

This page intentionally left blank.

TABLE OF CONTENTS

Preface: County Data Pages	5
INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES	7
What is the “Data Notebook?”	
How Do the Data Sources Define Older Adults?	
Resources: Where do We Get the Data?	
HEALTHY AGING AND THE OLDER ADULT SYSTEM OF CARE	11
Social Supports and Community Engagement for Mental Health	
Integrated Health Care for Older Adults: Treating the Whole Person	
DEMOGRAPHIC TRENDS : CHALLENGES FOR SERVICE ACCESS	13
Who are California’s Older Adults?	
How do We Plan for Future Needs in the Older Adult System of Care?	
BARRIERS TO SERVICES FOR OLDER ADULTS	15
Disabilities in Older Adults Can Present Barriers to Service Access	
Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services	
Limited English Proficiency is a Barrier for Behavioral Health Access	
BEHAVIORAL HEALTH: OLDER ADULTS CONTINUUM OF CARE	18
Substance Use Treatment for Older Adults: Barriers and Stigma	
Mental Health Services for Older Adults	
Community Supports for Mental Health Emergencies and Crisis Services	
Mental Health Supports for Older Adults who Provide Care for Children or other Family Members	
Significant Changes in Behavioral/Cognitive Function in Older Adults	
OLDER ADULTS HELPING OTHERS	32
Peer Counselors and Health Navigators	
QUESTIONAIRE: How Did Your Board Complete the Data Notebook? ...	33
Reminder: Where to submit your Data Notebook.....	34

This page intentionally left blank.

SONOMA COUNTY: DATA NOTEBOOK 2017
FOR CALIFORNIA
BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2017): 507,323

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

<http://www.sonoma-county.org/health/about/behavioralhealth.asp>

Website for Local County MH Data and Reports:

<http://www.sonoma-county.org/health/publications/index.asp>

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

<http://www.sonoma-county.org/health/meetings/mhboard.asp>

Specialty Mental Health Data¹ from calendar year (CY) 2014: Table 1. Race/ethnicity detail for total Medi-Cal beneficiaries who received Specialty Mental Health services.

Table 1—Sonoma MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	31,757	1,696
Hispanic	39,633	712
African-American	1,985	108
Asian/Pacific Islander	5,624	97
Native American	1,321	52
Other	9,288	423
Total	89,608	3,088
<i>*The total is not a direct sum of the averages above it. The averages are calculated separately.</i>		

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

Supplemental County Data Page

Sonoma County: 2008-2012 American Community Survey 5-year estimates^{2,3}

Population (2010): 483,456

Adult population over 18: 376,661

Civilian veterans: 33,049 (8.2% of the adult population)

Total civilian noninstitutionalized population: 478,561

 With a disability, all ages: 51,365 (10.7%)

 Under 18 years with disability: 3,655 (3.5% of those within this age group)

 Age 18-64 years with a disability: 24,807 (8.1% of those in this age group)

Total population age 65 years and older: 66,757 (13.8 % of total population)

 Age 65 and older with a disability: 22,903 (34.3% of those in this age group)

Total households: 184,502 (100%) Population in households: 472,738 (98.5%)

 Households with a member 65 years or over: 49,530 (26.8%)

 Householder living alone, age 65 years and over: 20,303

Grandparents living with own grandchildren under 18 years: 7,721

 Responsible for grandchildren: 2,287 (29.6% of those living with grandchildren)

 Grandparents who are female: 1,410 (61.7%)

 Grandparents who are married: 1,520 (66.5%)

Percentage of all families whose prior year income was below poverty level: 7.2%

Percentage of all persons living under the federal poverty level: 11.5%

Percentage of aged 65 and over with prior year income under poverty level: 6.4%

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

² All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 483,456 in the year of the last U.S. census, 2010.

³ <http://www.labormarketinfo.ca.gov/file/census2012/sonomdp2012.pdf>, see pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc.

INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the “Data Notebook?”

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

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

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

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

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

- To assist local boards to meet their legal mandates⁴ to review performance data for their county mental health services and report on performance every year,
- To serve as an educational resource on behavioral health data for local boards,
- To obtain opinion and thoughts of local mental health boards on specific topics,
- To identify unmet needs and make recommendations.

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

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

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

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

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

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

- 1) An integrative view of "whole person care" for older adults in the overall system of care for behavioral health.
- 2) Discussion of demographics and challenges presented by expected increases in total number of older adults and increased needs for behavioral health services; we also want to know about different groups of older adults in order to promote appropriate outreach and engagement with services.
- 3) Conditions that can create barriers to accessing services (language, geographic or other social isolation, and disabilities, etc.) and therefore call for specialized attention and effort.
- 4) Data and information about the continuum of care for older adults with mental health and/or substance use treatment needs, including those providing care to dependent loved ones, those facing crises and/or significant changes in their ability to care for themselves.

How Do the Data Sources Define Older Adults?

It is common to refer broadly to adults age 60 and over as "older adults." However, discussions of data require precise definitions which differ depending on the information source and its purpose. Researchers may define age subcategories to describe psychological or biological⁵ stages of development and aging, for example: the "young old" (60-75), the "medium old" (75-85), and the "older old" (86 and older). These categories are used widely in the mental health and medical literature, because the likelihood of frailty, chronic disease and disability increases across these age spans.

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

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

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

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

Resources: Where do We Get the Data?

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

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

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

⁶ Frank JC, Keitzman 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 Outcomes and Indicators for Older Adult Public Mental Health Services](http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559). <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>

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

<p>CA DHCS: Mental Health Analytics Services and Performance Outcomes Systems,⁷ http://www.dhcs.ca.gov</p>	<p>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 EPSDT⁸ benefits).</p>
<p>CA DHCS: Office of Applied Research and Analysis (OARA)</p>	<p>Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the “Cal-OMS” data system.</p>
<p>CA Department of Aging</p>	<p>Administers programs and services for older adults in partnership with the federal government and federal funding. See www.aging.ca.gov for information.</p>
<p>External Quality Review Organization (EQRO), at www.CALEQRO.com</p>	<p>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.</p>
<p>American Community Survey 5-year Estimates</p>	<p>The 2008-2012 ACS report is a detailed survey of communities based on the 2010 U.S. Census.</p>
<p>Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov</p>	<p>Independent data reports and links to other federal agencies (NIMH, NIDA). Example: <u>National Survey on Drug Use and Health (NSDUH)</u>, which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.</p>
<p>County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/</p>	<p>An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the “Measures Outcomes and Quality Assessment” (MOQA) database. Also used by counties to report some data for MHSA programs and outcomes.</p>

⁷See: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

⁸ EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

HEALTHY AGING AND THE OLDER ADULT SYSTEM OF CARE

Social Supports and Community Engagement for Mental Health

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

Examples of services for older adults include:

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

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

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

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

Integrated Health Care for Older Adults: Treating the Whole Person

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

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

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

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

- Procedures for referral to primary care (1)
 Procedures for screening and referral for substance use treatment (2)
 Program or unit focused on the Older Adult System of Care (AOSOC) (3)
 Linkage to Federally Qualified Healthcare Center (FQHC) or similar (4)
 Links to Tribal Health (5)
 Case management/care coordination to other social services e.g., housing, CalFRESH, Meals on Wheels, In-Home Supportive Services (IHSS) (6)
 Health screenings, vital signs, routine lab work at Behavioral Health site (7)
 Health educator or RN on staff to teach or lead wellness classes (8)
 Training primary care providers on linking medical with behavioral health
 Use of health navigators, *promotores*,⁹ or peer mentors to link to services (9)
 Other, please specify. _____

- 1) Sonoma County Behavioral Health coordinates closely with primary care for Older Adult beneficiaries who receive specialty mental health services. Personal Services Coordinator are responsible for ensuring beneficiaries have a primary care provider.

