CALIFORNIA COMMISSION ON AGING

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July 25, 2018

Chairman John Boyd
Mental Health Services Oversight & Accountability Commission
1325 J St., Suite 1700
Sacramento, CA 95814

Re: SB 1004 (Wiener) – Mental Health Services Act: prevention and early intervention ---- OPPOSE unless amended

Dear Chairman Boyd,

The California Commission on Aging (CCoA) respectfully requests that you postpone action on SB 1004 (Wiener), a bill that would effectively limit access to Mental Health Service Act Prevention and Early Intervention (PEI) services to adults, older adults and low-income communities of color.

The CCoA is established in the Welfare and Institutions Code as the principal advocate on behalf of California's older adults. An independent state advisory body, Commission members are appointed by the Governor and both houses of the Legislature. Commissioners represent the state's cultural and geographic diversity, as well as a range of expertise within and outside of the field of aging.

SB 1004 would establish new priorities for how Proposition 63 Mental Health Service Act funds can be spent for Prevention and Early Intervention programs (PEI). The bill contains findings that focus almost exclusively on children and youth, making it appear as though other populations do not need PEI services.

The June 13th amendments add a single finding regarding older adult mental health needs, but ignore the fact that **adults and older adults have the highest suicide rates in the nation.** A June 13, 2018 article in the Sacramento Bee cites data showing that older adults over 85 actually have five times the suicide rate of any other age group.

The SB 1004 findings also omit any reference to January 2018 research by the UCLA Center for Health Policy Research (contracted by the Mental Health Oversight and Accountability Commission) which points out the need for greater PEI services for California's growing older adult population.

The SB 1004 findings indicate that one out of seven children have experienced some form of abuse. There is no reference to the growing epidemic of elder abuse, which experts believe affects as many as one in four older adults.

SB 1004 would direct counties to focus their PEI dollars on students, even re-defining "outreach and engagement" under PEI to apply specifically to transition age youth and focusing "trauma prevention and early intervention" efforts on children. Outreach and engagement are essential approaches to overcoming stigma and bringing services to underserved populations of all ages. Trauma prevention and early intervention also are needed across the lifespan, as traumatic events occur at every age.

The June 13 amendments' addition of the term "across the lifespan" in several places and the references to serving all ages within the context of "Underserved cultural populations" are insufficient to guarantee that counties will understand the great need to provide PEI services for older adults.

When the original MHSA priorities were established in 2007, men over age 75 actually had the highest rate of suicide completion. More recently, Centers for Disease Control currently lists adults between age 45 and 64 as experiencing the highest rates of suicide nationally, with the rate having increased 28 percent in adults age 35 to 64 between 1999 and 2010.[1] The tragic suicides of Robin Williams, Kate Spade and Antony Bourdain are painful illustrations of this trend. Within the smaller cohort of white males over age 85, the suicide rate is far higher than that of the general population,[2] and due to their frailty, isolation and greater determination, older adult suicide attempts prove more lethal.

Research demonstrates that from 70% to 90% of adults age 65 and over have been exposed to at least one potentially traumatic event during their lifetime,[3] with as many as 4% of assault survivors suffering from PTSD.[4] Counted among this population are Holocaust survivors, Korean War and Viet Nam War veterans, survivors of Jim Crow racial discrimination and hate crimes, elderly refugees, and an increasing number of survivors of elder abuse and exploitation.

LGBT older adults also suffer disproportionate levels of discrimination, victimization, anxiety, isolation, and substance abuse, following a lifetime of feeling ostracized by both family and community. According to SAGE, more than 50% of LGBT elders in a national study had been diagnosed with depression by a health care provider, and 39% reported having seriously considered suicide, yet have few mental health resources available to them.

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1 Suicide in Adults age 35 to 64 years – United States, 1999 - 2010; **Article** in. Morbidity and mortality weekly report · May 2013

2 Suicide Prevention Resource Center. (2014, September). Suicide Screening and Assessment. Education Development Center, Inc.; Waltham, MA.

3 Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*, 409-418

4 Acierno, R., Lawyer, S. R., Rheingold, A., Kilpatrick, D. G., Resnick, H. S., & Saunders, B. E. (2007). Current psychopathology in previously assaulted older adults. *Journal of Interpersonal Violence, 22*, 250-258.

