

SAN BERNARDINO COUNTY: DATA NOTEBOOK 2017

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS



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

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PLEASE NOTE: San Bernardino’s responses are in bold. All other text and information was provided by the California Mental Health Planning Council.

County Population (2017): 2,168,360

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

<http://www.sbcounty.gov/dbh/index.asp>

Website for Local County MH Data and Reports:

<http://www.sbcounty.gov/dbh/index.asp>

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

<http://www.sbcounty.gov/dbh/mhcommission/mhcommission.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.

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.

Table 1—San Bernardino 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	112,221	9,056
Hispanic	362,681	11,679
African-American	69,670	4,880
Asian/Pacific Islander	24,660	662
Native American	1,463	118
Other	62,898	3,662
Total	633,591	30,057

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

Supplemental County Data Page

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

Population (2010): 2,041,029

Adult population over 18: 1,433,302

Civilian veterans: 108,816 (7.6% of the adult population)

Total civilian noninstitutionalized population: 2,001,380

 With a disability, all ages: 214,146 (10.7%)

 Under 18 years with disability: 19,468 (3.3% of those within this age group)

 Age 18-64 years with a disability: 120,479 (9.8% of those in this age group)

Total population age 65 years and older: 179,954 (8.8 % of total population).

 Age 65 and older with a disability: 74,199 (41.2% of those in this age group)

Total households: 599,698 (100%) Population in households: 1,996,088 (98.5%)

 Households with a member 65 years or over: 130,692 (21.8%)

² All numbers are based on the civilian population not residing in institutions. Assumptions and statistical models are based on the population of 2,041,029 in the year of the last U.S. census, 2010.

³ <http://www.labormarketinfo.ca.gov/file/census2012/sanberdocitydp2012.pdf>, see pages 2 and 7 for details about race/ethnicity, cultural origin, languages spoken at home, etc.

Householder living alone, age 65 years and over: 40,302
Grandparents living with own grandchildren under 18 years: 77,490
Responsible for grandchildren: 25,244 (32.6% of those living with grandchildren)
Grandparents who are female: 15,366 (60.9%)
Grandparents who are married: 18,890 (74.8%)
Percentage of all families whose prior year income was below poverty level: 14.1%
Percentage of all persons living under the federal poverty level: 17.6%
Percentage of aged 65 and over with prior year income under poverty level: 10.6%
Statewide: of those age 65 and over, 10 % live below the federal poverty level.

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

Procedures for screening and referral for substance use treatment

Program or unit focused on the Older Adult System of Care (AOSOC)

Linkage to Federally Qualified Healthcare Center (FQHC) or similar

Links to Tribal Health

Case management/care coordination to other social services e.g., housing, CalFRESH, Meals on Wheels, In-Home Supportive Services (IHSS)

Health screenings, vital signs, routine lab work at Behavioral Health site

Health educator or RN on staff to teach or lead wellness classes

Training primary care providers on linking medical with behavioral health

Use of health navigators, *promotores*,⁹ or peer mentors to link to services

Other, please specify. **Several of the above services and additional services are provided by the County through the Department of Aging and Adult Services (DAAS), including Senior Centers, transportation, Health Insurance Counseling and Advocacy Program, care coordination through the Senior Information and Assistance Program and the Multipurpose Senior Services Program, Senior Supportive Services, Long Term Care**

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.

Ombudsman, Family Caregiver Support Program, Senior Community Service Employment Program, and Office of the Public Guardian

Community Crisis Response Teams (CCRT)

All staff at each of the three regional CCRTs are required to complete training specific to the needs of older adults:

- **Behavioral Health Issues in Older Adults for Paraprofessionals**
- **Diagnosing Substance Use Issues in Older Adults**

The CCRT teams work closely with law enforcement on field calls and provide education on the specific needs of older adults, which also includes the utilization of Adult Protective Services. There are three Crisis Walk In Centers (CWICs); two of which are contracted Crisis Stabilization Units (CSU). The countywide Adult Drop In Centers (“Clubhouses”) offer services, socialization, and linkage to resources to adults and older adults with behavioral health needs. In San Bernardino County, there are two inpatient psychiatric programs, Loma Linda University Behavioral Medicine Center and Canyon Ridge Hospital, that offer gerontology units for older adults who present with acute psychiatric needs and require inpatient services.

Prevention and Early Intervention (PEI)

The PEI Older Adult Community Services Program integrates physical health care with behavioral health care through the inclusion of the following four components in its program:

1. Older Adult Mobile Resource Unit
2. Older Adult Wellness Services
3. Older Adult Home Safety
4. Older Adult Suicide Prevention

The Older Adult Mobile Resources Unit provides mental health and substance use screenings and referrals.

The Older Adult Wellness Services delivers comprehensive wellness activities and transportation services. This component offers informational health and wellness classes/presentations, groups, social activities, and outings and provides referrals to a variety of physical and behavioral health services.

The Older Adult Home Safety component assists older adults with maintaining an appropriate level of personal and home safety. A staff member will go to the participant's home to provide education, an assessment, and resources to ensure personal safety, home safety, fall prevention, and medication management for the consumers.

The Older Adult Suicide Prevention component provides suicide prevention education, screenings, and direct support services. This component uses peer counselors who are professionally trained and certified to provide supportive services specifically to the older adult population.

The Promotores de Salud/Community Health Worker (PdS/CHW) is a countywide program utilizing participants of all ages to provide the following services:

- 1. Crisis Intervention**
- 2. Outreach**
- 3. Case Management**
- 4. Peer Providers**

The PdS/CHW service providers are trained on the fundamentals of crisis intervention principles. They are able to assess the level of crisis, provide non-therapeutic crisis intervention and assist with referrals to the proper medical and/or behavioral health agencies for treatment. They are designed to be the subject matter experts in their community for community resources relating to health care.

The PdS/CHW program specifically targets Family Resource Centers, medical offices, and social service locations for outreach purposes. Service providers can assist responders with how to recognize and respond effectively to early signs of potentially severe and disabling behavioral health conditions and provide health promotion, educational services, alternative activities, or identify risk factors that can contribute to the development of a behavioral health condition. PdS/CHW outreach also includes connecting with individuals with signs and symptoms of substance abuse and/or behavioral health conditions, so they can respond to their own symptoms.

PdS/CHW service providers offer case management services that directly assist participants in accessing needed medical, educational, social, or other community services.

The PdS/CHW peers provide support to participants on a one-on-one basis or through peer groups. Each PdS/CHW provider is trained to address the specific needs of the communities/peer groups they represent.

Centralized Hospital Aftercare Services (CHAS)

Age Wise I (Circle of Care-OAI) in the East Valley, West Valley, Central Valley regions or in the lower regions and Age Wise II (Mobile Outreach-OA2) in the High Desert provide for programs that are focused on the older adult system of care as well as case management and care coordination to other social services. The Age Wise Programs are non-traditional behavioral health programs for the high-risk and underserved older adult population. These programs provide in-home behavioral health and case management services to older adults, aged 59 and over, living with a chronic behavioral health condition. The following are field-based behavioral health services provided, specifically tailored to the older adult population:

- **Mobile clinical assessment and individual therapy**
- **Mobile case management services to provide linkage to community resources such as In-Home Supportive Services (IHSS), medical and dental services, assist with housing, transportation, and other community resources to ensure stability**
- **Crisis intervention**
- **Full Service Partnerships**
- **Groups in the community**

Integrated Healthcare

Physical healthcare has been integrated with behavioral healthcare in the following settings:

- **The Integrated Healthcare Team currently has a pilot program, Building Bridges, coordinating care between the primary care providers (PCPs) and a DBH psychiatrist. The program arranges the consumer's medical appointments and psychiatric appointments on the same day providing increased communication between the PCP and the psychiatrist facilitating coordination of care. In addition, the Integrated Healthcare Team is able to assist the consumer participating in the Building Bridges program with transportation needs, benefits applications and other services that may be needed.**
- **The Behavioral Health Integration Complex Care Initiative (BHICCI) adds complex medical case management in addition to the psychiatric services that consumers are receiving from the Adult Residential Services (ARS)**

Clinic. The BHICCI Team works collaboratively with the psychiatric services providers to identify medical needs that the consumers may have. The BHICCI Team assists the consumers to schedule appointments with their PCP, educates the consumer on navigation of the complex healthcare system and attends appointments providing advocacy for the consumer. The field based services that are provided by the BHICCI Team facilitate bi-directional communication and coordination between the physical healthcare provider team and the psychiatric care team.

Substance Use Disorder and Recovery Services

San Bernardino County Department of Behavioral Health Substance Use Disorder and Recovery Services (DBH – SUDRS) assure integration with physical health care for older adults through developed systems of referrals to primary care and screening and referring for substance use disorders.