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

Primary care coordination for seniors is complex with many variables. Some of those variables include, payor, setting, and access. Older Adults who receive specialty mental health services may have Medi-Cal, Medicare, or both.

Older Adults (and all adults) who receive out-patient specialty mental health services from Sonoma County Behavioral Health Santa Rosa-based teams are signed up to receive their primary care at Bridges to Health. Bridges to Health. Launched in March 2015, the Bridges to Health program increases integrated care to Sonoma County Behavioral Health clients with severe, persistent mental illness. This SAMSHA funded (Primary & Behavioral Health Care Integration Program Grant) program is a partnership between Santa Rosa Community Health Centers and Sonoma County Behavioral Health. This award expanded the Bridges Health Clinic, which now provides primary care services by a Family Nurse Practitioner, two full days per week. A Registered Nurse, two Care Coordinators/Medical Assistants, full time LCSW Program Manager, and two Peer Providers support the clinic onsite 5 days per week. The Bridges staff focus on whole person health and utilize a recovery framework. Through care coordination, the staff also meet the practical needs of the clients and staff by assisting with making appointments, following up on specialty referrals, and helping make sure clients have a smooth transition home from medical hospitalizations. Staff regularly go on home visits in order to engage individuals and provide comprehensive support. Staff also provide classes for beneficiaries' health and wellness classes.

For those Older Adults in communities other than Santa Rosa, the treatment teams work closely with their primary care providers at the local community health centers to coordinate care. Sonoma County Behavioral Health Community Mental Health Centers (CMHC) in Petaluma, Sonoma, Guerneville, and Cloverdale, the staff meet regularly primary care staff at the community health centers in those areas.

For Older Adults who are in Skilled Nursing Facilities (SNF), their primary care may or may not be provided by a contracted MD in that SNF. Personal Service Coordinators ensure Older Adults are referred and receive these primary care services at the SNF and are referred to specialty services as well. Sonoma County Behavioral Health employs a psychiatrist whose specialty is geriatric psychiatry. This psychiatrist goes to SNFs, board and cares, and other residential facilities to coordinate care. The CMHC staff also coordinate care with the beneficiaries served in local SNFs, particularly in Cloverdale and Sonoma Valley.

- 2) Sonoma County Behavioral Health uses an eleven element Medi-Cal assessment that includes collection of data regarding substance use patterns (type amount, frequency, duration) to understand the substance use issues of each individual. This information coupled with the functional impairment scale Adult Strengths and Needs Assessment (ANSA) allows Behavioral Health to assess for substance use disorders in all beneficiaries including Older Adults.

- 3) Sonoma County Behavioral Health Division, with the advent of Mental Health Service Act, has formed a comprehensive older adult system of care that provides the spectrum of intervention: from prevention, early intervention, treatment, long term care, and recovery.

Prevention and Early Intervention

The MHSA funded Older Adult Collaborative (OAC) is a four agency collaborative comprised of: the Sonoma County Human Services Department – Adult & Aging Division (A&A), Council on Aging (COA), Petaluma People Services Center (PPSC) and West County Community Services (WCCS).

The members of the collaborative are the primary senior services agencies in Sonoma County, serving older adults (60+) in their respective communities. The services provided include case management, nutrition programs, adult day services, peer support, counselling, and transportation programs, among others. COA, JFCS, PPSC, and WCCS are all nonprofit agencies, while A&A is a Division of Sonoma County Human Services Department.

Incorporated into the services mentioned above, the OAC implements Healthy IDEAS, an evidence-based prevention and early intervention model designed to reduce depression and suicide among older adults. The primary components of the Healthy IDEAS intervention include:

- A. Administration of a depression screening by trained agency staff who are supervised by licensed professionals
- B. Educating older adults about depression and its treatment
- C. Referral of case managed clients to various community resources, including medical providers, in-home counseling, and/or psychotherapy for those older adults identified as at risk for depression
- D. When appropriate, working with older adults to empower themselves through identification and completion of an activity goal, thereby learning how their own engagement in daily activities can reduce their depression symptoms.

Contracted services include:

- Healthy IDEAS intervention
 - Depression screening
 - Mental health education
 - Resource referrals
 - Establishing goals for activity engagement
- In-Home Counseling

Specialty Mental Health Treatment

Older Adults receive specialty mental health treatment from all outpatient treatment teams. However, the Older Adult Team works with older adults who require a level of care and intervention works with older adults on all its outpatient teams and intensive

outpatient teams. Seniors receive services from the Older Adult Outpatient Team whose mental health issues put them at risk for medical issues.

A. Older Adult Team Outpatient Team

Sonoma County Behavioral Health provides the following specialty mental health services to people with severe and persistent mental illness: assessment, case planning and management, crisis intervention, medication support, therapy, rehabilitation, referral, and linkage (including supportive housing and employment). Services are provided on multidisciplinary teams. These teams include:

- Integrated Health Team (IHT)
- Older Adult Team (OAT) for people aged 60+ years
- Community Mental Health Centers (CMHCs) located in Sonoma, Petaluma, Cloverdale, and Guerneville

Beneficiaries who receive services on OAT are individuals who are over the age of 60, whose mental health issues put him or her at risk for exacerbating current medical conditions.

B. Full Service Partnerships are multidisciplinary teams that provide intensive field based specialty mental health services targeted at specific populations with a service commitment of doing "whatever it takes". While there is an FSP specifically for seniors, beneficiaries over the age of 60 can receive services from any of the adult FSPs if they qualify. These focal populations include:

i. Older Adult Intensive Team –

Sonoma County Behavioral Health's Older Adult Intensive Team (OAIT) is a Full Service Partnership that provides intensive, integrated services for older adults with serious mental illness, coupled with more complex medical conditions who are at risk for being placed out of the home and are requiring close coordination between the mental health and primary or specialty medical providers.

- The team provides intensive case management, helping clients to access needed primary and specialty medical care and to ensure ongoing coordination between the clients' mental health and physical health providers.
- The program includes supported housing services designed to assist the older adult clients in living as independently as possible. The support services include medication management and adherence support, coordination with health care providers, and coordination with family or friends who are acting as caregivers for the clients.
- The program leverages existing MHSA funding peer support services – JFCS Caring Connections.
- The program provides support to the family and friends of clients who are acting as caregivers.

ii. Forensic Assertive Community Treatment (FACT) Team -
This FSP works with a probation officer to provide community-based specialty mental health services to people referred through Mental Health Court.

iii. Integrated Recovery Team (IRT)
This FSP serves beneficiaries who have co-occurring substance use and mental health disorders.

C. Assertive Community Treatment, contracted through *Telecare Sonoma ACT*, provides intensive specialty mental health services similar to an FSP, targeting mental health clients with serious mental illness who are at risk for placement at an extended care facility. Services are also available to seniors.