Older adults are in the only age group that is certain to face one or more of the following: loss of career (loss of purpose), failing health, the death of friends and loved ones, economic insecurity, isolation, and vulnerability to exploitation. These factors place them at significant risk for depression, anxiety, psychological trauma and suicide. Add to these certainties the fact that the population of older adults is the fastest growing age cohort in the nation, with numbers expected to double by 2050, and the need to bolster these services, rather than reduce access, seems clear.

Even though SB 1004 provides counties with the discretion to develop their own priorities in addition to those spelled out in the bill, CCoA is not confident the discretionary provision is sufficient. Local governments that have a strong focus on children's services or limited resources may feel obligated only to follow the direct priorities outlined in the bill, instead of conducting the local stakeholder process to identify broader local needs. By ignoring other populations in both the findings section and the priorities, SB 1004 is implicitly stating that other groups are less important.

CCoA has offered amendments that would assure all underserved groups would be appropriately considered for PEI program dollars. Along with the May 25th language that establishes more reporting and accountability for county use of these funds, we believe our proposed amendments adhere to the spirit of Proposition 63 and the intent of the Mental Health Services Act.

Sincerely,

Edward F Walker

Chair
California Commission on Aging

IV. Populations Served by PEI Programs/Activities

This chapter presents the numbers served by PEI programs/activities in FY 2011-12 by age, gender and racial-ethnic group. [82] Numbers served are presented by study category (prevention, early intervention, 'out of study scope', stand-alone 'indirect' and 'mixed'). A statewide summary of numbers served is provided at the end of the chapter.

A. Populations Served by Prevention Programs/Activities

Table IV.1 presents the age groups served by the 45 counties that provided prevention programs/activities in FY 2011-12.

Table IV.1. Number of Counties Providing Prevention Programs/Activities by Age Group
(N=45 Counties)
FY 2011-12

	Counties: CY		Counties: TAY		Counties: Adults		Counties: Older Adults	
	N	%	N	%	N	%	N	%
Prevention Programs/Activities	43	95.6%	31	68.9%	26	57.8%	15	33.3%

Table IV.2 shows the unduplicated number of individuals served by age group. Counties provided prevention programming to 134,797 individuals in FY 2011-12. Age group information was provided for 130,045 (96.5%) of the 134,797 individuals served by prevention programs/activities, and was missing for 4,752 individuals (3.5%).

Table IV.2. Age Groups Served by Prevention Programs/Activities: Number of Individuals by Age Group
FY 2011-12

Participants: Prevention Programs/Activities	Individuals Served	
	N	%
Children/Youth	84,405	64.9%
TAY	18,954	14.6%
Adults	24,734	19.0%
Older Adults	1,952	1.5%
TOTAL	**130,045**	**100.0%**

The majority age group served by prevention programs/activities was children/youth (n=84,405; 64.9%). [83] Adults represented the next-largest group (n=24,734; 19.0%), followed by TAY (n=18,954; 14.6%). Older adults represented only a small percentage of individuals that participated in prevention programs/activities in FY 2011-12 (n=1,952; 1.5%). In addition, counties reported serving 11,650 families. Among individuals served by prevention programs/activities, counties reported that 938 were GLBTQ and 444 were veterans. Although each of these groups represent less than one percent of those served by prevention programs/activities, not every county collects data about sexual orientation and/or veteran status.

Table IV.3 shows the unduplicated number of individuals that participated in prevention programs/activities during FY 2011-12 by gender. Because all 45 counties indicated provision of prevention programming to both males and females, a separate table displaying the number of counties serving each gender group is not provided. Information about gender was provided for 91.6 percent of the 134,797 individuals served (n=123,456). The 'other' category for gender was mainly used by counties to report participants for whom gender data was not collected

Suicide Rates in California

Trends and Implications for Prevention and Early Intervention Programs

Rajeev Ramchand and Amariah Becker

This brief is based on an interim evaluation report of the California Mental Health Services Authority (CalMHSA) Prevention and Early Intervention Programs, which are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). In that report, we present the results from RAND's analysis of suicide fatalities in the state of California to provide necessary context for evaluating CalMHSA's investment in suicide prevention activities in the State.

