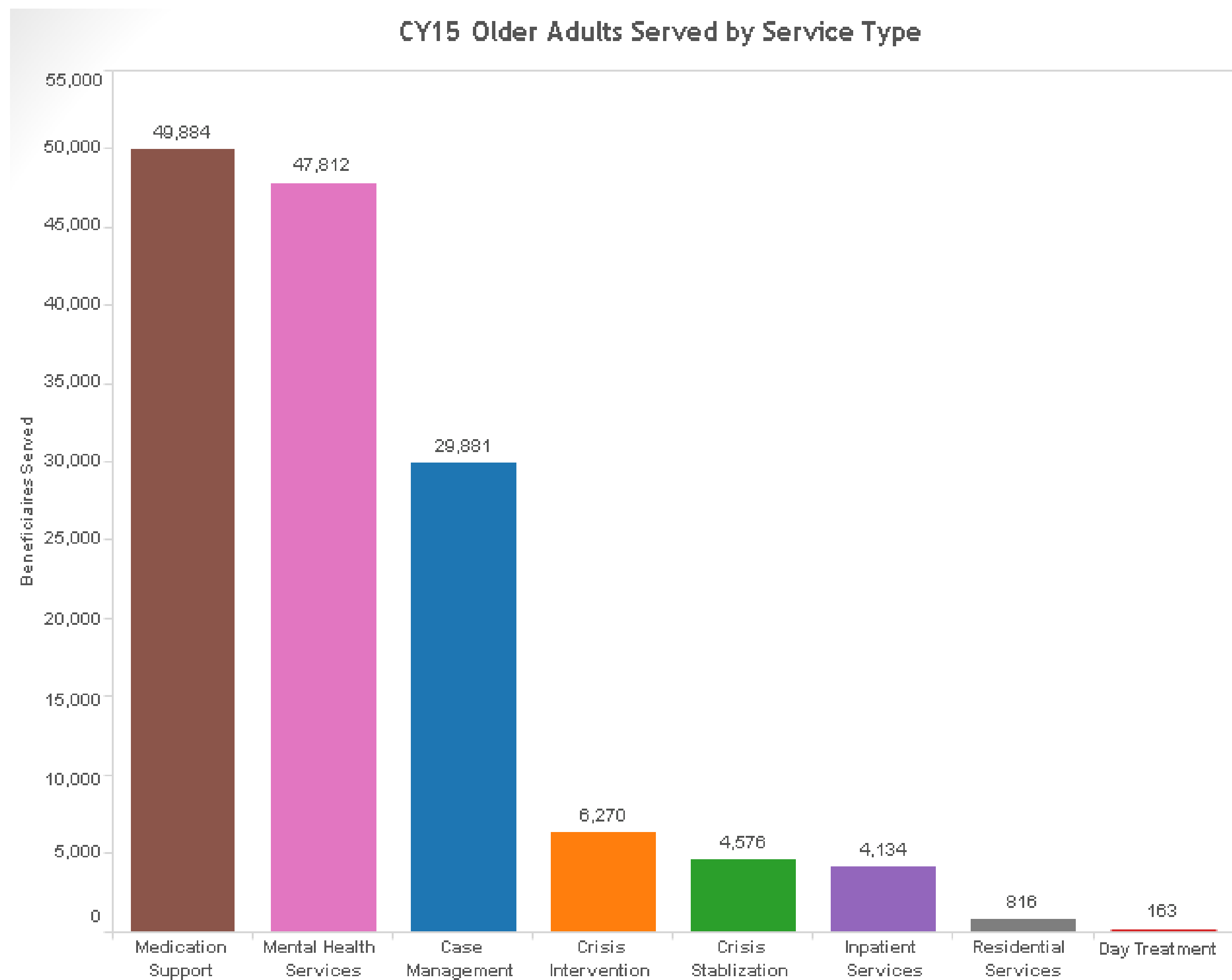
A more complete understanding of the MH needs in California's older adults requires information about the most common types of MH services received by older adult clients. These data are shown in the figure below. The top three most frequent types of

[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").

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.

Figure 9. 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.



We have reviewed summaries of several types of MH data for older adults in all of California in this section. Next, we wanted to assess local community needs and the adequacy of services available to older adults at the county level. Therefore, we asked the local boards: “Do you think your county is doing a good job of reaching and serving older adults in need of mental health services?” Twenty-seven counties answered “yes,” and twenty-three answered “no.” We followed up by asking, if “No,” then what strategies might better meet the mental health needs of older adults in your county?

In the responses we received, one repeated theme addressed problems with insurance and legal barriers restricting the eligibility of older adults for certain services. There are not enough therapists and physicians that accept Medicare, likely due to low reimbursement rates and paperwork burdens. Some counties recommended that we examine the eligibility criteria and other barriers, including funding for Title IX services.

Another frequent response called for better outreach to inform older adults, primary care providers, and the community about the local availability of BH services. Suggestions for outreach listed churches, community and senior centers, military veterans’ groups, assisted living facilities, and health clinics. Proposals included public service announcements, newspaper articles or advertisements, and classes such as ‘Safe Talk’ for older adults about depression, suicidal thoughts, and treatment resources. Recommendations included the ability to provide MH screenings in the person’s home, and to “meet the person wherever the person is at” and “whatever it takes,” emphasizing the MHSA values and efforts to reduce stigma. A few counties noted the need to find a safe and reliable way to serve remote areas in bad weather, perhaps using mobile clinics. Some counties provide FSP services for older adults but note that they need resources to expand the numbers of ‘slots’ available to serve more people.