4. As part of service provision of specialty mental health, Personal Service Coordinators are responsible for insuring beneficiaries have a Medical Home so they can receive physical health care.

In Sonoma County, primary care medical homes for the Medi-Cal beneficiary are Federally Qualified Health Centers (FQHC) and Indian Health Services (IHS) and Kaiser. Sonoma County has seven (7) separate private non-profit organizations who operate FQHCs all around Sonoma County. Sonoma County Indian Health Project (SCIHP) operates the Indian Health Services in the northern bay area. Collectively they are referred to as community health centers. Beneficiaries can choose from any one of these community health centers to serve as their medical home.

As discussed in 1 above, many of the Santa Rosa-based Older Adults seen by Sonoma County Behavioral Health Division receive their primary care from Bridges to Health.

5. See #4 above.

6. Older Adults who are receiving specialty mental health services each area assigned a Personal Service Coordinators (PSC). The PSC is responsible for case management services that includes ensuring the individual is receiving mental health treatment as well as referring and linkage to other available social services.

7. See discussion in #1 above for information about Bridges to Health.

8. As part of the system of care Sonoma County Behavioral Health contracts with two (2) organizations to provide peer supports. These services are as follows:

Jewish Family and Children's Services (JFCS):

Seniors At Home program in Sonoma County helps older adults and their families each year. One key component of these services involves matching clients with caring

volunteers who want to give back in meaningful ways to make a positive difference in seniors' lives.

Caring Connections Program provides focused support to older clients recovering from depression or other challenging behavioral health issues. Concerned community members serve as volunteer visitors to these clients playing an integral role in their continued recovery with targeted support.

Clients referred by Sonoma County Behavioral Health can receive a minimum of 6 months of volunteer support. Volunteer Visitors visit weekly, working directly with an older adult to help him or her combat isolation, loneliness, and depression. Recruitment, screening, training and ongoing support of volunteers will be provided by Seniors At Home.

West County Community Services (WCCS)

WCCS has managed its Senior Peer Counseling Program since 2002. Seniors struggling with issues of aging and mental health are matched with trained volunteer Senior Peer Counselors. The program strives to reach at-risk seniors before they experience crisis, helping them to re-main self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the County.

A key component of this program is WCCS's free 35 hour Senior Peer Counseling Training Program for volunteers who are seniors themselves. Senior Peer Counselors (SPCs) are trained in issues related to aging, and each peer counselor brings a special area of skill that reflects his/her own life experience. They are trained in active listening, communication techniques, problem solving, assertiveness, and grief issues, and they learn how to screen for depression, anxiety and a multitude of other mental health issues. A recovery orientation is integrated throughout. They are also trained in reporting elder abuse according to current law, and in making appropriate referrals to other community resources. Once trained, SPCs provide counseling, outreach, information, education and support to seniors in their homes or at the agency.

DEMOGRAPHIC TRENDS : CHALLENGES FOR SERVICE ACCESS

Who are California's Older Adults?

"Older Adults comprise a substantial portion of the people in California. In 2016, approximately 5.5 million Californians, or 14% of the population, were age 65 or older.¹⁰

Of those, "approximately 1.6 million (30 per cent of California's total older adult population) was foreign-born."⁵

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

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

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

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

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

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

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

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

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

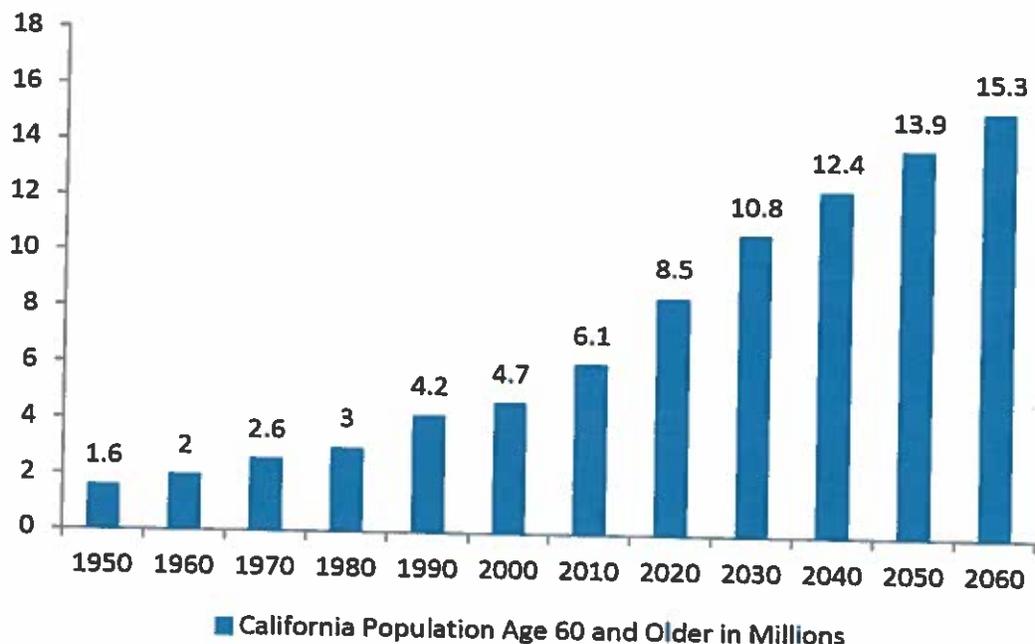


Figure 1. Projected Increases in Population Age 60 and over in California.¹³

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

	2010 Population age 60+	2030 Population age 60+	Per Cent Change over 20 years
Sonoma County	100,334	156,174	56 %
California	6,016,871	10,879,098	81 %

3. Is your county doing any advanced planning to meet the mental health and substance use service needs of your changing older adult population in the coming years? Yes No If yes, please describe briefly.

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

Sonoma County Behavioral Health staff participate in local and statewide efforts to do advance planning to meet the changing needs of the older adult population. The efforts include:

Senior Advocacy Services - Elder Justice Initiative

The Elder Justice Initiative strives to ensure seniors are safe and supported in Sonoma County with dignity, honor and respect. The Elder Justice Coalition is a collaboration of Sonoma County organizations unified in the common goal of elder justice.

Sonoma County Area Agency on Aging – Sonoma Access Coordinated Transportation Consortium

The Transportation Consortium meets two to three times a year to discuss transportation issues, including challenges faced by older adults and physically disabled individuals in the community. This is a place where various community partners come together to share transportation resources and try to explore creative solutions thru collaboration, planning and development.

Sonoma County staff also attend monthly clinical meeting at Adult and Aging, to provide clinical consultation to the social workers and supervisors from Linkages Case Management, Archstone Project, and Care Transition. As well as Human Services Division unit meetings several times a year to provide consultation (and sometimes presentations) to In Home Support Services (IHSS) and IHSS/Pubic Authority teams.

Sonoma County participate in providing services to homeless individuals through work the Community Intervention Program (CIP). CIP works with the Homeless Outreach Services Team (HOST) as well as co-locates staff in homeless shelters and other homeless service provider locations. These activities, while not expressly for seniors, puts CIP staff in touch with many of Sonoma County's homeless senior population.