RESEARCH QUESTIONS

- How do California suicide rates compare with those of the nation as a whole?
- How do those rates break down by age, sex, race, and geography in the state?
- What are the implications for prevention and early intervention programs?

KEY FINDINGS

Over the Past Decade, the Suicide Rate in California Has Been Consistently Lower Than the National Suicide Rate

- Between 1999 and 2009, the suicide rate in California averaged around 9.4 per 100,000 individuals; national averages are around 11.1 per 100,000.

Nearly Three-Quarters of California Suicides Are Among Adults, Which Is Generally Consistent with the Nation As a Whole

- California's lower suicide rate relative to the nation is driven by a rate that is generally lower among those *over* 55. The suicide rate among those *under* 55 in California is slightly higher than the rate in the United States.
- Adults (ages 20–59) account for 71 percent of suicides in California, with those over 60 accounting for 26 percent and adolescents accounting for less than 5 percent.
- Suicide rates in California increase with age, starting at age 10 and increasing until age 55, where they plateau, only to rise again at age 70.

In 2009, Males Accounted for Three-Quarters of California Suicides

- Nationally, suicide rates are four times higher among males than females. In California, as in the rest of the United States, this difference is greater at older ages, where men over 70 have a suicide rate eight times that of women.

Suicide Rates in California Are Consistently Higher Among Whites, As Is True More Broadly for the United States

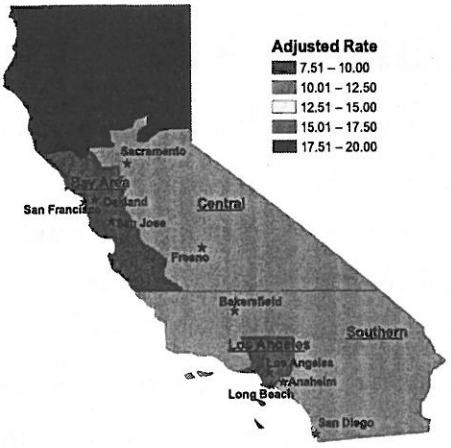
- Between 1999 and 2009, California suicide rates for whites hovered between 9 and 12 per 100,000. The state's suicide rates for blacks and Asian/Pacific Islanders are around half that of whites, ranging from 5 to 7 per 100,000.
- American Indians/Alaskan Natives have the lowest suicide rate across all racial groups in California at 4 per 100,000. This is notably lower than the national suicide rate for American Indians/Alaskan Natives: 11 per 100,000.

continued on back

Suicide Rates Vary Dramatically by Region in California

- After accounting for age differences across the state, California's Superior region (the most rural region) has the highest suicide *rates* from 2008–2010—around 20 per 100,000; Los Angeles (the most populous region) has the lowest rates—around 8 per 100,000.
- But the *number* of suicides is highest in the more populous regions: for example, there were 2,358 suicides in Los Angeles county between 2008 and 2010, compared to 660 across the entire Superior region. The highest number of suicides over the three-year period was in the Southern region—nearly 4,000.

2008–2010, Age-Adjusted Suicide Rates by Region



Suicide Surveillance in California Could Be Improved

- There is a two- to three-year lag in the availability of suicide data in California, primarily because of the time it takes to collect, compile, verify, and prepare data.
- Verifying suicide data is an important component of surveillance because there is variability in how suicide deaths are defined, in requirements for who makes cause-of-death determinations, in how suicide deaths are investigated, and in how data are managed across counties.

IMPLICATIONS FOR SUICIDE PREVENTION PROGRAMS

- Reducing suicide in California requires balancing efforts between rural areas where individual risk is highest and more-populated regions that account for most suicides. Strong and effective suicide prevention programs are needed in California's rural Superior area, where focus should be on reducing individual risk of suicide. But it is critical that suicide prevention programs also be strong in the denser regions to ultimately reduce the societal burden of suicide in the state.
- Significant efforts are needed to prevent suicide among California's adult male population, which accounts for the bulk of suicides in the state.
- Suicide surveillance could be improved by enhancing the efficiency by which counties verify suicide deaths, data are submitted to the state, and these data are made available for analysis. Such improvements would provide more-timely data on the burden suicide poses to California and support evaluation of the impact of California's investment in suicide prevention programs.