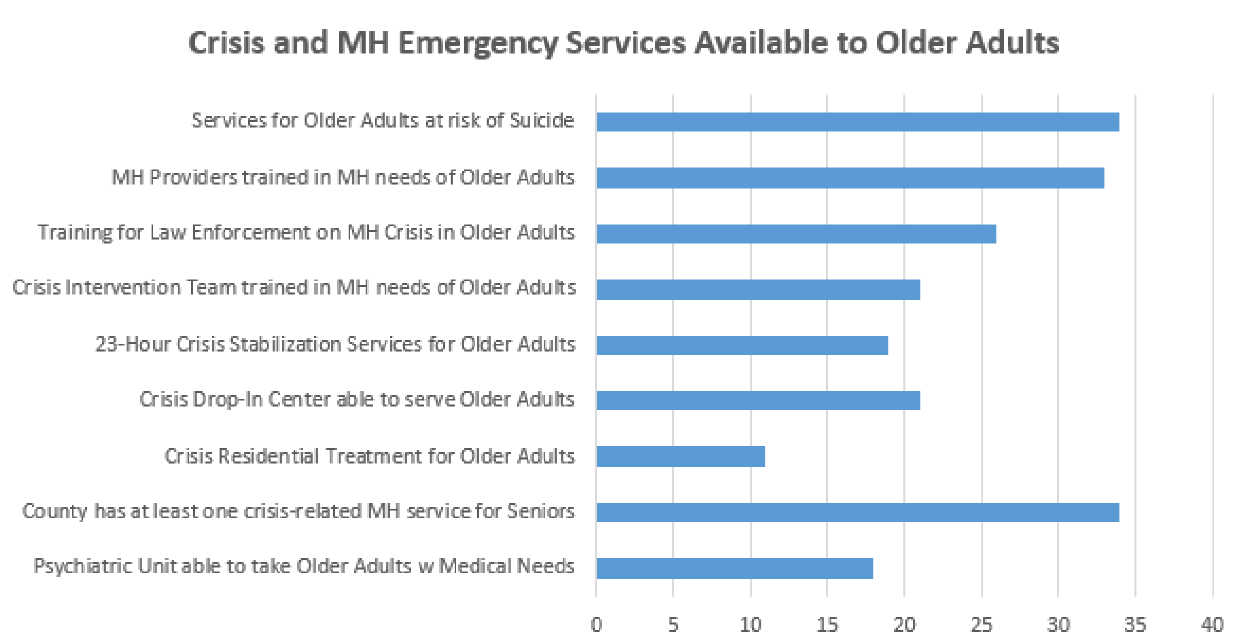
An illuminating experience is that of Contra Costa County’s Older Adults MH program (OAMH). That program focused on 35 older adults with repeated psychiatric emergency admissions and hospitalizations during the 3.5 years prior to being admitted to the OAMH program in 2012. Analysis of program data in 2016 found that there was an estimated savings of $12.25 million in reduced utilization costs, while the cost of the entire OAMH program over those same 3.5 years was slightly more than $10 million, yielding a net savings of $2.25 million. Their program, “in addition to delivering MH services and facilitating connection to other medical care, also focuses on some of the social determinants of health such as housing security, food security, transportation and communication….” The director of the program concluded that “The future health of our count y… will depend on increasing our focus on the ‘upstream’ cause[s] of ill-health….” The Contra Costa evidence supports a statewide policy goal of focusing on upstream causes of crises in MH and physical illness. These goals rely on broad public health prevention and education programs as well as services to support basic needs for housing, nutrition, transportation, and meaningful social connection.

Community Supports for Mental Health Emergencies and Crisis Services

Our understanding is that there are relatively few counties with crisis intervention teams or stabilization services that have 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[28] (2015), responses from a number of counties identified the need for crisis services specifically targeted to older adults. We wanted to pursue this issue further and determine whether the availability of different types of crisis services for older adults had improved since our 2015 report.

Therefore, we asked local boards: "Does your county have resources to provide mental health crisis services designed specifically to meet the needs of older adults? If yes, please check all that apply from the list provided below." At least 34 counties had at least one service designed for older adults, including at minimum, suicide prevention services. Sixteen counties answered "no." The responses describing the availability of different services or programs in the counties are summarized below.

Figure 10. Crisis and MH Emergency Services Available to Older Adults: Availability by Type and Number of Counties



Most commonly, counties indicated that all of their adult services are available to older adults. Relatively few counties noted the availability of services designed specifically for older adults. Only a few crisis teams or county departments had access to specialists in

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

gero-psychiatric care. However, several counties stated that training in the BH needs of older adults is given routinely to therapists and other care providers. Training of law enforcement personnel in the crisis needs of older adults was seen as important but that there is an ongoing need to expand training in some regions.

Responses to this section included suggestions for legislation (and funding) to increase the number of available beds in gero-psychiatric crisis stabilization units (CSU) and in gero-psychiatric hospitals. These facilities should have the ability to treat older adults with physical disabilities that require mobility assistance devices such as walkers and canes (which are seen as potential weapons in some places).

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Beyond the ongoing needs for BH services and crisis treatment in our communities, the last two years (2017-18) have seen a number of mass disasters. Regardless of whether these were natural disasters or those of principally human origin, they all contained the potential for individual and community trauma. For the purposes of this report, we take note that a significant number of those affected were older adults living on fixed incomes with limited outside resources. Several California counties that experienced large scale wildfires commented on the displacement of hundreds of residents and the loss of thousands of housing units, many of which had been the homes of working residents, retired older adults, disabled persons, and family members across all ages, demographics, and income ranges.

The affected counties noted an expanded need for emergency crisis counseling. Crisis services of all types required an “all hands on deck response” from the departments of BH to meet the surge in MH needs as well as the needs of their current SMI clients. In these counties, there was a multi-agency approach to providing emergency services and resources to meet the basic needs of shelter, food, clothing, medical care and medications, unemployment support, and information about “next steps” for the processes of recovery and rebuilding. These counties noted the loss of jobs and a substantial part of the tax base that normally helps fund all services, including health. In short, there are now more BH and health needs and fewer resources to meet those continuing needs due to the funding crises that occurred during and after the fires.

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. Nationally, there are over a million children who are cared for by grandparents where the child's parent does not live in the home, in many cases due to problems arising from the opioid crisis. The state of California also has a large number of children cared for by grandparents, partly as a result of the increased effort to identify relatives who can provide foster care under programs such as "KinCare."

Although we do not have data for foster children living with relatives to share with you, 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 9. 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%**

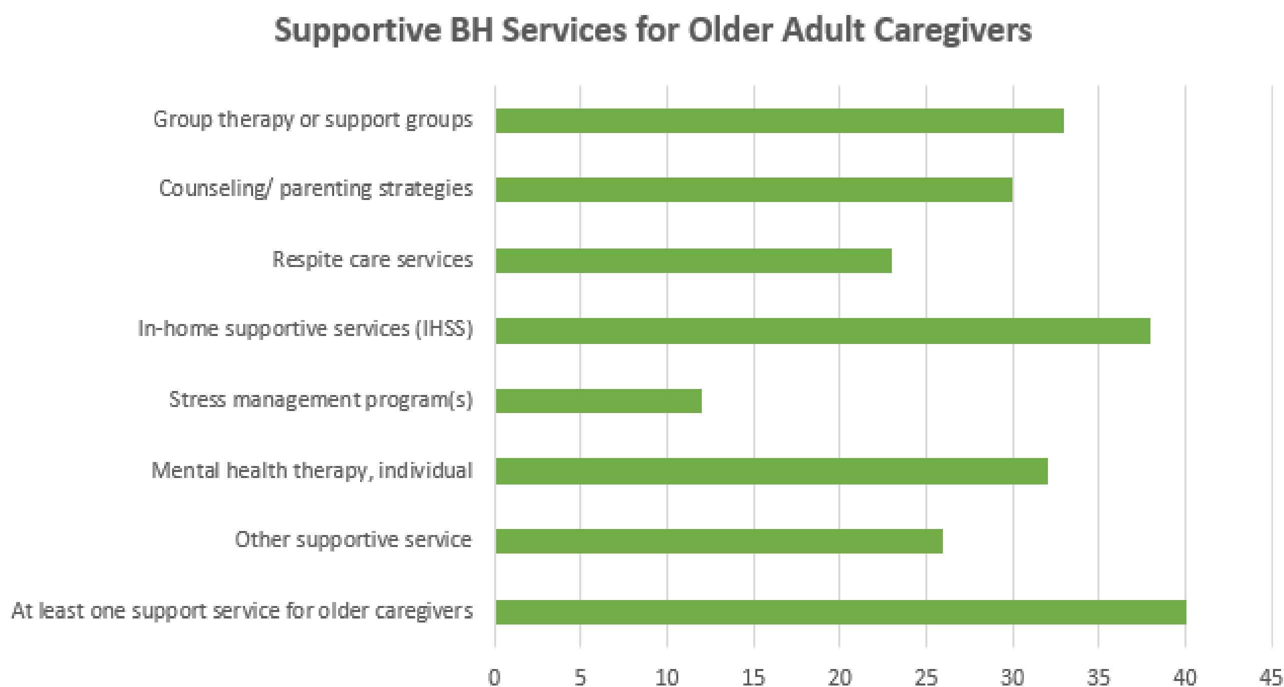
The stresses and demands experienced by elderly foster parents or grandparents also apply to another population of caregivers. Older adults may be the primary care providers for other adults: perhaps an adult child or an aging spouse. Such dependent family members may have cognitive impairment, developmental delay, complex medical or mental health issues, or serious physical disabilities.