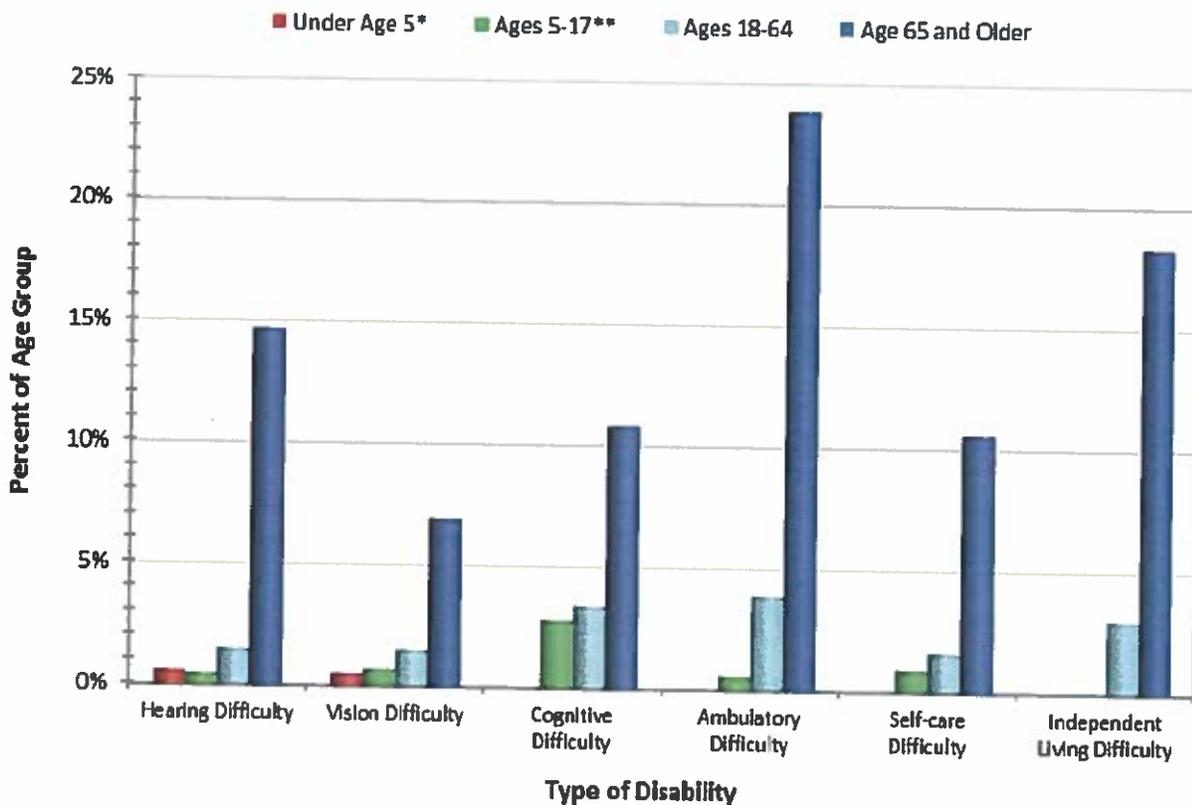
Barriers to Services for Older Adults

Disabilities in Older Adults Can Present Barriers to Service Access

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

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

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	1,776,367	9.7%	1,978,079	10.5%	3,753,446	10.1%



*For children under 5 years old, only questions regarding hearing and vision difficulties were asked.

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

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

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

In your county, the data show:

Sonoma County (2011): There were 66,757 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 22,903. That number represents 34.3 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

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

The California Department of Aging prepared the following demographic projections¹⁴ for 2016 for your county:

Sonoma County (2016):

Age 60+: 123,789	Age 75+: 33,982
Nonminority: ¹⁵ 104,094	Minority: ¹⁶ 19,695
Low income: 10,475	Non-English proficient: 1,510
Medi-Cal: 13,346	SSI/SSP (65+): 2,680
Lives alone (60+): 27,160	Geo-isolation (60+): 17,953

Limited English Proficiency is a Barrier for Behavioral Health Access

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

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

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

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

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

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

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

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

Yes No

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

LANGUAGES

- Latino seniors who are mono-lingual in Spanish.
- Asian seniors who are mono-lingual in their native language.
- Eritrean seniors who are mono-lingual in their native language.

COMMUNITIES

- Hospital Emergency Rooms
- Geographically Isolated Communities
- Homeless Seniors
- Seniors Who Are Home-Bound And Isolated
- LGBTQ Senior Community Needing Care Facilities

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

Our Community Intervention Program has a significant Latino home visiting program. This program employs a non-licensed Spanish speaking clinical staff person who receives

calls from all over Sonoma County to visit individuals who are experiencing a behavioral health crisis, including seniors.

This small program is well known by individuals in the Latino community and most of the referrals to the program are done by word of mouth; people who have used the service and are recommending it to others. These services are offered throughout Sonoma County.

Sonoma County provides translation services for specialty mental health treatment in ALL languages using the Corporate Translation Services (CTS). CTS provides phone and in person translation services for individuals who require services are provided in a language other than English.

Though support from Mental Health Services Act funded CalMHSA, the Division provides outreach and engagement materials specifically targeting the Asian and Pacific Islander communities at the Annual ASIAN/Pacific Islander Health Forum as well as the Latino Health Forum. While these forums are not expressly targeting Sonoma County's senior population, these activities can touch their lives as well.

With the implementation of MHSA PEI funds, Jewish Family and Children's Services (JFCS) received one time funding for the express purpose of ensuring services to LGBTQI seniors in Sonoma County receive culturally relevant services. JFCS providing training for services staff, policy makers to ensure that services are welcoming and desirable for the senior LGBTQI. While this funding was only one year, the work of this project has long lasting effects.

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

Transportation

Geographic Isolation

Lack of awareness of services

Mobility issues due to co-occurring physical conditions or disabilities

Lack of geriatric-trained practitioner

BEHAVIORAL HEALTH: OLDER ADULTS CONTINUUM OF CARE

Substance Use Treatment for Older Adults: Barriers and Stigma

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

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

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

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

In the U.S. (2015) it was reported¹⁹ that there were at least 1.7 million adults aged 50 or older who had both mental illness and SUDs in the past year. That number corresponds to 1.6 percent of all adults 50 and older. Of these, 57 percent received mental health care or SUD treatment at a specialty facility in the past year. Mental health care only was received by 47 percent of these, both mental health care and SUD treatment were received by 7 percent, but less than 4 percent received SUD treatment alone.

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

¹⁸ Addiction in Older Adults: Why It's Prevalent. What Can Be Done. – Hazelden.

<https://www.hazelden.org/web/public/document/older-adults-prescription-medication-abuse-addiction-generic.pdf>

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

Focus on Fifty-five (and over) in California: Analyses²⁰ of SUD services for clients age 55 and over yielded these findings for those admitted to treatment in FY 2014-2015.

- About 11,000 unique clients ages 55 and over were admitted to publically monitored SUD treatment. This age group accounted for only about 10% of total clients. Very few--about 80 clients--were age 75 or older.
- Most were admitted to the Outpatient Narcotic Treatment Program (NTP) -- maintenance service type (33%), or to the Outpatient Drug Free service type (27%). Residential Detoxification was next at 17%, and then Residential Treatment at over 16%.
- About 47% reported only drug (other than alcohol) problems, about 29% reported both alcohol and drug use, and 24% alcohol only.
- The top four drugs of abuse that are most commonly reported include heroin (35%), alcohol (34%), methamphetamine (almost 12%), and cocaine/crack over 6%). These four drugs accounted for 87% of substance use in adults over 55.
- For clients under 55, methamphetamine is the most commonly-reported drug.