Procedures for Referral to Primary Care

Referral to primary care physicians is achieved by utilization of DBH – SUDRS physicians embedded in each of the SUDRS outpatient clinics. When an older adult accesses treatment services, the individual completes a Client Health Questionnaire that captures a baseline history of medical condition in addition to a self-disclosure of their medical conditions including physical health, dental health, hearing, and vision. The Client Health Questionnaire is then reviewed with the client and all medical conditions are documented in the medical record. Information such as whether the client has a primary care physician and is currently receiving medical treatment is discussed. If the client has not had a physical examination within the twelve months prior to admission to SUD outpatient services, the client has the following options:

- 1. An appointment for a physical examination is scheduled with the SUDRS physician in the clinic**
- 2. The client may opt to receive a physical examination with their primary care physician and provide verification of the physical examination to the clinic**

If the client chooses to seek a physical examination from their primary care physician, SUD outpatient staff work with the client by providing case management to assure follow through with their physician. If they do not have a primary care physician, the client is assisted with the process of attaining a physician. All physical and dental health needs are incorporated into the client's treatment plan with goals to attain and action steps to take to ensure the physical

health needs of the older adult is met. The progress toward the goals are reviewed each month and discussed with the client.

Screening Assessment and Referral Center

DBH – SUDRS operates a Screening Assessment and Referral Center (SARC) where older adults can access services to substance use disorder treatment. When an older adult presents at SARC, either in person or by telephone, they are assisted by a licensed/certified SUD professional who conducts a confidential assessment for substance use disorder treatment placement based on American Society of Addiction Medicine (ASAM) criteria. The older adult’s withdrawal/acute intoxication potential, bio-medical conditions and complications, emotional/behavioral/cognitive conditions and complications, readiness or stages of change, relapse/continued problem potential, and recovery environment are included in the confidential assessment. The results of the assessment and recommended level care are discussed with the older adult and an agreement to the level of care is reached. SARC then assigns a case manager who will navigate the system of care with the older adult to determine the best SUD treatment based on need.

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 \geq 65	Percent of All Adults \geq 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.

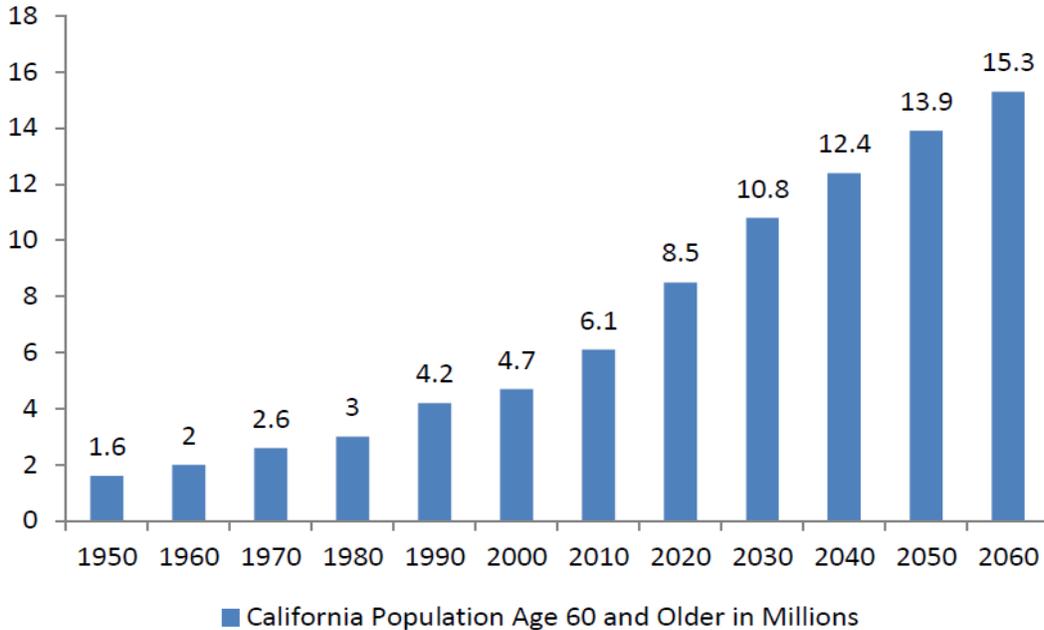


Figure 1. Projected Increases in Population Age 60 and over in California. ¹³

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
San Bernardino County	270,467	586,293	117 %
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 X No If yes, please describe briefly.

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

Centralized Hospital Aftercare Services

- a. The MHSAs Three Year Plan includes a section that addresses older adult programs under the auspices of Centralized Hospital Aftercare Services (CHAS) and includes:
- **Age Wise I: Circle of Care-OAI FY2018/2019-** Program expands services in coordination with the San Bernardino County Department of Adult and Aging Services (DAAS). This expansion allows for a clinician to be co-located at each of the three DAAS sites to assist in the field with Adult Protective Services (APS) referrals, address behavioral health needs, and assist to differentiate dementia from behavioral health disorders
 - **Age Wise II: Mobile Outreach-OA2 FY2018/2019-** Program provides countywide from its original service area in the High Desert. This allows for the provision of mobile Full Service Partnership services for older adults throughout the County, as well as the addition of outreach and engagement efforts to place consumers into permanent supportive housing to meet the increased needs of the MHSAs Housing Developments.
- b. There are currently four permanent housing developments funded through MHSAs where DBH provides administrative and clinical oversight of DBH older adult consumers:
- **Vintage at Kendall - 1095 Kendall Dr., San Bernardino, CA 92405 (10 Units)**
 - **Magnolia at 9th - 181 E. 9th Street, San Bernardino, CA 92410 (20 Units)**
 - **Lillian Court - 18028 Valley Blvd., Bloomington, CA 92316 (9 Units)**
 - **Horizons at Yucaipa - 12279 Third Street, Yucaipa, CA 92399 (10 Units)**

DBH Housing and Employment provides the administrative oversight for the MHSAs permanent housing developments including assisting consumers with application completion and process; collaboration with San Bernardino County Housing Authority, property management companies, DBH Regional Outpatient and specialty clinics, and other County and community agencies who provide services to those older adult consumers residing in the permanent housing development; tracking vacancies and occupancy; completion of Schedule Es, which track demographics and special needs to assist with funding in future housing projects in the county; facilitate the monthly cross-walk meetings with property management companies, County Housing Authority, DBH clinics, and other County and community

agencies who provide services to those older adult consumers residing in the permanent housing development; and consumer advocacy to ensure that those older adult consumers with criminal justice background and behavioral health conditions which has impacted hospitalization can access permanent housing.

Age Wise I (Circle of Care-OAI) provides the behavioral health clinical treatment services to those older adults residing in the above MHSA permanent housing developments including clinical assessment and individual therapy; case management services to provide linkage to community resources such as In-Home Supportive Services (IHSS), medical and dental services, assist with housing in higher level of care, if necessary, transportation, and other community resources to ensure stability in their housing; and crisis intervention to address behavioral health crises that may occur to those older adult consumers residing at the permanent housing site. Services are primarily field-based and are initiated at the older adult consumer's housing to ensure that the older adult consumer can access needed services.

Integrated Healthcare

- The Integrated Healthcare Team has been working to provide an increased focus on care coordination for consumers being served over the past two years. The Team has increased planning to provide the capability of conducting home visits, transporting consumers to appointments and moving toward increased field based service provision to meet the needs of the consumers that are being served. In addition, the Integrated Healthcare Team plans to expand its Building Bridges pilot program to consumers who are receiving services from additional DBH psychiatrists coordinating primary care, substance use disorder, and behavioral health services on the same day at the same site.
- The Behavioral Health Integration Complex Care Initiative (BHICCI) Team is currently working to develop an acuity stratification model to assist with determining the staffing level that is required to provide complex medical case management to consumers with severe mental illness and/or co-occurring substance use disorders. Inland Empire Health Plan (IEHP) is collecting data from multiple sites that are participating in the BHICCI to assist with development of a case rate that can be paid by IEHP to locations that provide complex medical care management to IEHP members.

Increased funding availability will promote the addition of field based medical staff to additional DBH clinic sites.

Substance Use Disorder and Recovery Services

DBH – SUDRS recently submitted an implementation plan for a Drug Medi-Cal Organized Delivery System (DMC-ODS) demonstration project to California Department of Health Care Services (DHCS). The plan was reviewed by DHCS and the Center for Medicare and Medicaid Services (CMS) and was approved for implementation pending memorialization of a contract with DHCS. The DMC-ODS requires DBH – SUDRS to assess SUD needs countywide and ensure adequate capacity of SUD services are available throughout the county. In preparation for the DMC-ODS, DBH conducted a needs assessment based on the total county population and the DMC population factoring in a DMC penetration rate variance of four to six percent. Based on the results of the assessment, DBH – SUDRS is building capacity to meet the SUD needs in the following areas:

1. Withdrawal Management (Detoxification) Services:

DBH – SUDRS currently provides withdrawal management services in a clinically managed residential setting. These services are appropriate for older adults who experience mild to moderate withdrawal symptoms not requiring medical/nursing care but are sufficiently severe enough to warrant a 24-hour structure and support.