The elderly caregivers may be in need of emotional support, mental health services, respite care, or other assistive services. We have limited data for how many older adult caregivers provide extensive care in their home for a dependent adult family member. Data from the Family Caregiver Alliance in San Francisco shows that more than 3.4 million Californians are informed caregivers. The wellbeing and MH needs of older adult

caregivers were identified as important issues by members of the Planning Council involved with this project.

Therefore, we asked local boards: “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?” Forty counties responded “yes,” with varying amount and types of services available (as detailed below). Only 10 counties indicated that they do not have services or programs specifically designated for older adults who provide extensive care for others.

<u>Figure 11</u>. Types of Supportive Services for Older Adults who provide Care for Children or other Family Members, Availability by Number of Counties



Additional information was provided by the 26 counties who answered “Other.” Some respondents noted that county MH Plans are designated to provide services to those with severe mental illness. Therefore, the MH Plan cannot provide Medi-Cal billable services to older adults who do not meet Title 9 criteria for SMHS. However, some services are provided--or linked to--through other county human services agencies, including training and education for caregivers. Many agencies contract with nonprofit groups to provide services for older adults, as illustrated in the examples below.

- Kinship Center programs: http://kinshipcenter.org/services/kinship-care.html.

- Area Agency on Aging's Family Caregiver Support Program and their contracts with nonprofit service providers.

- JFCS Volunteer Visitor Services (JFCS = Jewish Family and Children Services)

- Catholic Charities: family wellness services through OA outreach and engagement services (for OA and dependent family or their caregivers) and offer support to family members who are caregivers through the IHSS program.

- Council on Aging Senior Peer Support

- West County Community Services: Sonoma Senior Peer Counseling (WCCS).

- Multipurpose Senior Services Program (MSSP)

- Alzheimer's Association: in some regions provides extensive family resources

- Geriatric and primary care clinics may have family support and stress management services via links to Adult Day Services in the local senior center.

A number of counties described their own unique approach to support older adult caregivers or to families who provide care for frail older adults. These programs may receive funding from MHSA or grants from other organizations such as NAMI. A few of these programs are illustrated by the following examples.

- Napa County: a PEI program for OA, 'Mentis Healthy Minds Healthy Aging,' COPE Strengthening Families at Risk (family support groups), 'Collabria Care,' their health and human services agency's comprehensive services for older adults, and the Veterans' services in Yountville.

- Yolo County: NAMI grant to enhance support programs, includes older adults.

- Monterey County: example of respite care, 'Senior Companion' program.

- Merced County: Program to Encourage Active and Rewarding Lives for Seniors (PEARLS).

- San Joaquin County's Older Adult Services offers group therapy to clients who provide direct caregiving to dependent family members, which commonly include older adults provide care to a sibling, child, grandchildren or an even more elderly parent. These stressors can aggravate the caregiver's own symptoms.

- San Diego county BHS contracts with “Southern Caregivers” to provide support groups. The county also provides numerous programs and services for older adults or their caregivers, administered by the Aging and Independence Services Division.

- San Bernardino county: PEI program with an “Older Adult Wellness” component which includes support groups and services specifically for OA who care for disabled adults and/or children under 18. Services are also provided by Centralized Hospital Aftercare Services and Integrated Healthcare. There are linkages to IHSS or CBAS programs (CBAS = Community-Based Adults Services).

- Los Angeles County: provides a unique workforce training program: the “Family Caregiver Program” through Workforce Development, Aging and Community Services (WDACS).

As we were completing this report, the U.S. Congress passed a law that was signed July 9, 2018 called the ‘Supporting Grandparents Raising Grandchildren Act,’ which facilitates a “one-stop shopping” approach to providing resources and services for coordinated access to all educational, health, MH, and other foster care- related services that would be needed for their grandchild. This Act was given inception by the opioid crisis which has had a major effect on families, children, and their relatives. As noted above, more than one million children are being raised by grandparents in the U.S., and when we add in those children being cared for by other family members as well, then fully 2.6 million children are provided care by a family member who is not the parent. This act also establishes a federal advisory council.

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 behavior 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 differentiate those clients who (1) 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" which is a 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 by 10-30 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."[29] 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.

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[29] 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.

Table 10. Characteristics of Depression, Delirium and Dementia[27]

	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 often 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.

Therefore, we asked local boards: “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?” Twenty-seven answered “No,” and twenty-three counties answered “Yes.” We asked respondents to provide one (or more) examples in order to survey the types of programs available.

A common response was that there is no special program for this population (even in some medium and large population counties), due to a lack of resources. Counties

continue to provide services for their chronic SMI clients who develop early dementia, and then refer clients to appropriate services as their dementia progresses. One such county stated that they are starting to discuss how to implement such services in their Adult System of Care or by their Older Adult Team. Their planning process will include Public Health, In-Home Supportive Services, and BH staff, among other county partners. A need for cultural or ethnic-specific resources was noted. An important constraint is that Medi-Cal does not cover SMHS for clients with significant cognitive impairments. Thus, caution must accompany decisions about when to transfer a client's care to another agency or facility.

From the responses received, we learned that a number of counties of various sizes use individualized strategies to provide a continuum of services for their SMI or chronically mentally ill clients with early signs of cognitive changes. A few noteworthy examples are described below.