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

- The combined percentages for clients reporting ER (emergency mental health use) or 24 hours or more psychiatric facility days are small: 3-4% range.
- About 24% reported psychiatric drug use. This is a concern because SAMHSA estimates the same 24% for all adults nationally (not just older adults).

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

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

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

Your County: SONOMA

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	188 51.23 %	39 10.63 %	81 22.07 %	59 16.08 %	367
Age 37-54	371 38.53 %	64 6.65 %	323 33.54 %	205 21.29 %	963
Age 26-36	308 27.28 %	114 10.1 %	402 35.61 %	305 27.02 %	1129
Age 15-25	170 23.78 %	58 8.11 %	348 48.67 %	139 19.44 %	715

CALIFORNIA: Statewide

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

Age Group	Detoxification	Outpatient NTP	Outpatient non-NTP	Residential Tx	Total (each row)
Age 55 & over	3,005	3,674	3,363	2,061	12,103
Age 37-54	8,395	7,340	16,475	9,148	41,358
Age 26-36	7,442	7,719	20,216	11,170	46,547
Age 15-25	3,555	2,974	18,467	6,014	31,010
Column TOTALS:	22,397	21,707	58,521	28,393	131,018

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

- The number of adults age 55 and over who received SUD treatment of any type is generally much less than for other age groups, even though older adults represent an increasing share of the total population.
 - In the majority of small counties with populations <100,000, there are relatively few options for types of SUD treatment besides outpatient treatment (non-NTP). The large number of "zeroes" shown under other types of treatment may indicate a disparity in access to those services.
7. One of our goals is to identify unmet needs for substance use treatment in older adults. Based on local community needs assessments or other reports, what substance use treatment services are available in your county for older adults?

Please check all that apply.

Outpatient NTP (narcotics treatment program (methadone, etc.)

Outpatient (non-NTP)

Detoxification

Residential Treatment

Dual Diagnoses Programs

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

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

SUD Treatment program designed for older military veterans

Other, please specify. _____

Mental Health Services for Older Adults²¹

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

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

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

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

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

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

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

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

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

²³ Geriatric Mental Health Foundation, 2008.

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

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

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

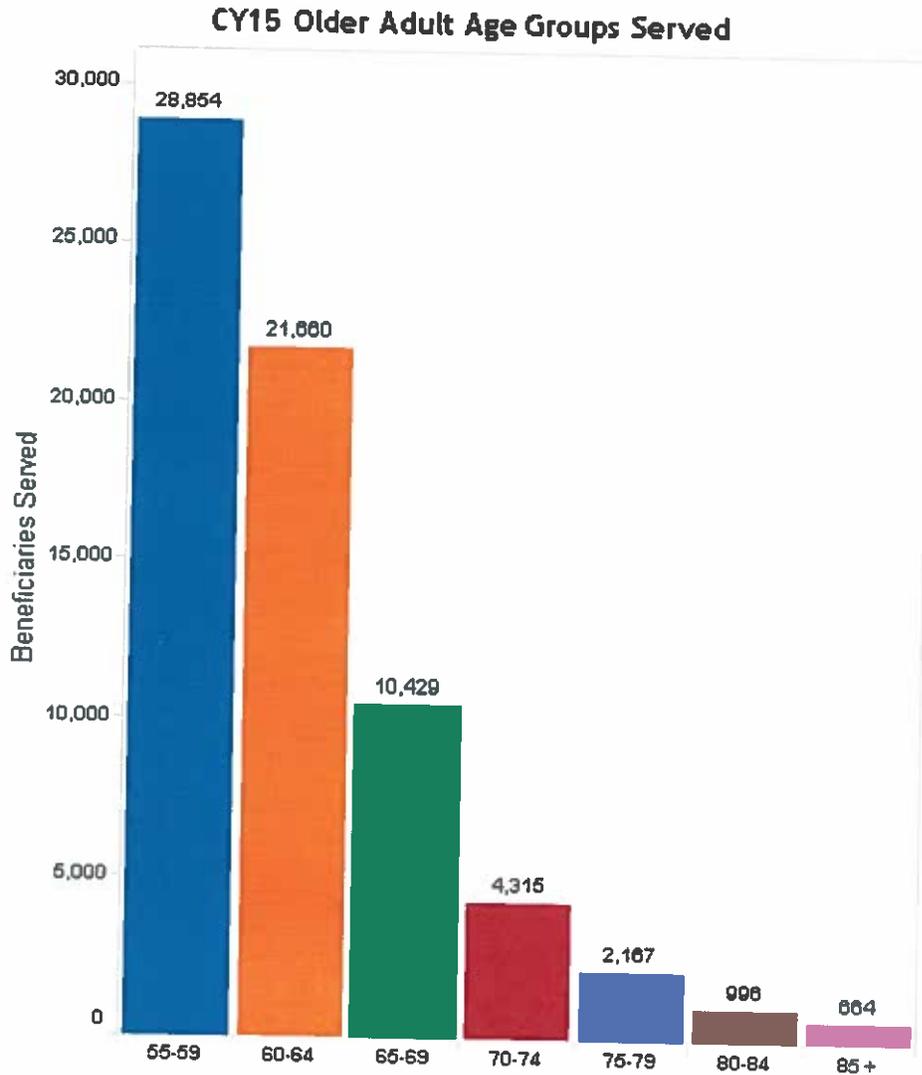


Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).