DBH – SUDRS identified a need to provide Medically Monitored Inpatient Withdrawal Management where services are provided by nursing/medical staff and 24-hour evaluation in a hospital setting. These services are provided following a defined set of physician approved policies and physician-monitored procedures. DBH – SUDRS will implement this level of service within the first year of the full DMC-ODS implementation.

2. Medication Assisted Treatment:

While DBH – SUDRS provides some medication assisted treatment (MAT), an assessment of needs identified additional MAT that would benefit the older adult population experiencing opioid/alcohol dependence. DBH – SUDRS is enhancing the MAT services to include the naltrexone (oral and injectable) and buprenorphine in addition to the already available methadone. These services will be offered in all county-operated SUD outpatient treatment clinics and will be monitored under the supervision of

physicians from the California Emergency Physicians of America through a Memorandum of Understanding.

3. Recovery Support Services:

As part of the assessment and enhancement of services, DBH – SUDRS identified the benefit of providing recovery support services for those older adults who have completed a higher level of care. The benefit to the recovery support services is that they will be offered in an appropriate setting in the community. This is beneficial to older adults, as they are a population who experience mobility challenges and would otherwise be unable to participate in the services. As part of the Recovery Support Services, it will be necessary to assess the client’s needs and accommodate for those needs. Therefore, if an older adult does not drive or has other mobility challenges, DBH – SUDRS will be able to meet that older adult in a location in which it is most beneficial to receive services.

As part of the DMC-ODS, DBH has entered into a Memorandum of Understanding with the two Managed Care Plans (MCPs) in San Bernardino County, Inland Empire Health Plan (IEHP) and Molina Healthcare, to ensure seamless access to all levels of SUD treatment services to the older adult population.

DBH - SUDRS will continue to assess the unique challenges that often confront the older adult population with delivery of SUD services, such as mobility, physical difficulty with mobility requiring extra time to navigate the system of care, reimbursement of services through the enhancement of Drug Medi-Cal reimbursement, and engaging the older adult population who may be challenged with social isolation. This will be addressed by enhancing the SUD treatment discharge planning requirement. DBH – SUDRS will continue to assess the effectiveness of discharge planning for older adults.

In addition to these services and planning directly by DBH, the Department of Aging and Adult Services (DAAS) is a close partner in serving Older Adults, as DAAS is the designated Area Agency on Aging. Some of the partnership between DBH and DAAS, as well as DAAS’ work is highlighted in a video available at <https://youtu.be/Nczt2lO7pi4>. Disparities in service delivery is on the forefront of our program planning; DAAS continues to work collaboratively with DBH to explore creative and innovative methods to expand programs and bridge the gap in services provided within the Older Adult System of Care. In conjunction with DBH, the Office of the Public Guardian (OPG) recently expanded the conservatorship program to enhance service delivery to individuals on Lanterman-Petris-Short (LPS) conservatorships (due to behavioral health

conditions) as well as individuals on probate conservatorship. The program expansion has enabled the County to facilitate improved service delivery for older adults and individuals who are gravely disabled or have behavioral health conditions. Additionally, OPG implemented a Family Support Program, which facilitates support groups for the families of individuals on conservatorship.

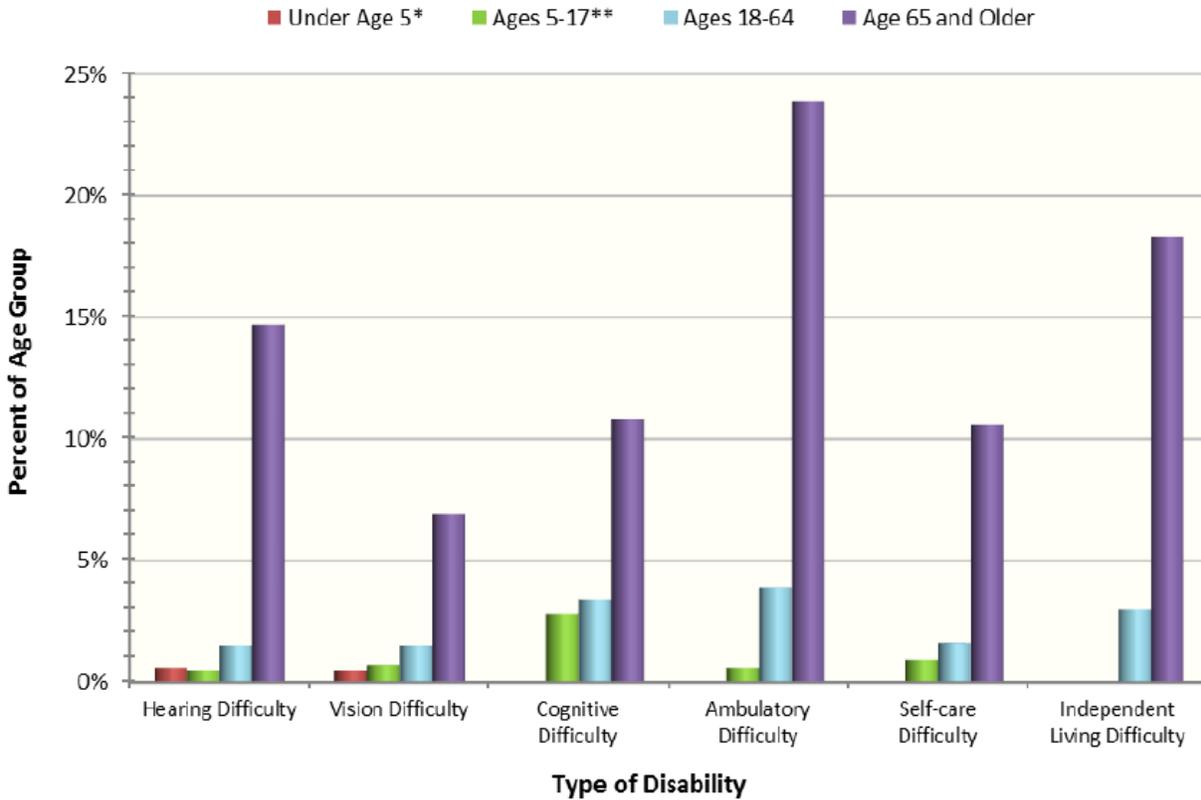
BARRIERS TO SERVICES FOR OLDER ADULTS

Disabilities in Older Adults Can Present Barriers to Service Access

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

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

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



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

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

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

In your county, the data show:

San Bernardino County (2011): There were 179,954 persons age 65 years and older. Of those, the number of individuals age 65 and older with a disability: 74,199. That number represents 41 % of this age group.

Geographic Isolation and Socioeconomic Factors can Present Barriers to Accessing Services

Next, we consider some data about the older adults that describe some challenges for mental health and well-being that also can present obstacles to accessing mental health

services. These challenges include: living alone, in geographical isolation, in poverty or near poverty, disability status (SSI/SSP support indicator), whether the individual is from a historically underserved minority or cultural group, or communicates primarily in a language other than English.

The California Department of Aging prepared the following demographic projections¹⁴ for 2016 for older adults (60+) in your county:

<u>San Bernardino County (2016):</u>	
Age 60+: 346,805	Age 75+: 92,011
Nonminority: ¹⁵ 180,947	Minority: ¹⁶ 165,858
Low income: 44,975	Non-English proficient: 15,950
Medi-Cal: 72,893	SSI/SSP (65+): 23,543
Lives alone (60+): 52,710	Geo-isolation (60+): 21,182

Limited English Proficiency is a Barrier for Behavioral Health Access

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

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

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

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

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

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

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

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

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

Yes X No ___

Hispanic/Latino Populations

- **Hispanic/Latinos collectively constitute 40% of total consumers served for FY 2016-17, many of whom speak Spanish.**
- **7.0% (3,236) of all consumers served identify Spanish as their preferred language.**

Asian/Pacific Islanders

- **Asian/Pacific Islanders collectively constitute 2.5% of total consumers served for FY 2016-17, many of whom have limited English proficiency.**
- **Of all consumers served, the following are the most common preferred languages reported from the Asian/Pacific Island regions:**
 1. **Vietnamese (102 consumers, 0.2%)**
 2. **Thai (59 consumers, 0.1%)**
 3. **Cambodian (25 consumers, 0.1%)**

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

1. **Spanish**
2. **Vietnamese**
3. **Thai**

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?

There are several disparities facing Department of Behavioral Health (DBH) consumers that are shaped by socio-economic and cultural factors. Often these disparities are driven by the following barriers to treatment: access to transportation, affordability of services (perceived or actual), lack of treatment accepted by the community, stigma, and lack of awareness of linguistically and culturally appropriate services. In an effort to mitigate these identified disparities, DBH employs a variety of strategies to increase access to services for our older

adult population including the “no wrong door” approach. This approach is set up to help individuals seeking services to obtain those services regardless of where they present for care. The “no wrong door” approach helps the potential consumer access the right level of care as health care providers are able to link the consumer to services at a location conveniently located near the potential consumer.