Butte County: the BH Department approaches this problem on a case by case basis utilizing its SEARCH (Support, Employment, Assistance, Recovery, and Consumer Housing) program, which is the name of their FSP program for adults. Coordination of care is managed by SEARCH staff, and may include use of nonprofit organizations such as 'Passages.' This group runs the Multi-purpose Senior Services Program (MSSP), caregiver services, and provides information regarding Long-Term Care, and related services. 'Passages' established a network of services, supports, and information throughout the county designed for the unique needs of older adults.

Humboldt County: The Alzheimer Resource Center (through the Senior Resource Center) provides education, information and services throughout the county regarding Alzheimer Disease and other dementias. Their Dementia Care Coalition, a group of professional and community members, work together to inform the larger community.

Napa County: A nonprofit, 'Collabria Care,' has programs including Alzheimer's Services, Adult Day Health Center, early stage and brain stimulation programs. Their social workers, counselors and program staff are trained to work with OA with chronic mental illness who also are affected by mild cognitive impairment or early dementia.

Imperial County: They have a geriatric specialty psychiatrist who specializes in assessing clients for dementia and mild cognitive impairment. Consult for a second opinion is available, especially if the case is complicated or identified as high risk.

Siskiyou County: Their OA residents may be served by Dignity Health Connected Living (located in Redding), which provides clients with necessary services when they begin to have cognitive impairment and dementia.

Kern County: 'Chateau de Bakersfield' is a community-based program that provides services and support to clients with cognitive impairments and dementia. These services include independent living skills and behavioral support tailored to fit the individual's needs. 'Chateau' is not a program of the Kern County MHP but does partner with the MHP's to provide services in coordination with their teams.

Kings County: The SAFE program and caregiver support groups are services offered by their County Commission on Aging.

Marin County: The HOPE program is specialized for OA and others with a primary serious mental illness but it does not exclude clients when they develop onset of mild cognitive impairment or early dementia.

Merced County: The County Human Services Agency is a collaborative partner with BH. The Agency contracts with Valley Caregiver Resource Center for (a) support groups for persons with Alzheimer's disease or Dementia, and (b) Health House offers a support group for elders of various ethnic identities, providing them with health education and transportation assistance (bus passes, etc.).

Riverside County: They have recently constructed a Dual Diagnosis Committee to address service needs for child, adults, and older adults with both cognitive impairments and mental illness. Currently, treatment specialty teams are being identified.

Sacramento, San Francisco, San Joaquin, Ventura and Los Angeles Counties are examples of large counties that have implemented comprehensive approaches to meet a spectrum of mental health and cognitive needs for diagnosis, treatment, and services in their older adult clients as their needs change over time. The counties all provide case management and linkages to other services as necessary.

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OLDER ADULTS HELPING OTHERS:
Peer Counselors and Health Navigators

Peer counselors are individuals with "lived experience" in recovery from mental illness and/or substance use disorders. These peer counselors receive training in the legal 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 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. These programs have their roots in the experience of the self-help community and recovery support groups. Both research and community experience have shown that peer support counselors with lived experience or who are family members of BH clients are very effective at supporting recovery and that their efforts are synergistic with those of therapeutic professionals. The federal agency SAMHSA has formalized principles and guidelines for peer recovery support specialists.[30] Programs to train, certify, and employ peer counselors may be found in most states of the country, in various forms.

California has begun the legislative process of setting standards that apply statewide. However, up to this point, counties have been defining their own programs and policies. Therefore, we asked local boards: "Does your community train and/or utilize the skills and knowledge of older adults as peer counselors, and/or health navigators? If yes, then please provide one (or more) example(s) of how this occurs." Of the twelve respondents that answered "No," some of these mentioned plans 'in progress' to hire older adult peer support mentors, or they may rely on HICAP counselors from the local Area Agency on Aging, or have *promotoras*, some of whom may be older adults.

We found that thirty-eight counties do have programs that include older adults as peer counselors, peer mentors, or health navigators and that there is substantial variety in the types of programs and their implementation. The major differences are that some programs use individuals as volunteers and some use paid employees in these peer support roles (and some have both types). Those programs that use volunteers generally provide training on their role, functions, and how to be most effective. Their training may partially overlap or have similarities to the more extensive training provided to paid peer specialists. Counties' descriptions of the volunteer training ranged from 12-30 hours of initial training/orientation, provided by BH professionals, with periodic follow-

[30] See SAMHSA Summary and Handouts on Peers Supporting Recovery from Mental Health Conditions: Definitions, guidelines, and some research findings.
https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf

up training and group meetings. One county described training that includes "Mental Health First Aid" classes (similar to training provided by NAMI) to understand how to identify signs and symptoms of mental illness or a MH crisis, and how to intervene to get the client linked to professional services.

Some counties employ older adults as community health workers to assist consumers with activities such as travel to/from appointments, performance of daily tasks like shopping, and to make home visits to clients with limited mobility. Senior centers or assisted living facilities may have older adult peer mentors that lead field trips, social activities, and/or wellness classes. Older adult peers also may conduct outreach activities and assistance to link either community-dwelling or homeless seniors with services such as food, housing, and assisted living facilities.

Other counties have older adults work with their senior FSP clients and provide confidential, non-judgmental listening, coaching, and links to peer-run wellness and support groups. Such counselors usually work under weekly supervision by licensed psychotherapists. Peer counselors or support specialists with appropriate training also may be included in some crisis response teams. Peer mentors or support specialists may work for the direct service agencies which have contracts with county departments of behavioral health.

Many counties listed programs linked to national programs that either use or are conducted by older adult volunteers, mentors, and/or paid employees. Some of the better-known national programs implemented in California include: PEARLS, HOPE and HOPE-sponsored FSP programs, PATH (homeless projects), WISE teams, and WISEWOMEN, a group which is involved in health screening and wellness campaigns.

Los Angeles County has an interesting and flexible approach. Their "Service Extenders" program recruits older adult clients in recovery or other interested individuals to serve as members of the DMH multi-disciplinary MH teams throughout the county. These Service Extenders help provide a variety of services under the supervision of licensed professionals. These volunteers provide home visits and telephone contacts to offer support and decrease isolation. Services may include ensuring clients have food and capacity for meal preparation, taking walks, recreational activities, accompany clients to medical appointments, and ensuring that client's homes are safe. Service Extenders also provide advocacy to assist clients in obtaining needed resources and achieving goals. This role definition provides flexibility in that one Service Extender may support case management and linkage to services, another such person participates in a crisis response team, and someone else may help mentor FSP clients or conduct outreach to homeless older adults. For older adults, the Service Extender designation may help reduce stigma that might otherwise be attached to a job (or volunteer) title that explicitly states mental or behavioral health.

Summary, Conclusions, and Recommendations

In this report, we have reviewed the behavioral health needs of older adults in California. We also surveyed perceptions regarding the current ability of the counties' public behavioral health systems to meet those needs, as evaluated by local advisory boards. We discussed the types of services provided by county departments of behavioral health that address needs in older adults. Most services available to older adults are not different from those available to all eligible adults in their county. However, some counties do have resources to design and direct a program of services intended to address the unique needs of older adults in a defined "system of care."