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

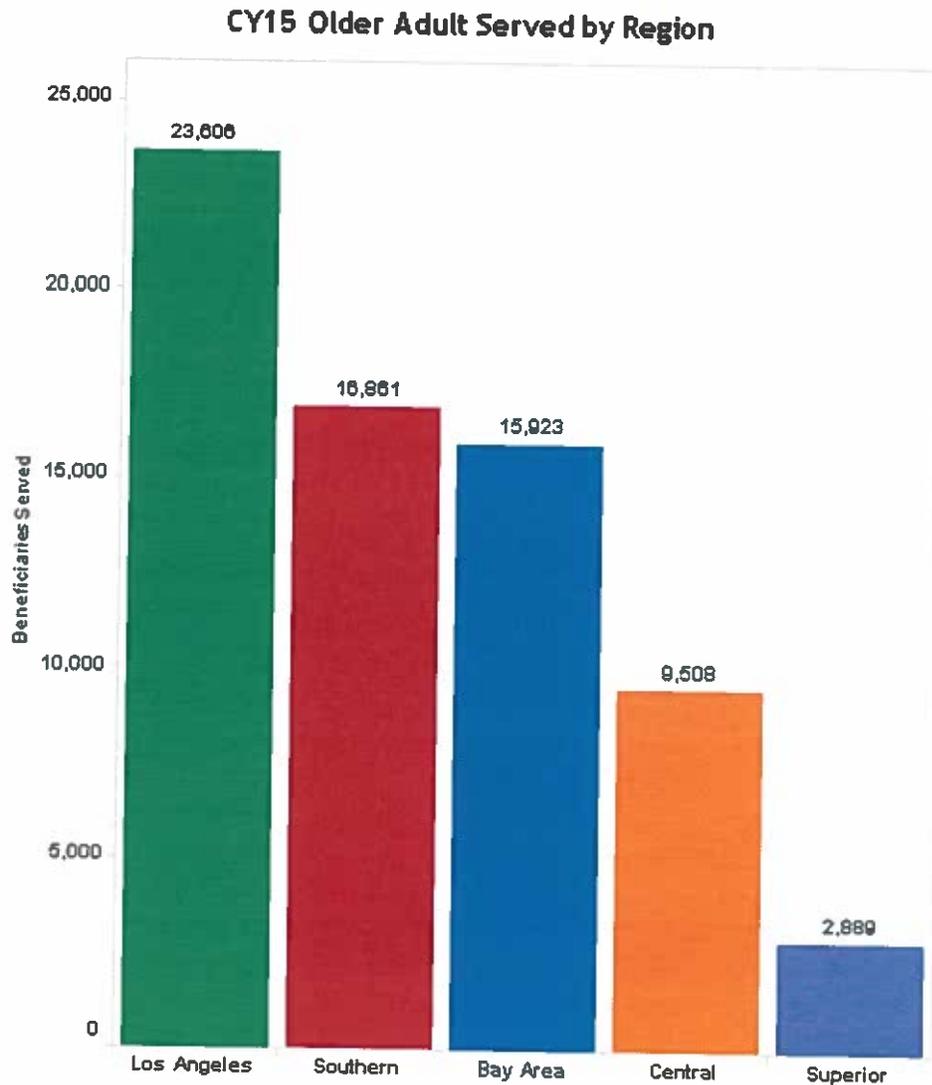


Figure 4. The numbers of persons in each region who received Specialty Mental Health Services (“beneficiaries”, CY 2015). Los Angeles County is taken to be its own region.

²⁶ Bay Area : Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma counties

Central region: Amador, Alpine, Calaveras, El Dorado, Fresno, Inyo, Kings, , Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Sierra, Stanislaus, Sutter, Tuolumne, Tulare, Yolo, Yuba counties

Superior Region: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity counties

Southern: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura.

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

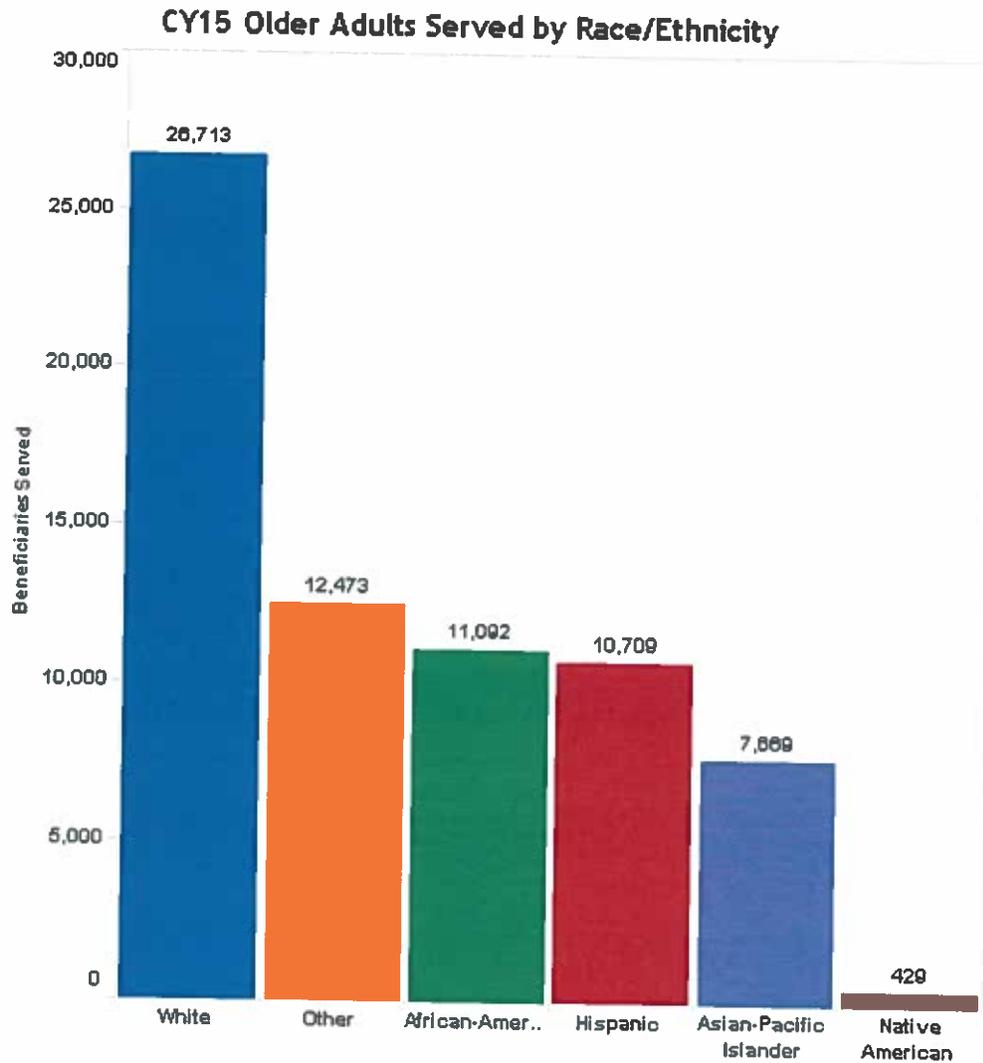


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group (“beneficiaries served”).