RAND HEALTH

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CalMHSA
California Mental Health Services Authority
Compassion. Action. Change.

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

RB-9737-CMHSA (2014)

CHILDREN AND FAMILIES
EDUCATION AND THE ARTS
ENERGY AND ENVIRONMENT
HEALTH AND HEALTH CARE
INFRASTRUCTURE AND TRANSPORTATION
INTERNATIONAL AFFAIRS
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Advocates for Mentally Ill Housing Inc. case managers help Egbert Visker settle into his new bedroom in Auburn in November 2017. Paul Kitagaki Jr. Sacramento Bee file

SOAPBOX

Legislature must not slight seniors in mental health money

BY CHERYL BROWN
Special to The Sacramento Bee

July 06, 2018 01:00 PM
Updated July 06, 2018 01:01 PM

An important measure to expand access to mental health care services in California is going through the Legislature, but it would make it more difficult for counties to serve older adults.

Senate Bill 1004, which was approved by the Assembly Health Committee on June 19, would amend Proposition 63, passed by voters in 2004 to provide funding for county mental health services with a 1 percent tax on annual incomes of more than $1 million.

Sens. Scott Wiener, D-San Francisco, and John Moorlach, R-Costa Mesa, who introduced SB 1004, appear to be at odds with the needs of older adults because

the bill shifts the focus of the Mental Health Services Act primarily to young people.

The bill says that 75 percent of mental illnesses begin by 14 years of age, citing a study showing the relationship between early trauma and life-long problems.

But we should not lose sight of our seniors.

Cheryl Brown

Most of them grew up when mental health problems were less understood, diagnosed or appropriately treated. As a result, many tend to shy away from mental health services. Yet adults between 45 and 64 old are at the highest risk for suicide nationally, and in recent years California's suicide rate among adults 65 and older has been higher than the national average.

The senior community believes that SB 1004 should also address the mental health needs of seniors as much MHSA money remains unspent. The California Commission on Aging offered amendments stressing that older adults are also at risk of anxiety depression, anxiety, psychological traumas and suicide.

Sadly, the Assembly Health Committee did not consider the amendments. As a result, the Commission on Aging opposes SB 1004 because it would make it more difficult for seniors to secure the mental health services they need.

Cheryl Brown is a member of the California Commission on Aging and former chairwoman of the Assembly Committee on Aging and Long-Term Care. She can be contacted at cheryl1242@gmail.com.

Rural Suicide: One California County's Fight To Save Lives

Capital Public Radio | www.capradio.org

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A Problem, A Movement: What We're Learning About Suicide In Amador County

Sammy Caiola

Tuesday, July 17, 2018 | Sacramento, CA | Permalink

LISTEN 0:47

Reporter Sammy Caiola listens to Terri Works of NAMI Amador and Nadine Magana of Nexus Youth & Family Services talk about available mental health resources.

Vanessa S. Nelson / Capital Public Radio

A crowd of nearly 50 people from Amador County and surrounding communities gathered in Sutter Creek last month to discuss suicide risk in rural California and what community members can do. It was a conversation that residents said would not have happened a few years ago, and would still be considered taboo in most circles.

That's because many residents in this quiet community don't realize that their neighbors are taking their own lives at higher rates than nearly any other California county. The 2018 County Health Status Profile from the California Department of Public Health shows that Amador County has the third highest suicide rate in the state. This tiny county has more than twice Sacramento's suicide rate, though the two regions are separated by a mere hour's drive.

Capital Public Radio wants to find out why these numbers are so high, and how Amador and other rural communities can tackle the problem. So reporter Sammy Caiola, editor Linnea Edmeier and community engagement strategist jesikah maria ross joined Olivia Henry, engagement editor with the University of Southern California's Center for Health Journalism, to hold a community discussion. Caiola has also been on the ground talking with folks since April. We'll be working on this project, with support from USC, for the next two months.

Here's what we've learned so far.

Why is this happening in Amador County? Is it similar to or different from what's happening in cities?