In an effort to reach and serve various cultural and/or race/ethnicity groups within our population of older adults, DBH provides both in-house and contracted interpretation and translation services in any language requested. Translated material is created at a level the community can understand and connect with. All material distributed to community members is translated into Spanish, which is San Bernardino County’s threshold language. However, DBH has translated various material into other languages based on community need. Languages translated include Tagalog, Vietnamese, Mandarin, and Cambodian. All material used by the department is field tested. DBH also provides services for deaf and hard of hearing consumers, including sign-language interpreters and the California Relay Service (7-1-1).

During the FY 2016-17, DBH began a video interpretation pilot project. This project employs the utilization of two video interpretation machines strategically placed at two of our high utilization clinics. The video interpretation machine provides real time interpretation services in over 200 languages, including those which are identified as “exotic” or only occurring in remote areas of the world.

In an effort to reduce barriers to access for our various diverse communities, DBH strives to create a culturally and linguistically competent workforce. The Office of Cultural Competence and Ethic Services (OCCES) provides quarterly “Un Momento Por Favor” and “Deaf Sensitivity” trainings. The “Un Momento Por Favor” training is designed to teach DBH and contract provider staff how to respond appropriately to Spanish speaking callers using an approved Spanish phrase. Every DBH and contract employee is required to complete this training. The “Deaf Sensitivity” training is designed to teach participants about Deaf culture and strategies to improve communication with consumers who are Deaf and Hard of Hearing.

In addition, all DBH staff are required to complete cultural competence training. There is a four hour training requirement for all direct service providers and a two hour annual training requirement for administrative staff, management, support staff, and all other staff who are non-direct service providers. The below table is a

list of all online cultural competency trainings available to staff. In addition, the department offers live trainings throughout the year on the following topics:

1. Cultural Formulation
2. Multicultural Knowledge
3. Cultural Sensitivity
4. Cultural Awareness
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES Elderly, Disabilities, etc.)
6. Mental Health Interpreter Training
7. Staff training in the use of mental health interpreters

Relias Trainings – Online Learning System
Cultural Competency Training Credits Awarded

Name	CC Training Credit Hours
Legal Procedures and Client Rights for Behavioral Health Interpreters	0.5
Basic Introduction to HIV/AIDS	1
Family Psychoeducation: Introduction to Evidence-Based Practices	1
Integrated Treatment for Co-Occurring Disorders Part 2--EBP	1
Overview of the Behavioral Health System for Behavioral Health Interpreters	1
Person-Centered Planning	1
Prolonged Exposure Therapy for PTSD for Veterans and Military Service Personnel	1
Promoting Recovery in Mental Health Treatment	1
Recovery and Severe Persistent Mental Illness	1
Recovery Promoting Relationships	1
Safety Crisis Planning For At-Risk Adolescents and Their Families	1
Self-Direction, Person Centered Planning and Shared Decision Making to Facilitate Recovery Part 1	1
The Role of the Behavioral Health Interpreter	1
Understanding Recovery	1
A Culture-Centered Approach to Recovery	1.25
Barriers to Recovery	1.25
Cognitive Behavioral Therapy	1.25
Cultural Diversity	1.25
Dialectical Behavioral Therapy: An Introduction	1.25
Early Childhood Mental Health Consultation	1.25
Epidemiology of PTSD in Military Personnel and Veterans	1.25
Family Assessment and Intervention	1.25
Identifying and Preventing Dependent Adult Abuse and Neglect	1.25
Military Cultural Competence	1.25
Solution Focused Therapy	1.25
Dialectical Behavioral Therapy: Advanced Techniques	1.5
Goals, Values and Guiding Principles of Psychosocial Rehabilitation	1.5
Illness Management and Recovery: Evidence-Based Practices	1.75
Overview of Assertive Community Treatment: Evidence-Based Practices	1.5
Overview of Severe Persistent Mental Illness	1.5
Self-Direction, Person Centered Planning and Shared Decision Making to Facilitate Recovery Part 2	1.5
WRAP One on One	1.5
Identifying And Preventing Child Abuse And Neglect	1.75
Elder Abuse	2
Therapeutic Communications	2
Overview of Cognitive Processing Therapy for PTSD in Veterans and Military Personnel	2
The Impact of Deployment and Combat Stress on Families and Children, Part I: Families and Deployment	2.75

DBH employs several strategies when it comes to engagement and outreach to diverse populations including the older adult community. DBH has a Cultural

Competency Advisory Committee (CCAC), which acts in an advisory capacity to the Cultural Competency Officer and the OCCES to ensure that DBH is embedding and integrating the tenets and philosophy of Cultural Competence. Under the CCAC, there are 13 sub-committees, which include the following populations:

- **African American**
- **Native American**
- **LGBTQ**
- **Co-Occurring**
- **Women**
- **Veterans**
- **Consumer and Family Members**
- **Disabilities**
- **Spirituality**
- **Latino**
- **Asian and Pacific Islander**
- **Transitional Aged Youth**
- **Older Adult**

The Older Adults Awareness Subcommittee of the Cultural Competency Advisory Committee (CCAC) is making efforts to promote behavioral health and wellness for the older adult population. The subcommittee is a collaborative effort between DBH and the Department of Aging and Adult Services (DAAS). The goals of subcommittee include:

- **Increase awareness of behavioral health services for older adults through the identification and development of a resource guide to be dispersed.**
- **Increase accessibility of behavioral health services for older adults by engaging local and community based providers to collaborate and encourage participation in education and treatment.**
- **Reduce the stigma of seeking behavioral health services for older adults through the facilitation of communication, coordination of services, and education to the community.**