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

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

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

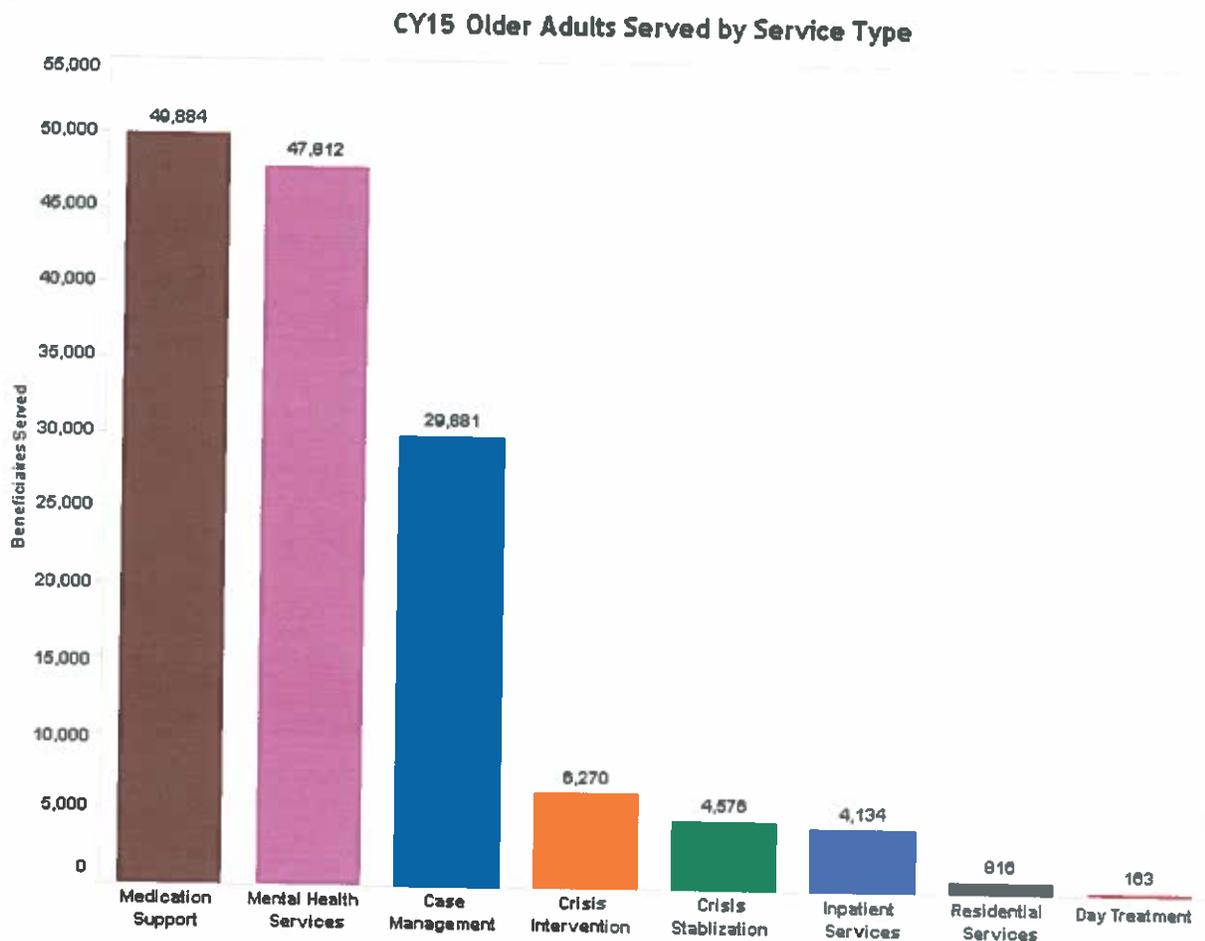


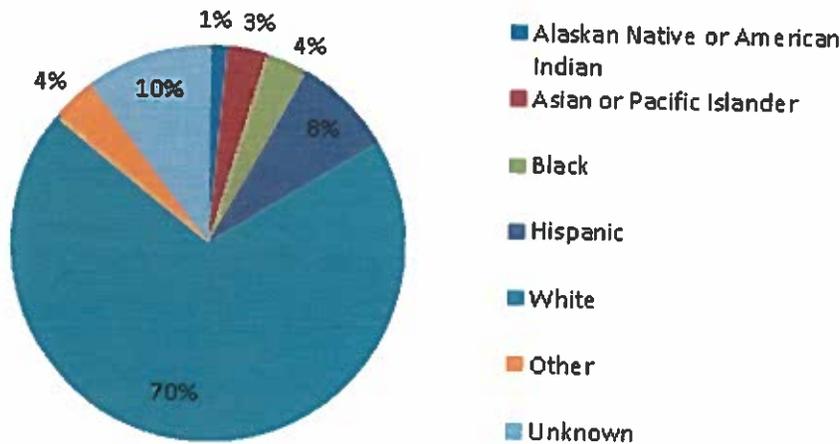
Figure 6. The most frequently used specialty mental health services are shown by the total number of older adults (“beneficiaries served”) who received each type of service.

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

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

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

Fiscal Year 14-15 Race Distribution



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.

Fiscal Year 14-15 Age Group Distribution

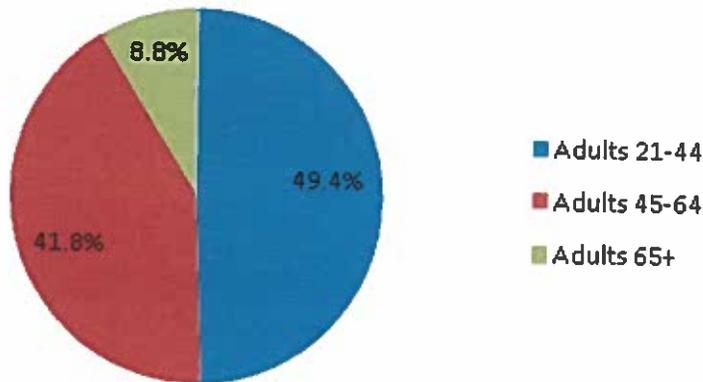


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).²⁸

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

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

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

	Adults with 1 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	1,920	67,784	2.8%
Adults 21-44	948	33,810	2.8%
Adults 45-64	803	24,658	3.3%
Adults 65+	169	9,316	1.8%
Alaskan Native or American Indian	25	1,253	2.0%
Asian or Pacific Islander	61	7,018	0.9%
Black	69	1,778	3.9%
Hispanic	157	10,808	1.5%
White	1,334	38,349	3.5%
Other	75	4,763	1.6%
Unknown	199	3,815	5.2%
Female	893	37,409	2.4%
Male	1,027	30,375	3.4%

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

	Adults with 5 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	1,442	67,784	2.1%
Adults 21-44	700	33,810	2.1%
Adults 45-64	606	24,658	2.5%
Adults 65+	136	9,316	1.5%
Alaskan Native or American Indian	14	1,253	1.1%
Asian or Pacific Islander	49	7,018	0.7%
Black	50	1,778	2.8%
Hispanic	116	10,808	1.1%
White	999	38,349	2.6%
Other	53	4,763	1.1%
Unknown	161	3,815	4.2%
Female	677	37,409	1.8%
Male	765	30,375	2.5%

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

The chart below indicates the number and percentage of individuals over the age of 65 who receive specialty mental health services in FY 16/17:

By Age	Count of Clients	%age
0-17	1319	37.03%
18-64	2265	59.36%
65+	189	3.61%
Grand Total	3773	100.00%

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

Yes with the following exceptions identified below in comments No

COMMENTS

- Need to understand how those seniors who are home-bound and isolated are accessing mental health services.
- Difficult to engage people who are offered but don't accept services, for example homeless people.

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

Community Supports for Mental Health Emergencies and Crisis Services

Our understanding is that there are relatively few counties with crisis intervention or stabilization services with specialized training in helping older adults, but instead they rely mainly on the adult system of care for all adults. In the CMHPC Statewide Overview Report²⁹ (December, 2015), responses from a number of counties identified needs for crisis services specifically targeted to older adults.

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

Yes No If yes, please check all that apply below.

²⁹CMHPC Statewide Overview Report 2015: Data Notebook Project on Behavioral Health in California, <http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx>.

- Mental health providers trained in MH needs of older adults
- Crisis Intervention Teams have someone trained in the needs of older adults
- Provide training and work more closely with law enforcement in handling MH crisis of older adults
- Crisis Drop-In Center with ability to serve older adults
- Services for older adults at risk for suicide
- 23-Hour Crisis Stabilization Services for older adults
- Crisis residential treatment for older adults
- Psychiatric hospital or unit able to take older adults with complex medical needs, when mental health crises are too serious to be met by other services.

Individuals receiving specialty mental health services on the Older Adult Team and The Older Adult Intensive Team who may be experiencing a crisis are provided crisis intervention services by the Older Adult Team members.