There's no single answer to why suicide tends to be more common in rural areas, but we did find out about some relevant factors.

Age

For one, rural areas tend to skew older. Many people live alone, miles away from central services. They may lack transportation and be estranged from friends or family. If they're grieving a loved one, struggling financially or suffering from substance addiction, depression can thrive. Researchers say loneliness and social isolation may represent a bigger threat to public health than obesity (http://www.apa.org/news/press/releases/2017/08/lonely-die.aspx).

In Amador County, about 61 percent of the 62 people who died by suicide between 2010 and 2014 were age 50 or older, according to a study of death certificates conducted by Amador County Public Health and a UC Davis medical student. This research only analyzed deaths that were marked as suicides. It did not include suicide attempts, or deaths by other methods such as car accidents or overdoses.

Linnea Edmeier, CapRadio's managing editor for news and a resident of Sutter Creek, kicks off a conversation about the suicide crisis in Amador County.

Vanessa S. Nelson / Capital Public Radio

"Some folks might be retired now and they've had a wonderful career, and then they buy a house here and they're kind of isolated," said Joseph Bartholomew, director of the Sierra Wind Wellness and Recovery Center in Jackson. "So that can be a barrier, getting someone to them or getting them out of the house ... that is something that really needs to happen, especially in these areas."

Military Status

About 12 percent of Amador County residents are veterans, compared to 6 percent nationally. Post-traumatic stress disorder, substance use, chronic pain, traumatic brain injury and experience with firearms make veterans about 22 percent more likely to die by suicide than the rest of the population, according to research from the Department of Veterans Affairs.

The public health study found that about a third of people who died by suicide in Amador were veterans.

Nichole Mulford, who runs a nonprofit veterans home in Jackson, said her clients are unlikely to seek out mental health services.

"Oftentimes when they come to Victory Village they're at rock bottom," she said, referencing her organization. "Because veterans have a really hard time asking for help. When they're in the military, it's ingrained into them to be self reliant ... and asking for help would negate all of that training."

Economic Hardship

The issue is, many of the people who could benefit from these services aren't aware that they exist. Most attendees want to see a push to get the word out. They also want to see more training of law enforcement, school officials, primary care providers and just everyday people around how to recognize suicide risk and intervene.

Trixxie Smith, a peer support counselor and chaplain, said it can be as simple as just checking in with somebody.

"[People] need to feel that other people care about them and want to hear their story," she said. "And anyone can do that."

Reporter Sammy Caiola aims to collect personal stories about suicide and share them out as a means of reducing stigma and raising awareness. You can call her at 916-278-8930 or get in touch using this form. You can also find local prevention resources here (http://www.capradio.org/ruralsuicide).

The group discussed the best ways to share our public radio reporting project with Amador and the surrounding community, and how to collaborate with local groups during Suicide Prevention Week (http://www.ledger.news/news/opinion/guest-editorial-suicide-prevention-week/article_32899ea0-9400-11e7-95ca-535ef6a49734.html) in September. Our community engagement team will be working on that, while reporter Sammy Caiola keeps reporting on the ground.

And if you or someone you know needs help, call the National Suicide Prevention Lifeline at 1-800-273-8255.

rural suicide

Sammy Caiola
Healthcare Reporter

July 26, 2018 Commission Meeting

Lunch

Catering From Edible Events

Commissioners	Cash $15
Alvarez ★	need 15
~~Ashbeck~~	~~owe 15~~ ✓
~~Aslami-Tamplen~~	~~Paid owe 15~~ ✓
~~Boyd~~	✓
~~Brown~~ ★	owe 5
~~Bunch~~ ★	~~need 15~~
~~Madrigal-Weiss~~ ★	owe 5
Mitchell	need 15
~~Wooten~~ ★	owe 10

Exec Staff	Cash $15
~~Toby~~	owe 5
Norma ★	need ~~owe~~ 15
~~Fil~~	✓
Brian	

owe
~~Brown 5~~
~~Munoz 5~~
~~Tina 10~~
Toby 5

need
Munoz
Mitchell
Norma

?
Brian

Received 134
owe Toby $5
Alvarez
Norma owe $15
not sure Brian ate

135