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

X Transportation

X Geographic Isolation

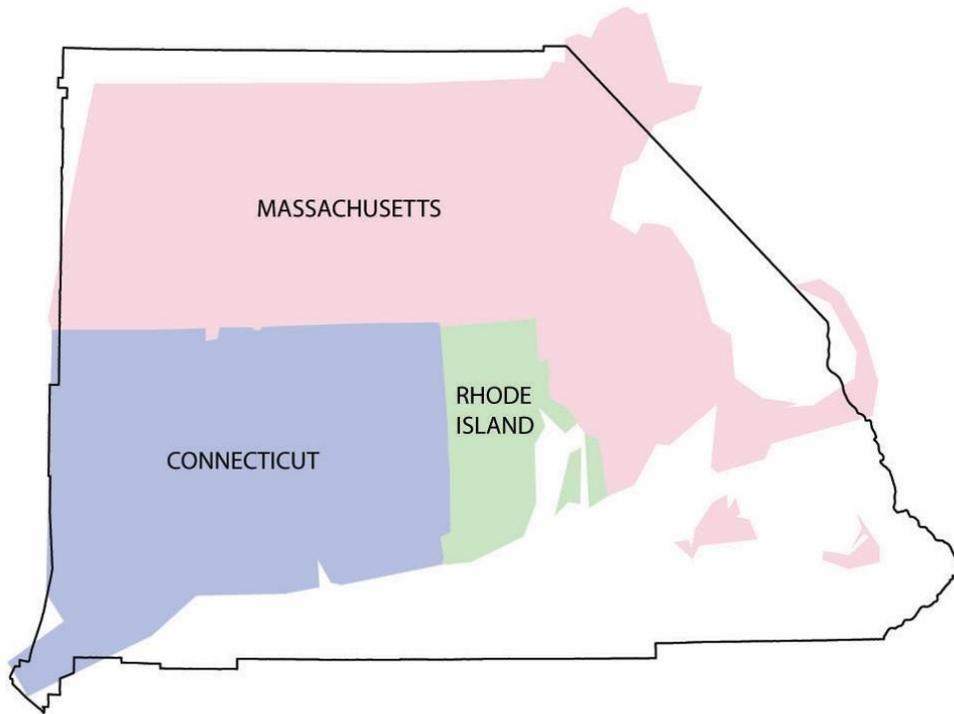
X Lack of awareness of services

X Mobility issues due to co-occurring physical conditions or disabilities

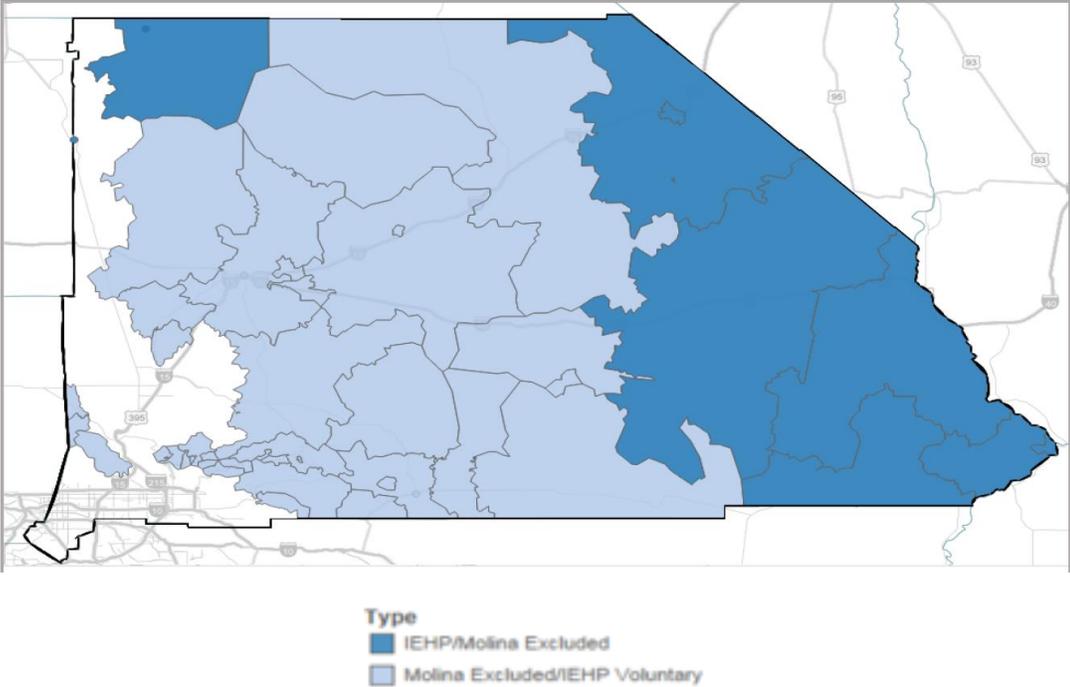
X Lack of geriatric-trained practitioner

The most significant barrier for the older adult population includes transportation and geographic isolation, specifically in the vast High Desert region. Although there are agencies which may offer assistance with transportation, these agencies are often costly for individuals who must maintain a fixed income or they exclude specific geographic areas in which our consumers who require assistance reside. Medi-Cal and Medicare have transportation benefits, and DBH is partnering with the health plans, who administer these benefits, to be able to access and implement the transportation options. The two maps below highlight the transportation challenges in San Bernardino County.

The first map displays the physical size of the county compared to other states, demonstrating the wide areas that DBH must cover for services.



The second map displays blue shaded areas that are too rural for managed care companies to maintain a network of providers and therefore they are excluded from conducting business in these geographic regions. However, DBH is still required to maintain services in all of these areas.



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-- 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: SAN BERNARDINO

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	29 7.07 %	137 33.41 %	122 29.76 %	122 29.76 %	410
Age 37-54	161 8.26 %	326 16.73 %	769 39.46 %	693 35.56 %	1949
Age 26-36	164 6.48 %	347 13.72 %	1139 45.02 %	880 34.78 %	2530
Age 15-25	88 6.56 %	138 10.29 %	682 50.86 %	433 32.29 %	1341

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 increased impairment in subsequent years. Examination of the data across many counties results in two key observations (among others possible):

- The number of adults age 55 and over who received SUD treatment of any type is generally much less than for other age groups, even though older adults represent an increasing share of the total population.
- In the majority of small counties with populations <100,000, there are relatively few options for types of SUD treatment besides outpatient treatment (non-NTP). The large number of “zeroes” shown under other types of treatment may indicate a disparity in access to those services.

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

Please check all that apply.

Outpatient NTP (narcotics treatment program (methadone, etc)

Outpatient (non-NTP)

Detoxification

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. _____

The Veterans Administration is the primary provider for SUD treatment for service-connected substance use disorders. Military veterans are served throughout DBH’s system of care, including Substance Use Disorder and Recovery Services (DBH – SUDRS).

For veterans who do not have service-connected substance use disorders, DBH provides a range of services.

Outpatient NTP

DBH – SUDRS provide NTP services currently at three locations throughout San Bernardino County. Based on the current opioid crisis and higher need for NTP services, DBH – SUDRS is working with a licensed NTP provider to open a fourth location in Redlands, CA. The anticipated date of operation is December 2017. All four NTP clinics will enhance already existing services to include additional medication assisted treatment, such as naltrexone, buprenorphine, disulfiram, and naloxone.

Outpatient Non-NTP

DBH provides outpatient SUD services at sixteen locations throughout the county. The SUD outpatient clinics will assess for appropriateness of the older adult and will individualize the treatment needs based on the assessment. Since SUD services will soon be available at any location where it is determined most appropriate in the community, access to outpatient SUD services will be enhanced since the services can be provided in the community in lieu of a certified building.

Withdrawal Management (Detoxification) Services

DBH – SUDRS currently provides withdrawal management services in a clinically managed residential setting. These services are appropriate for older adults who experience mild to moderate withdrawal symptoms not requiring medical/nursing care but are sufficiently severe enough to warrant a 24-hour structure and support.

DBH offers withdrawal management at five locations for San Bernardino County residents including the older adult population.

DBH – SUDRS will continue to assess the needs of the older adult population and enhance our system of care to include Ambulatory Withdrawal Management with extended On-Site Monitoring within the first year of the DMC-ODS.

Dual Diagnosis Programs

DBH – SUDRS provides both outpatient and residential dual diagnosis programs when the primary diagnosis is a substance use disorder. All dual diagnosis programs utilize evidence-based practices to address both the SUD and mental health challenges concurrently. DBH – SUDRS works closely with DBH Mental Health Services to ensure all dimensions of the American Society of Addiction Medicine (ASAM) domain related to emotional, behavioral, or cognitive conditions and complications are addressed in the appropriate setting.

DBH – SUDRS offers dual diagnosis residential SUD services at three locations for San Bernardino County residents. Outpatient SUD services are provided at six DBH operated SUD outpatient clinics.

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

DBH – SUDRS has implemented the process of embedding licensed clinical therapists in all DBH operated SUD clinics along with certified counselors to treat mental health conditions. All staff are provided adequate training with evidence-based practices to effectively address both the SUD and mental health conditions in the dual diagnosis clinics.

Therapeutic Alliance Program (TAP)

TAP is a voluntary community resource providing services to consumers who have a behavioral health condition and a co-occurring substance use disorder. DBH contracts with Cedar House Residential Treatment facility to provide behavioral health services in coordination with their substance use treatment through a 90 day program. TAP provides the following services:

- **Individual Therapy**
- **Case Management that addresses individual needs, including assistance to obtain entitlements, transportation to court hearings, psychiatric appointments, placement interviews, etc.**
- **Groups to assist with budgeting and Activities of Daily Living (ADLs)**
- **Aftercare services upon discharge to ensure long term maintenance of the recovery plan and smooth transition into community, including placement and providing referrals and linkage**

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.

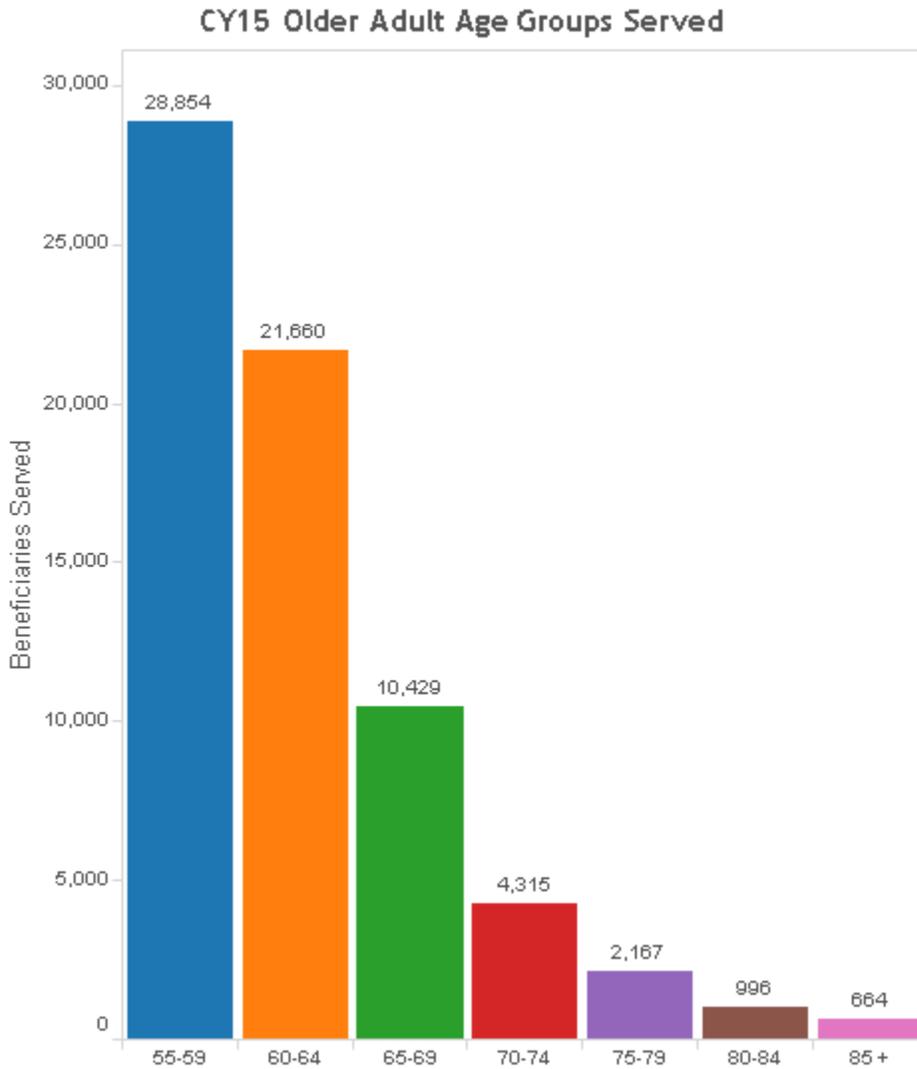


Figure 3. Subcategories by Age of Older Adults who received Specialty Mental Health Services in California (CY2015).