MHSA funded programs provide services to older adults who may be at risk for suicide. programs include:

The Council on Aging (COA) provides volunteer Senior Peer Support to seniors 60 or older, who have an Axis-I diagnosis, residing in the broad geographic area served by the agency (Sonoma County cities of Santa Rosa, Sebastopol, Rohnert Park, Cotati, Windsor, Healdsburg, Cloverdale, Sonoma and their surrounding rural areas), and who require assistance as a means of maintaining their optimum level of functioning in the least restrictive setting possible.

West County Community Services (WCCS) has managed its Senior Peer Counseling program since 2002. Seniors struggling with issues of aging and mental health are matched with trained volunteer Senior Peer Counselors. The program strives to reach at-risk seniors before they experience crisis, helping them to remain self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the County.

As a subcontract of this grant, Jewish Family and Children's Services (JFCS) provides Volunteer Visitor services and as needed case management to seniors with mental health issues and serious mental illness to enhance recovery, increase socialization and

involvement and reduce isolation for seniors from Windsor to Petaluma, Sonoma to Sebastopol.

In collaboration with Human Services, Adult and Aging Division, the Sonoma County Behavioral Health Division Older Adult Team identifies older adults, age 60 and older, who show symptoms of depression, serious mental illness and/or suicidal thinking, and provide an in-home assessment and care coordination with the SC-BHD Older Adult Mental Health Outreach Liaison. From peer support to in-home counseling to Specialty Mental Health services, older adults who are interested in receiving support are offered a warm handoff to the appropriate level of care. This partnership enables older adults the opportunity to live healthier, more connected and fulfilling lives.

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

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

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

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

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

The data for your county show:

Sonoma County (2011):

Total persons age 65 years and older: 66,757 (13.8 % of total population).

Grandparents living with own grandchildren under 18 years: 7,721.

Grandparents responsible for grandchildren: 2,287 (which is 29.6 % of the grandparents living with children under the age of 18.)

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

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

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

Yes No

The Mental Health Plan is cannot provide services to older adults who do not meet Title 9 criteria for specialty mental health.

Sonoma County Human Services does offer grandparents supports who provide care for child family members. The organization Lilliput Families offers the following NON-SPECIALTY KSSP provides support to relatives facing the challenge of raising kin, and also helps connect families in similar situations. In addition, they offer: In-home Support, Counseling, Support Groups, Respite Resources, Advocacy, Information & Referrals, Legal Referrals, Guardianship, Workshops & Adoption Assistance, Family Activities, Play Care, Mentoring, Assistance with Basic Emergency Needs

Santa Rosa Junior College: Foster and Kinship Care Education Program provides classes, workshops, resource referrals; support for foster, kinship, and adoptive parents, helping them to care for special needs of children who are unable to live with biological parents. Also welcome are agencies and individuals working with children and youth in foster, kinship, and adoptive families or other out-of-home placement.

If yes, please check all that apply below.

Group therapy or support groups

Counseling/parenting strategies

Respite care services

In-home supportive services (IHSS)

Stress management program

Mental health therapy, individual

Other, please specify: training and education

Significant Changes in Behavioral/Cognitive Function in Older Adults

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

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

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

Delirium is an acute confusional state caused by an underlying medical disorder which usually resolves promptly in response to medical treatment. Delirium may be experienced 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."³⁰ Other functions, called instrumental activities of daily living (IADLs), include preparing food, managing finances, grocery shopping, using a telephone, and doing housework.²¹

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

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

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

Table 8. Characteristics of Depression, Delirium and Dementia²⁷

	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)	May be intact or impaired	May be intact or impaired	May be intact early, but impaired before ADLs as the disease progresses.

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

10. Does your county have a special program(s) to address the needs of older adults with chronic mental illness who also begin to be affected by mild cognitive impairment or early dementia? Yes No

If yes, please provide one example.

Older Adult Team Outpatient Team: Sonoma County Behavioral Health provides the following specialty mental health services to people with severe and persistent mental illness:

assessment, case planning and management, crisis intervention, medication support, therapy, rehabilitation, referral, and linkage (including supportive housing and employment). Services are provided on multidisciplinary teams. For those older adults who have serious and persistent mental illness are experiencing cognitive decline that requires 24 hours supports, the Older Adult Team psychiatrists and case managers provide consultation and supports on site at the Skilled Nursing Facilities

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

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

11. Does your community train and/or utilize the skills and knowledge of older adults as peer counselors, and/or health navigators? Yes No

If yes, then please provide one example of how this occurs.

Jewish Family and Children's Services (JFCS):

Seniors At Home program in Sonoma County helps older adults and their families each year. One key component of these services involves matching clients with caring volunteers who want to give back in meaningful ways to make a positive difference in seniors' lives.

Caring Connections Program provides focused support to older clients recovering from depression or other challenging behavioral health issues. Concerned community members serve as volunteer visitors to these clients playing an integral role in their continued recovery with targeted support.

Clients referred by Sonoma County Behavioral Health can receive a minimum of 6 months of volunteer support. Volunteer Visitors visit weekly, working directly with an older adult to help him or her combat isolation, loneliness, and depression. Recruitment, screening, training and ongoing support of volunteers will be provided by Seniors At Home.

West County Community Services (WCCS)

WCCS has managed its Senior Peer Counseling Program since 2002. Seniors struggling with issues of aging and mental health are matched with trained volunteer Senior Peer Counselors. The program strives to reach at-risk seniors before they experience crisis, helping them to remain self-sufficient, independent, and out of the institutional care system. WCCS works with clients to instill hope and promote wellness through providing in home peer support as well as groups accessibly located in different areas of the County.

A key component of this program is WCCS's free 35 hour Senior Peer Counseling Training Program for volunteers who are seniors themselves. Senior Peer Counselors (SPCs) are trained in issues related to aging, and each peer counselor brings a special area of skill that reflects his/her own life experience. They are trained in active listening, communication techniques, problem solving, assertiveness, and grief issues, and they learn how to screen for depression, anxiety and a multitude of other mental health issues. A recovery orientation is integrated throughout. They are also trained in reporting elder abuse according to current law, and in making appropriate referrals to other community resources. Once trained, SPCs provide counseling, outreach, information, education and support to seniors in their homes or at the agency.

All services above are provided countywide.

QUESTIONNAIRE: How Did Your Board Complete the Data Notebook?

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

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

- MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.
- MH Board completed majority of the Data Notebook
- County staff and/or Director completed majority of the Data Notebook
- Data Notebook placed on Agenda and discussed at Board meeting
- MH Board work group or temporary ad hoc committee worked on it
- MH Board partnered with county staff or director
- MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
- Other; please describe: posted on County Behavioral Health website

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

Yes No

If yes, please provide their job classification Section Manager - Mental Health Board Liaison: Secretary - Mental Health Board Clerk

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

Name and County: Rhonda Darrow – Sonoma County Mental Health Board Clerk

Email: Rhonda.Darrow@sonoma-county.org

Phone # (707) 565-4854

Signature: 

Other (optional): _____

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

Name and County: Asghar Eshan – Sonoma County

Email: Asgharwafa@gmail.com

Phone # (707) 339-1793

Signature: 

REMINDER:

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

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

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

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

(916) 327-6560

Or, you may contact us by postal mail to:

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