Most importantly, there are older adult-related services spread across a number of agencies, including public health, social services, adult protective services, and the local Area Agencies on Aging. The most effective strategies include a collaborative multi-agency approach to meeting the behavioral and social service needs of older adults as they continue to age "in place" in their communities.

California county departments of behavioral health have been working diligently to invest additional resources and personnel to meet the needs of the expanded numbers of adults and children eligible for services due to the Medicaid expansion of the Affordable Care Act (2010). Increased numbers of adults aged 55 and over also became eligible for Medi-Cal as a result, including some who were working at low-wage jobs or had retired. During that expansion, counties also have been required to provide a more comprehensive array of MH services for children, youth, and foster kids under EPSDT designated services. Concurrently, many counties are also expanding services for Medi-Cal funded SUD treatment by implementation of the Drug Medi-Cal Organized Delivery System (ODS).

Our conclusion is that counties are being asked to serve many more clients, provide more services and new programs to all eligible clients, and continue to meet emergency and crisis needs on demand. All of these increased demands continue to challenge total county resources in terms of therapists, support staff, contractors, finances, and the total number of clients that can be served in any given day or week—regardless of the high level of personal commitment that county BH staff bring to this mission.

In considering the greatly expanded numbers of eligible clients, and increased numbers and types of program services, it would not be surprising to find 'resource constraints.' Such limits might mean that not everyone who needs BH treatment is able to get services, or not necessarily all of the services deemed optimal for recovery. We examined the data for clues to the nature of any potential unmet BH needs.

Our review of the Medi-Cal numbers for older adults enrolled in either SMHS or SUD treatment services seems to indicate that older adults as a group are under-served or

unserved in many cases, even though significant numbers of this age group do need BH services.

A number of county BH departments described having comprehensive and well-designed programs, including a geriatrician or a psychiatrist with geriatric expertise and regular training for therapists and staff about the needs and unique cultures of older adults. However, a few of these counties reported that they had committed a high input of effort, but had served relatively few participants, compared to their expectations based on local demographics and needs assessments.

Even when there is documented unmet need for BH services, some factors which could contribute to underutilization of available services may include: lack of awareness of one's own condition and needs, cultural stigma about acknowledging both need and/or receipt of BH services, and a lack of knowledge about available services. Depression and related mood disorders are noted for sapping the initiative and mental energy necessary to perform common daily tasks, including making phone calls to get appointments. Other major barriers to access BH services apply to most counties, large and small. These barriers include problems related to transportation, personal mobility, disability, or isolation due to residing in remote locations. Such barriers also create problems for timely and consistent access to general medical care.

Major Findings and Observations

There is anecdotal and research evidence that suggest that some national survey-based public data may under-estimate the incidence of MH disorders in older adults (even though these are often the best data available). If so, by extension, then current estimates of need for MH services by older adults would also be under-estimates. The evidence regarding incidence rates of death by suicide in older adults would seem to indicate that a considerable amount of depression and other contributory disorders are not being detected, diagnosed, or treated effectively or timely.

The accumulation of personal losses, increased physical illness and disability can combine with loneliness and severe poverty, so that taken together, the totality of stressors present greater challenges to individuals as they age. Lacking other interventions or social supports, individuals may find that hopelessness and despair begin to settle in and deepen over time, appearing to represent a permanent state of affairs—an unpleasant or even painful 'new normal.'

Another part of this picture is contributed by awareness of the statistic that persons with severe and persistent mental illness are more likely to die about 15-20 years earlier than would be predicted (based on actuary calculations) for their birth cohort and other sociodemographic characteristics. Thus, some may casually assume that most of the

severely mentally ill have died off before 'normal retirement age.' However, there are still many persons with SMI who do live fairly long lives and are part of the older adult population. These individuals will have ongoing needs for BH services to maintain their recovery and stability of living situation.

A review of the data (DHCS, 2017) for SMHS services indicates that older adults are underserved by SMHS services relative to their percentage of total adult clients eligible for Medi-Cal funded services. Adults age 65 and above were 16.0 % of the adult Medi-Cal population, but only 1.7% received one or more SMHS services during the year (FY 2016-2017). Compare that value to 4.0% of Medi-Cal adults ages 21-44, or 5.6% for those aged 45-64.

Upon examination of the data for those who received five or more SMHS services during the year (as one measure of continued access), the situation appears even more bleak. That group included only 1.1% of Medi-Cal eligible adults age 65 and above, a number which is much lower in comparison to 2.3% of adults age 21-44, and to the 3.7% of adults age 45-64. These rates of sustained or continued access to MH services are admittedly quite low for all Medi-Cal eligible adults. But examined another way, the rates of SMHS access for adults 65 and older range from one-half to one-third of the rates for adults in other age groups (age groups 21-44 and 45-64, respectively).

An argument could be made that perhaps the low numbers described above might be counterbalanced by Medicare-covered services received by those over 65. Also, some of these older adults qualify for both Medicare and Medi-Cal. Although most adult citizens over 65 are Medicare eligible, the types of BH services covered under part D are limited in scope and quantity. It is problematic to draw overall conclusions because we have little to no data about Medicare-funded delivery of BH services in California:

- How many older adults are/were served
- What types of services are/were received
- What BH conditions are/were treated (including SUD), and
- How many of those treated had mild-to-moderate or severe mental illnesses?

Most of all, it is difficult to determine how many older adults needed either BH treatment but did not receive it. Statistics for deaths by suicide in older adults,[31] compared to other age groups, show an increased occurrence in later adult life (i.e., ages 45-64 for both females and males, but with even greater incidence in males over 65). And the groups with the highest rate of death by suicide include whites, Native Americans and older males, relative to other groups of adults. These data may suggest that depression

[31]See Appendix VI for Illustration, taken from: Suicide is a Leading Cause of Death in the U.S., from National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/suicide.shtml.

and related disorders are undertreated in these older adult populations, relative to rates of occurrence. However, about 54% of all suicide deaths occur in individuals with no known history of mental illness, so the explanation for older adult suicide must be more complicated than depression, other forms of mental illness, or SUDs.

We consider a similar analysis and discussion of OA needs and services for SUD treatment. Some NSDUH survey-based data estimate that older adults have a similar (or lower) incidence of SUD related disorders compared to the general population. Although these survey data are widely used as a basis for policy, it is possible that these could represent an under-reporting of the true incidence of SUD in OA. Further research is needed to determine whether the NSDUH data for older adults may represent the lower bounds (or minimum) of estimates of SUD incidence in this group.

Reviews of other recent data suggest that older adults, especially those of the now-aging post World War II baby boomer cohort, have had more life experience with so-called 'recreational' substance use, and are experiencing an increased incidence of drug-based SUD relative to prior generations which may have experienced more alcohol related SUD than drug abuse *per se*. But all of these elder cohorts are experiencing vulnerability to dependence on opioid pain medications and accidental addiction following recovery from surgery or other painful condition.