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.

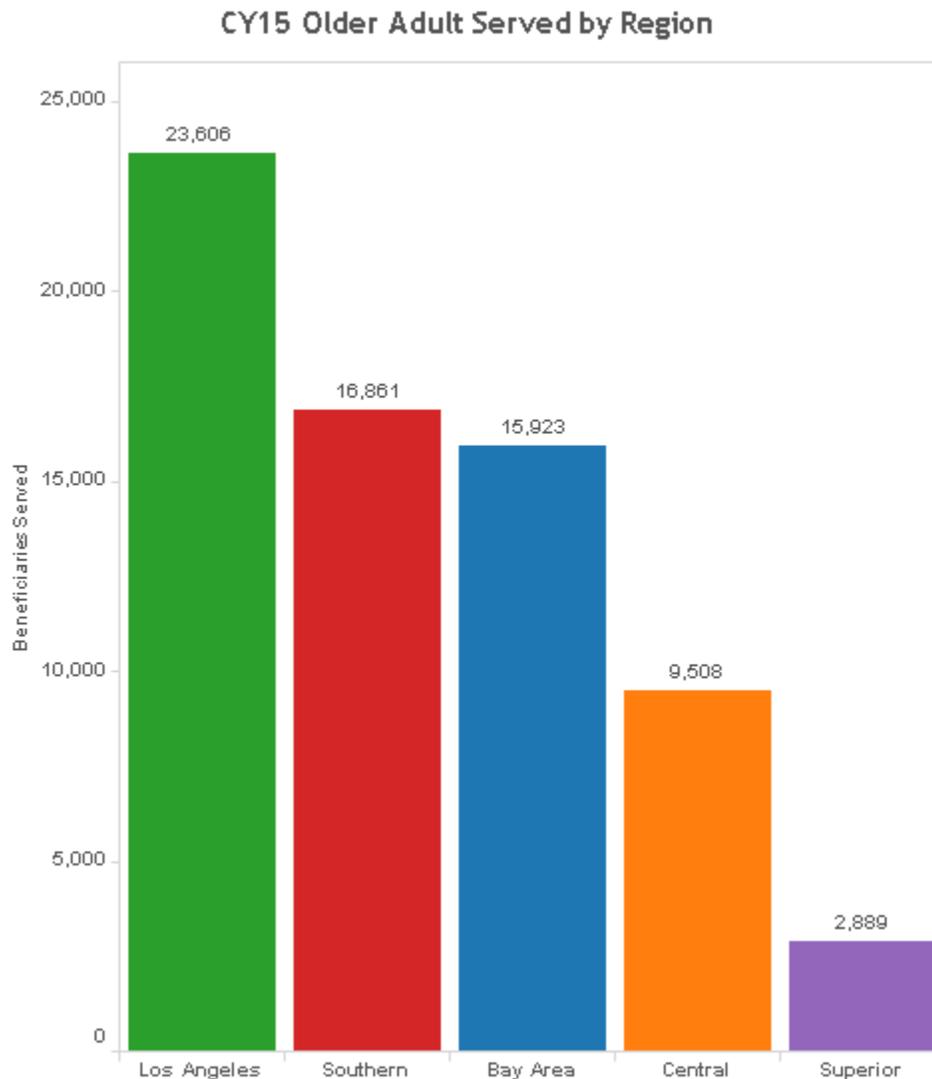


Figure 4. The numbers of persons in each region who received Specialty Mental Health Services (“beneficiaries”, CY 2015). Los Angeles County is taken to be its own region.

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.

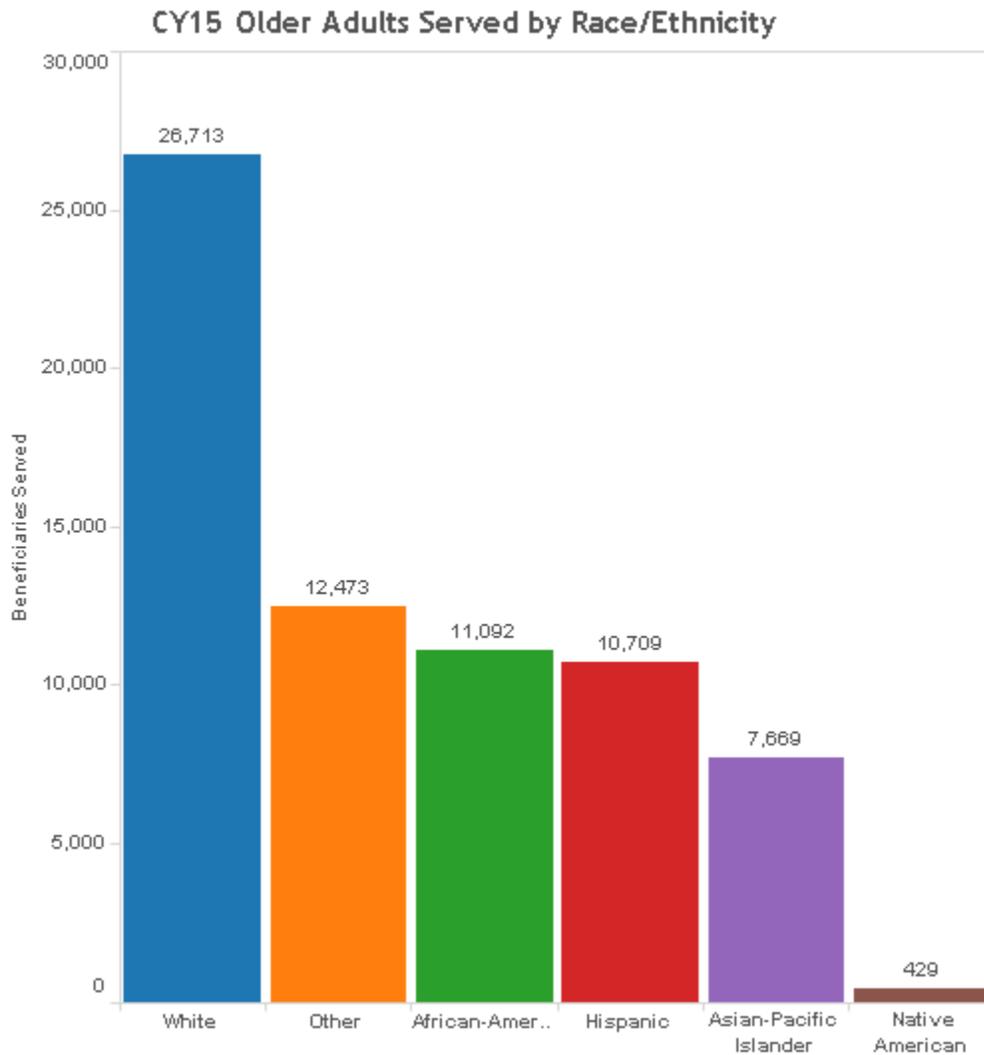


Figure 5. The major demographic groups of older adults who received Specialty Mental Health Services (CY2015), by race/Ethnicity, shown with the number of persons in each group (“beneficiaries served”).

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.