Based on our review of statewide 'Drug Medi-Cal' treatment data for adults, it appears that older adults are underserved by county-based or county-contracted SUD treatment relative to their percentage of total adult Medi-Cal clients eligible for services. These data show that the 12,103 adults age 55 and over who received SUD treatment services comprised only 9.2 % of the total SUD treatment clients (FY 2015-2016). Those data include all adults and youth age 15 and older who participated in at least one or more of the following types of treatment: detoxification, outpatient NTP, outpatient non-NTP, and residential treatment. One reason the older adult age break was set at 55+ is that the total treatment numbers are so much lower for those age 65 and above, and the client numbers become 'vanishingly small' for those age 75 and older.

There are many questions about why relatively few older adults are accessing SUD treatment services, and we do not have any definitive answers to such a complicated societal problem. There is a perception that many SUD treatment programs are not well-designed for the needs of older adults. That belief, combined with reluctance to seek treatment, may mean that relatively few older adults who need services will actually get them. As with MH issues, there is considerable stigma and reluctance for individuals to acknowledge having a substance use disorder that needs treatment.

Our observations are not unique to this study. Other researchers also found that older adults receive relatively fewer BH services across all public health systems, as shown

by the comprehensive landmark study of Drs. Janet Frank, Kathryn Kietzman, and colleagues at UCLA (2016).[32] They found "vast unmet need among older adults with mental illness in the public mental health delivery system," including those of MHSA-funded programs such as Community Services and Supports, Prevention and Early Intervention Programs, and Innovation Programs. One example of a successful MHSA service model finds that older adults who receive services under Full Service Partnership (FSP) programs improve, and they experience less homelessness, psychiatric emergencies, and involvement with the justice system. Housing support should be expanded to meet an increasing need in the older adult population. An essential strategy is to continue advocacy for improvements to, and expansion of, MHSA services for older adults, and to include them in MHSA planning processes.

Based on their research,[32] Frank, Kietzman, et al (2016) recommended the following:

- "Conduct dedicated outreach and document unmet need among older adults with mental illness.
- Designate an administrative structure of older adult mental health services with dedicated leadership positions, within and across state and county mental health and aging units.
- Promote standardized geriatric training of providers working with older adults across disciplines and scope of practice.
- Institute mandatory and standardized data reporting requirements at state and local (county) levels.
- Increase service integration efforts, especially the integration of medical, behavioral health, aging and substance abuse services….
- To improve the delivery of mental health care to older adults, State and county leadership, together with advocates and consumers, should utilize and leverage MHSA resources to implement strategies that fully address the unmet needs of older Californians with mental illness."

[32] 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

Proposed CBHPC Policy Recommendations Based on Our Findings:

(1) Continue advocacy at the Federal level to maintain existing supports for Social Security, Medicare, Medi-Cal, disability supports, long-term care supports, and all of the numerous federally-funded programs of the Area Agencies for Aging. All of these programs are essential to support stable housing, health care, nutrition and access to medications and maintain social connections: these comprise the minimum foundation on which one can build one's mental health, continued recovery, and physical health. These services represent another manifestation of the 'Housing First' philosophy to help prevent homelessness, mental health crises and medical catastrophe.

(2) Increase support and use of public health programs for nurses which help teach patients about self-management of their chronic diseases, including diabetes, hypertension and heart disease, obesity, and very importantly, depression and other ongoing mental health disorders. In view of the predicted increase in total numbers in the aging population that could swamp available treatment resources, public health officials are acutely aware of the critical need to increase public health and patient education programs for disease self-management in the immediate future.

(3) Continue multi-agency collaboration at the county and regional level between departments of BH, social services, adult protective services, public health, and the local Area Agencies on Aging. This collaboration should community-based provider staff, advocacy groups for mental health and for older adults, family members, and other stakeholders.

(4) Continue use, training, and support for both paid and unpaid older adults who may serve as peer specialists under a variety of designations in different counties, including such designations as: family member peer specialists, community assistance workers, service extenders, health care navigators, and as peer members of crisis teams, as appropriate. In some locales, these peer specialists/volunteers also help extend the work of case managers by helping to link individuals with necessary services across the complex array of agencies.

(5) Continue federal support for the use of older adults as HICAP counselors by the AAA. This essential program is another example of how linkage with one type of service—understanding one's health insurance options and paperwork—can help provide a basis for how to pay for and access mental health services as needed within (or outside of) those health plans. Addressing the high levels of anxiety people have regarding their Medicare and other insurance issues helps them with overall MH and wellbeing in addition to facilitating access to services.

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Data tables and figures:

- Behavioral Health Concepts, Inc. (External Quality Review Organization)—Data Reports
- Office of Applied Research and Analytics, DHCS —SUDS treatment data
- Mental Health Analytics, DHCS—Data and figures for access, engagement, penetration rates, post-hospitalization follow-up
- County Behavioral Health Directors Association— Full service partnership (FSP) data

Project development and stakeholder input:

- Jane Adcock and Susan Morris Wilson
- Continuous System Improvement/Evaluation and Quality Improvement Committee
- Local advisory board members for Behavioral Health
- California Association of Local Behavioral Health Boards/Commissions
- County Behavioral Health Directors, their Data and Quality Improvement Staff, and Mental Health Services Act Coordinators

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Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer/Sierra
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Siskiyou
Sonoma
Stanislaus
Sutter/Yuba
Trinity
Tulare
Tuolumne
Ventura
Yolo

References and Bibliography:

Relevant Laws, Regulations, and Codes

Affordable Care Act (2010).

California Mental Health Services Act of 2004; also called Proposition 63.

Health Insurance Portability and Accountability Act (1996), Section 1171, Part C, Subtitle F of Public Law 104-191.

W.I.C. 5604.2, mandated reporting roles of MH/BH Boards/Commissions in California.

W.I.C. 5772 (c), annual reports from the California Mental Health Planning Council.

Further Reading

List upon request, from DataNotebook@CMHPC.ca.gov.

Also see Appendices and Footnotes.

Appendix I: Who Produces the Data and What is Contained in these Resources?

American Community Survey 5-year Estimates	The 2008-2012 ACS report is a detailed survey of communities based on the 2010 U.S. Census. Examples of state and county data we used in this project can be found at this website: http://www.labormarketinfo.edd.ca.gov/data/california-and-counties-demographic-profiles.html
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.
CA DHCS: Mental Health Analytics Services and Performance Outcomes Systems,[33] 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[34] 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" system or a new system.
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.
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 the "Measures Outcomes and Quality Assessment" (MOQA) database; may include MHSA program outcomes.

[33]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.
[34] 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.