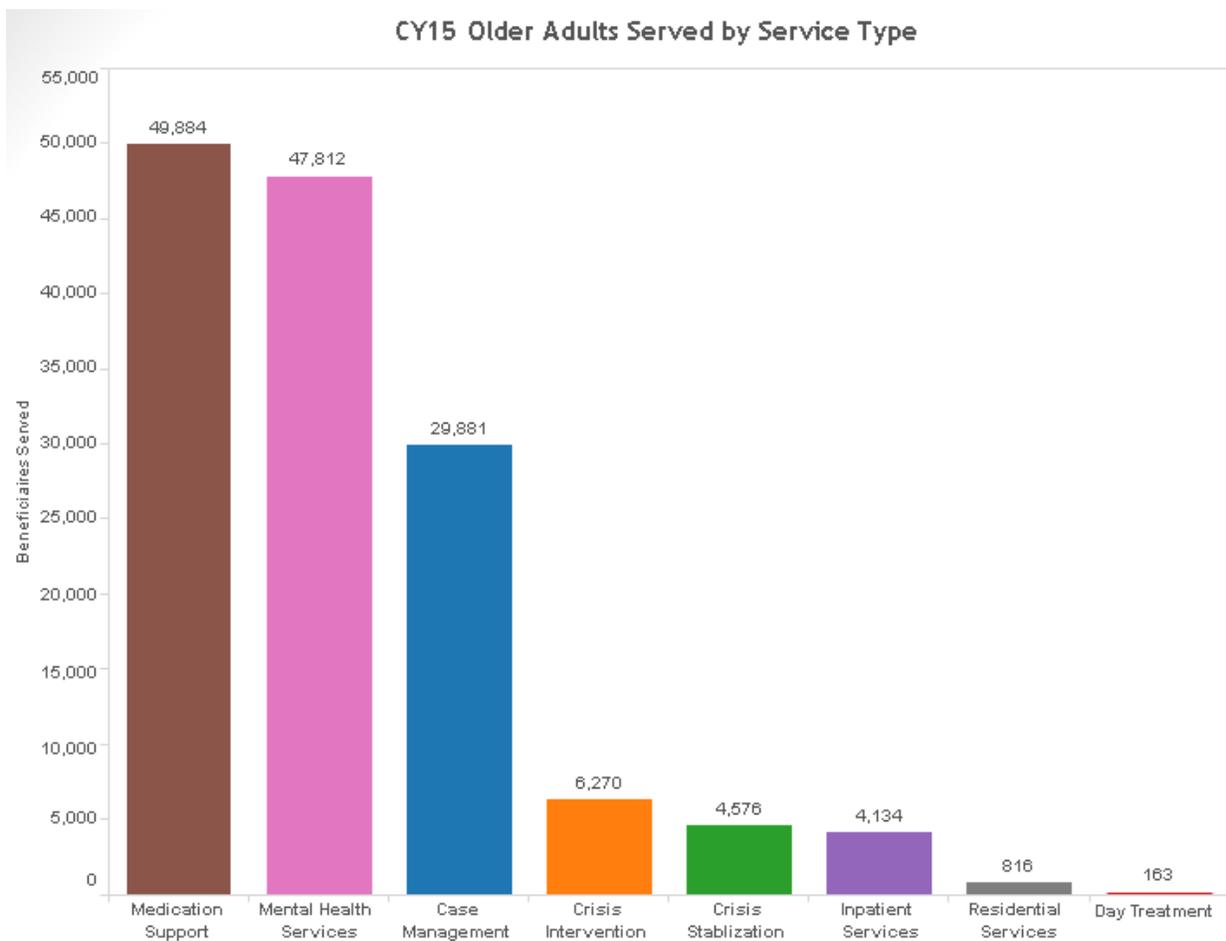


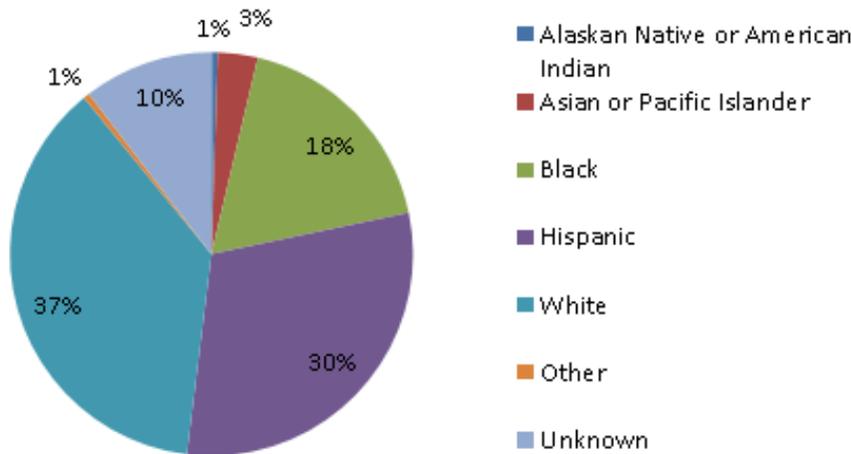
Figure 6. The most frequently used specialty mental health services are shown by the total number of older adults (“beneficiaries served”) who received each type of service.

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: San Bernardino (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

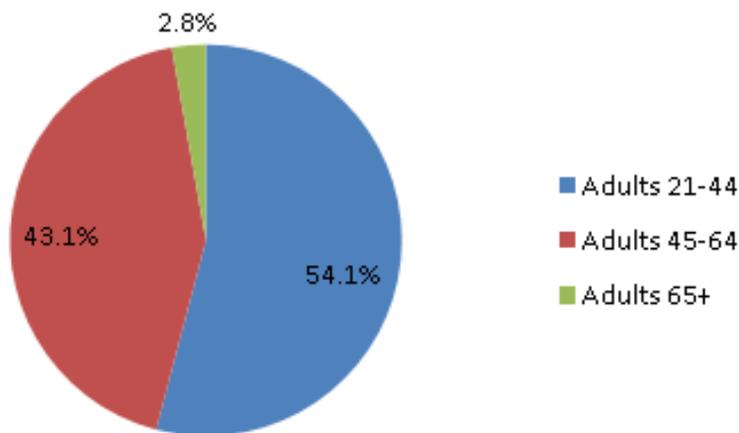


Figure 7. Demographic data for your county (FY14-15): adults and older adults who received Medi-Cal funded specialty mental health services (SMHS).²⁸

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 “^”.

**Table 6. Data for your County: San Bernardino (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	20,159	439,463	4.6%
Adults 21-44	10,899	242,937	4.5%
Adults 45-64	8,687	143,613	6.0%
Adults 65+	573	52,913	1.1%
Alaskan Native or American Indian	97	1,473	6.6%
Asian or Pacific Islander	647	27,188	2.4%
Black	3,637	55,035	6.6%
Hispanic	6,087	201,629	3.0%
White	7,479	115,945	6.5%
Other	108	2,199	4.9%
Unknown	2,104	35,994	5.8%
Female	10,969	250,875	4.4%
Male	9,190	188,588	4.9%

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

	Adults with 5 or more SMHS Visits	Certified Eligible Adults	Penetration Rate
All	12,856	439,463	2.9%
Adults 21-44	6,718	242,937	2.8%
Adults 45-64	5,808	143,613	4.0%
Adults 65+	330	52,913	0.6%
Alaskan Native or American Indian	64	1,473	4.3%
Asian or Pacific Islander	409	27,188	1.5%
Black	2,247	55,035	4.1%
Hispanic	3,825	201,629	1.9%
White	4,837	115,945	4.2%
Other	65	2,199	3.0%
Unknown	1,409	35,994	3.9%
Female	6,817	250,875	2.7%
Male	6,039	188,588	3.2%

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

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

Yes X No ___

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

DBH has several prevention and early intervention programs that make services available to older adults. DBH is working on strategies to increase the availability of resources for Older Adults in the mountain regions during the winter months. At times, it becomes unsafe for both older adults and providers to travel on dangerous roads. DBH is looking for additional ways to ensure the safety and wellbeing of older adults.

DBH also facilitates an Older Adults Awareness Subcommittee of the Cultural Competency Advisory Committee, which includes participants from Behavioral Health Staff, Behavioral Health Commissioners, Community Based Agencies, and Department of Aging and Adult Services Staff and who meet monthly and work towards the following goals:

- **Increase awareness of behavioral health services for older adults through the identification and development of a resource guide to be dispersed.**
- **Increase accessibility of behavioral health services for older adults through engaging local and community based providers to collaborate and encourage participation in education and treatment.**
- **Reduce the stigma of seeking behavioral health services for older adults through the facilitation of communication, coordination of services, and education to the community.**

Community Supports for Mental Health Emergencies and Crisis Services

Our understanding is that there are relatively few counties with crisis intervention or stabilization services with specialized training in helping older adults. Instead, they rely mainly on the adult system of care for all adults. In the CMHPC Statewide Overview

Report²⁹ (2015), responses from a number of counties identified needs for crisis services specifically targeted to older adults.

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

Yes No

If yes, please check all that apply below.

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 (**State waiver approval required for ages 60+**)

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

The Older Adult Prevention and Early Intervention (PEI) program has a Suicide Prevention component that will assess and assist Older Adults at risk of Suicide. Providers are equipped to manage most situations involving the risk of suicide through their early intervention counseling and supportive services. However, the program also provides a warm hand off to other crisis services, like the Crisis Walk In Center and/or Arrowhead Regional Medical Center's services, if the participant requires more intense crisis intervention that is beyond the scope of work at the provider level.