Appendix II. Census and ACS Data for Older Adults Used to Develop this Report

California: American Community Survey 5-year Estimates[35,36] for 2008-2012

Population (2010): 37,325,068

Adult population over 18: 27,894,767

Civilian veterans: 1,952,910 (7.0 % of the adult population)

Total civilian noninstitutionalized population: 36,783,532

With a disability, all ages: 3,693,528 (10.0 % of population)

Under 18 years with disability: 279,804 (3.0 % of those within this age group)

Age 18-64 years with a disability: 1,855,637 (8.0% of those in this age group)

Total population age 65 years and older: 4,204,623 (11.4 % of total population).

Age 65 and older with a disability: 1,558,087 (37.1 % of those in this age group)

Total households: 12,466,331 (100%) Population in households: 36,504,565 (99.2 %)

Households with a member 65 years or over: 3,034,715 (24.3 % of households)

Householder living alone, age 65 years and over: 1,046,386

Grandparents living with own grandchildren under 18 years: 1,080,232

Responsible for grandchildren: 303,217 (28.1 % of those living with their grandchildren)

Share of these grandparents who are female: 185,896 (61.3 %)

Share of these grandparents who are married: 222,441 (73.4 %)

Percentage of all families whose prior year income was below poverty level: 11.5 %

Percentage of all persons in CA living under the federal poverty level: 15.3%

Percentage of children under 18 living under federal poverty level: 21.3 %

Percentage of persons age 18-64 living under the federal poverty level: 14.0 %

Percentage of aged 65+ with prior year income under poverty level: 9.5 %, statewide.

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[35] All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 1,515,136 in the year of the last U.S. census, 2010.

[36] http://www.labormarketinfo.edd.ca.gov/file/census2012/californiadp2012.pdf . See pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc. For demographic and economic profiles of your county see: http://www.labormarketinfo.edd.ca.gov/data/california-and-counties-demographic-profiles.html

Appendix III. Examples of SUD Treatment Data by Age Group and Type of Treatment Available in Large, Medium, and Small Population Counties

Alameda: 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	230 14.7 %	188 18.3 %	201 12.7 %	12 3.9 %	631 14.1 %
Age 37-54	697 44.7 %	403 39.3 %	597 37.5 %	127 41.2 %	1824 40.6 %
Age 26-36	445 28.5 %	308 30.0 %	453 28.5 %	102 33.1 %	1308 29.2 %
Age 15-25	188 12.1 %	127 12.4 %	339 21.3 %	67 21.8 %	721 16.1 %
Column TOTALS:	1560 100 %	1026 100 %	1590 100 %	308 100 %	4484 100 %

Solano: 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	48 10.9 %	51 14.7 %	18 4.6 %	6 5.7 %	123 9.6 %
Age 37-54	166 37.8 %	86 24.7 %	145 37.1 %	35 33.3 %	432 33.7 %
Age 26-36	173 39.4 %	151 43.4 %	176 45.0 %	47 44.8%	547 42.6 %
Age 15-25	52 11.8 %	60 17.2 %	52 13.3 %	17 16.2 %	181 14.1 %
Column TOTALS:	439 100 %	348 100 %	391 100 %	105 100 %	1283 100 %

Nevada County: Number and Percent of Clients by SUD Treatment (FY 15-16)

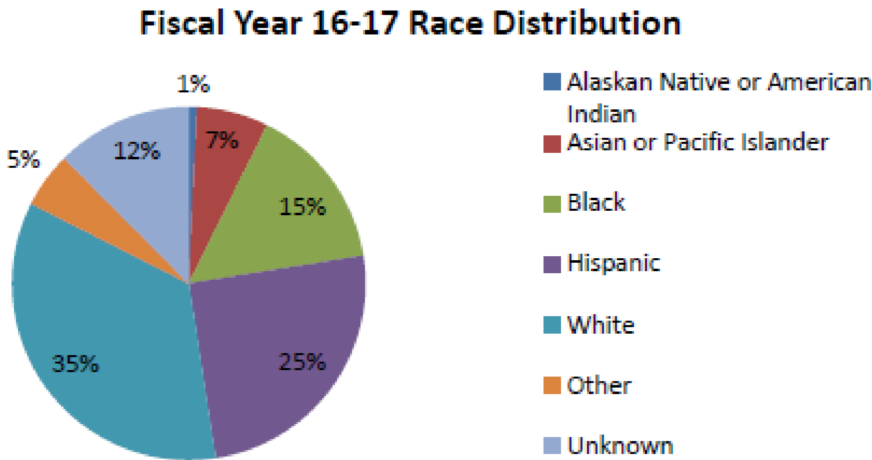
Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total
Age 55 & over	0 0 %	0 0 %	52 49.52 %	53 50.48 %	105
Age 37-54	0 0 %	0 0 %	163 60.15 %	108 39.85 %	271
Age 26-36	1 0.27 %	0 0 %	199 53.21 %	174 46.52 %	374
Age 15-25	0 0 %	0 0 %	159 60.46 %	104 39.54 %	263

Tehama: 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	0 0 %	0 0 %	18 5.2 %	0 0%	18 5.2 %
Age 37-54	0 0 %	0 0%	98 28.2 %	0 0 %	98 28.2 %
Age 26-36	0 0 %	0 0%	125 35.9 %	0 0 %	125 35.9 %
Age 15-25	0 0 %	0 0 %	107 30.7 %	0 0 %	107 30.7 %
Column TOTALS:	0 100 %	0 100 %	348 100%	0 100%	348 100 %

Appendix IV. Demographic Data for Adults[37] in California who received SMHS (FY 2016-2017)

Top: Major race/ethnicity groupings of Medi-Cal 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.

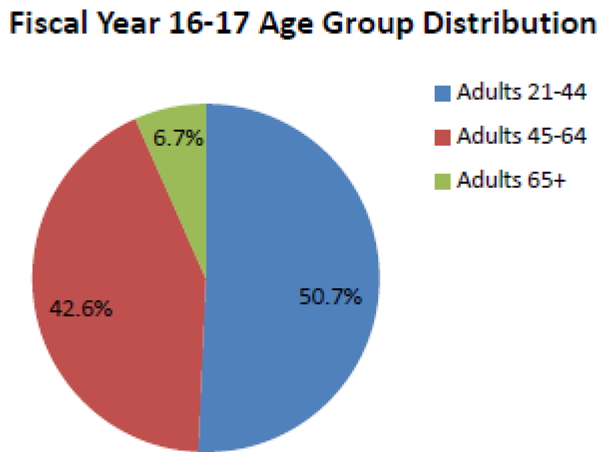


Figure 7. Demographic data for California (FY16-17): Adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).[38]

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[37] Adults in this report are those age 21 or over on the date of service(s). Data for those age 18-21 were incorporated in the reports for EPSDT Specialty Mental Health Services for Children and Youth.

[38] See Performance Outcomes Reports for adults from California Department of Health Care Services, see: http://www.dhcs.ca.gov/services/MH/Pages/SMHS_Performance_Dashboard.aspx. For reports FY 2016-17: http://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA.PDF.