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

The three regional Community Crisis Response Teams (CCRT) have been trained in the needs of older adults. They are required to complete two specialized trainings specific to the needs of older adults:

- **Behavioral Health Issues in Older Adults for Paraprofessionals**
- **Diagnosing Substance Use Issues in Older Adults**

The CCRT teams work closely with law enforcement on field calls and provide education on the specific needs of older adults, and the use of the utilization of Adult Protective Services. The three Crisis Walk In Centers (CWICs), two of which are contracted Crisis Stabilization Units (CSU) also serve older adults. The county wide Adult Drop In Centers (“Clubhouses”) offer services to adults and older adults experiencing mental health needs and offer socialization and linkage to resources. In San Bernardino County, there are two inpatient psychiatric programs, Loma Linda Behavioral Medical Center and Canyon Ridge Hospital that offer Gerontology units for older adults that present with acute psychiatric needs and require inpatient services.

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

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

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

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

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

The data for your county show:

San Bernardino County (2011):

Total persons age 65 years and older: 179,954 (9 % of total population).

Grandparents living with own grandchildren under 18 years: 77,490.

Grandparents responsible for grandchildren: 25,244 (which is 33 % of the grandparents living with children under the age of 18.)

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

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

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

Yes No

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: _____.

Prevention and Early Intervention (PEI)

Embedded within the Older Adult Wellness component are support groups and services that specifically target older adults who are caring for disabled adults and/or have custody of children under 18. This service is able to provide linkages to resources for Older Adults who need assistance for themselves as well as the dependents they care for. In addition, there are PEI programs that include a supportive parenting component for parents and caregivers of children and youth who have a behavioral health condition or could be at risk of developing a behavioral health condition. Those programs are the PEI Preschool Program, Student Assistance Program, Family Resource Center, Resilience Promotion in African American Children, and the National Curriculum and Training Institute Crossroads Education.

Centralized Hospital Aftercare Services

The County offers Older Adult Wellness Services, which focus on delivering comprehensive activities and basic transportation services (e.g., to medical appointments, for basic life needs, and transportation to activities) for older adults and older adults who are caring for disabled adults or have custody of children under the age of 18. Wellness services provide access to activities, decreasing isolation and increasing connections with other older adults and provides education on mental and physical wellness. This is accomplished through strategies that are non-stigmatizing (including self-stigma) and non-discriminatory by utilizing positive relationships amongst peers; factual messages/education on recovery, wellness, and resilience; efforts to acknowledge and address social stigma that affects attitudes about behavioral health and/or seeking services; and promoting positive attitudes and understanding recovery. These services are provided through Older Adult Community Services with four contract agencies initiating services countywide.

Integrated Healthcare

Integrated Healthcare provides on-site behavioral health and substance use disorder services to consumers who are receiving medical care in the primary care provider (PCP) offices. The Team receives a referral from one of the PCPs for an older adult consumer who is providing caregiver services for a dependent child or adult. The Integrated Healthcare Team, through the services of a Licensed Marriage and Family Therapist, provides:

- Supportive therapy
- Assistance for the older adult consumer to develop coping skills
- Techniques and education on self-care for the older adult caregiver

- **Linkage to substance use disorder services as indicated; a certified Alcohol and Drug Counselor is available on-site**
- **Case management services to assist with benefits applications, transportation needs, and linkage to community resources**

In addition, the Team offers resources for support groups in the community as well as education on the Community Based Adult Services (CBAS) programs that are available for the dependent they are providing care for. If the Older Adult is providing caregiver services to an Inland Empire Health Plan (IEHP) member, the caregiver will be assisted to apply for CBAS as well as In Home Supportive Services (IHSS) for the member, which would give them respite 2-5 days per week. If the Older Adult is providing caregiver services to Molina Healthcare Members, they will be assisted to apply for IHSS for the member as well as be provided information on the County Department of Aging and Adult Services and the Inland Regional Center, if appropriate. Inland Regional Center will also share information on resources that they are aware of in the community recognizing that the caregiver is an important part of the care team and providing this information will benefit the patient.

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.

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

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>.

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

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

If yes, please provide one example.

Age Wise I (Circle of Care-OAI) and Age Wise II (Mobile Outreach II-OA2) provide comprehensive behavioral health treatment to high-risk and underserved older adults experiencing a primary behavioral health condition, who also may also be experiencing mild cognitive impairment or early dementia. Services include:

- **Multi-disciplinary team of clinical therapists, mental health specialists, an occupational therapist, and peer and family advocates who offer a full spectrum of care tailored to individualized needs of consumers.**
- **Mobile individual therapy for consumers in their homes or other field locations that provide ease of access for the consumers who may have mobility, transportation, or other issues.**
- **As part of the continuum of care, staff have a specialty, though not exclusive, focus on: treating those who have been in long term locked facilities or on conservatorship, helping stabilize those who are in danger of being placed on conservatorship and hospitalized in Institution for Mental Disease (IMD) or state hospitals.**
- **Case management for items related to mental health, such as: Linkage to clothing and transportation resources, linkage to a primary care provider or specialized medical services, assistance in applying for SSI or other entitlements, and interpersonal/social (e.g., senior centers, clubhouses).**
- **Occupational therapy for individuals who are living with a behavioral health condition in need of specialty care: linkages and referrals for mobility equipment (wheelchairs, scooters, walkers, etc.), payment for various bills (medical, dental, utilities, etc.), regular transportation.**

OLDER ADULTS HELPING OTHERS:

Peer Counselors and Health Navigators

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

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

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

The County utilizes Older Adult Community Services (OACS) contracted to four community agencies. This is a Prevention and Early Intervention program to promote healthy aging and assist in maintaining mental wellness by delivering prevention and early intervention services to the older adult population in San Bernardino County. This program utilizes peer advocates to assist with suicide prevention and members who have been involved in the program for some time are encouraged to help newer participants with resources and encourage participation in activities. The OACS program includes four components: 1) Older Adult Mobile Resource Unit to provide behavioral health and substance use screening to older adults who reside in geographically isolated or economically challenged areas; 2) Older Adult Wellness Services to focus on delivering comprehensive activities and basic transportation services for older adults and older adults who are caring for disabled children or have custody of children under the age of 18, including peer counseling; 3) Older Adult Home Safety to assist older adults to maintain a level of appropriate personal and home safety, collaborating with primary care providers and other agencies to ensure in-home safety; 4) Older Adult Suicide Prevention providing comprehensive bilingual and culturally competent suicide prevention, education, screenings, and direct support services, including Peer Counseling, to provide supportive listening.

The Department of Aging and Adult Services (DAAS) utilizes State-registered senior peer counselors (health navigators) in the Health Insurance Counseling and Advocacy Program (HICAP). HICAP health navigators provide unbiased individualized counseling, community outreach, and public education about

Medicare and other related health insurance topics. HICAP counselors can help individuals understand:

- **Benefits and enrollment**
- **Prescription drug plan coverage**
- **Medicare Advantage plans**
- **Supplemental policies (Medigap)**
- **Employee and retiree coverage**
- **Affordable Care Act**
- **Medicare limited income assistance programs**
- **Long-term care insurance**

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.

A hyperlink to the Data Notebook, listed within a Behavioral Health Commission meeting agenda is provided to the County Board of Supervisors and designated staff as part of the public notice process for each Behavioral Health Commission meeting.

Other; please describe: **The Behavioral Health Commission and the San Bernardino Department of Behavioral Health work in collaboration with County staff to research, discuss, provide data, and facilitate a comprehensive response to the questions posted in the Data Notebook.**

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

Yes No

If yes, please provide their job classification

- ***One (1) Behavioral Health Director: Provides new member orientation upon appointment by the Board of Supervisors; participates in monthly sessions of Executive Committee and Board meetings or delegates staff to participate in her absence; provides regular updates on Federal, State, County and other policy issues.***
- ***One (1) Executive Secretary II - Ensures Board meetings comply with Brown Act; notifies stakeholders of meetings; works with the Chair and Director to set monthly agendas; transcribes meeting minutes; schedules educational presentations and mandatory trainings.***

- **One (1) Office Assistant III - Assembles meeting binders; transcribes meeting minutes, arranges travel and reimbursement.**
- **Four (4) Secretary I – Provides support to District Advisory Committee (DAC) meetings; notifies stakeholders of meetings; transcribes minutes; schedules educational presentations.**

The Behavioral Health Commission would like it noted that under the direction and leadership of the Behavioral Health Director, Veronica Kelley, LCSW, DBH staff are extremely responsive to the commission’s requests, such as educational presentations, attendance at conferences/trainings, and support at community events. Interaction with the Director and DBH staff includes information sharing, open dialogue and transparency.

In addition to the above, staff have worked hard to partner with Behavioral Health Commissioners to identify and quantify behavioral health outcomes on an ongoing basis so that meaningful analysis and conversations can take place throughout the year.

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

Name and County: Raquel Ramos, Executive Secretary, San Bernardino

Email: rros@dbh.sbcounty.gov

Phone #: 909-388-0801

Signature: _____

Other (optional): _____

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

Name and County: Raquel Ramos, Executive Secretary, San Bernardino

Email: rros@dbh.sbcounty.gov

Phone #: 909-388-0801

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