Appendix V. Medi-Cal Data for California Adults and Older Adults (FY 2016-17): Specialty Mental Health Service Visits (SMHS) and Service Penetration Rates[39]

Top: Adults and Older Adults who accessed at least one SMHS visit during the year.

	FY 16-17		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	341,362	8,220,974	4.2%
Adults 21-44	173,087	4,305,488	4.0%
Adults 45-64	145,546	2,602,031	5.6%
Adults 65+	22,729	1,313,455	1.7%
Alaskan Native or American Indian	2,457	41,766	5.9%
Asian or Pacific Islander	22,497	1,105,203	2.0%
Black	51,732	719,635	7.2%
Hispanic	85,652	3,024,780	2.8%
White	119,159	2,118,638	5.6%
Other	17,379	513,280	3.4%
Unknown	42,486	697,672	6.1%
Female	177,434	4,550,157	3.9%
Male	163,928	3,670,817	4.5%

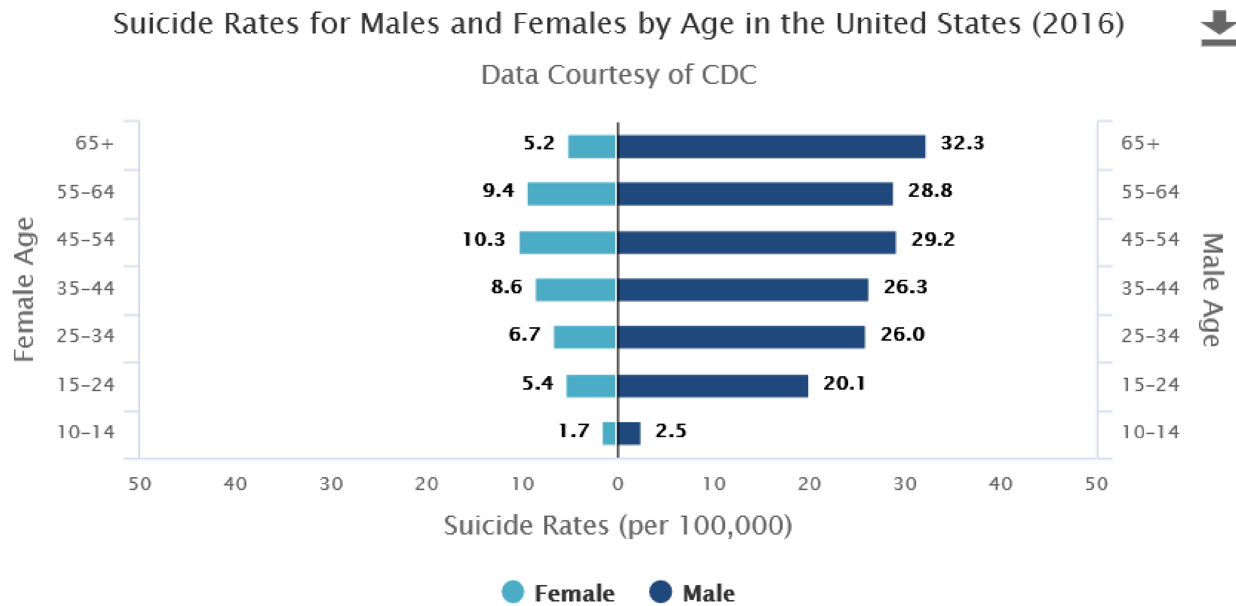
Below: Adults and Older Adults who received five or more SMHS visits during the year (one measure of engagement).

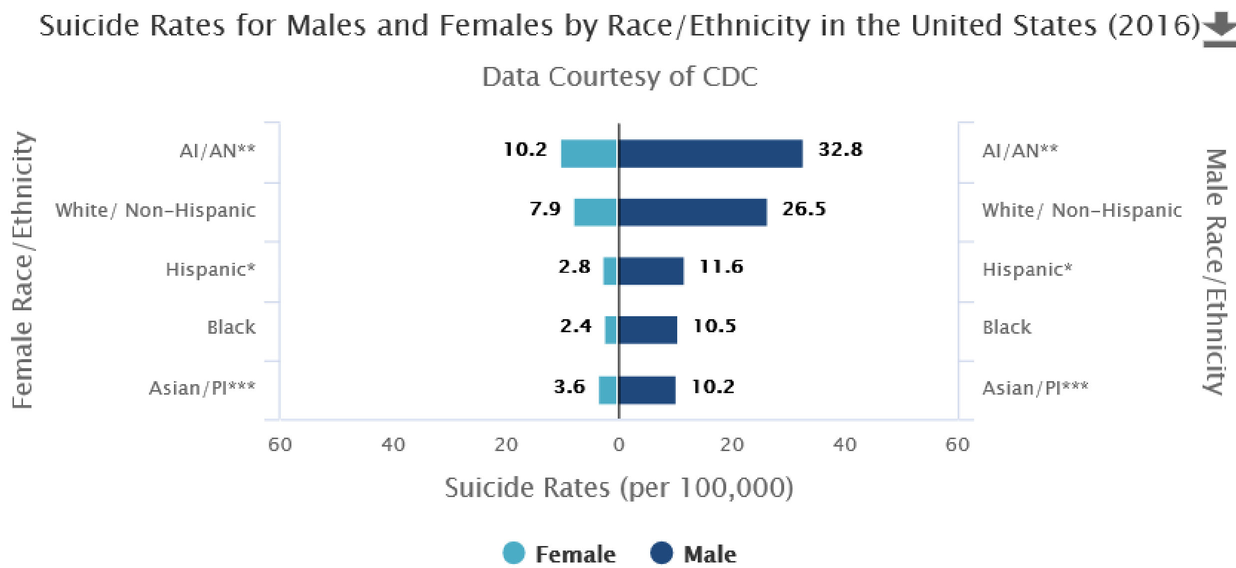
	FY 16-17		
	Adults and Older Adults with 5 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	209,648	8,220,974	2.6%
Adults 21-44	100,028	4,305,488	2.3%
Adults 45-64	95,053	2,602,031	3.7%
Adults 65+	14,567	1,313,455	1.1%
Alaskan Native or American Indian	1,399	41,766	3.3%
Asian or Pacific Islander	15,181	1,105,203	1.4%
Black	30,834	719,635	4.3%
Hispanic	51,308	3,024,780	1.7%
White	72,725	2,118,638	3.4%
Other	10,074	513,280	2.0%
Unknown	28,127	697,672	4.0%
Female	109,567	4,550,157	2.4%
Male	100,081	3,670,817	2.7%

[39] DHCS: http://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA.PDF.

Appendix VI. Suicide is a Leading Cause of Death in the U.S.

Illustration taken from National Institute of Mental Health.
https://www.nimh.nih.gov/health/statistics/suicide.shtml.





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