MENTAL HEALTH TASK TEAM REPORT TO THE CALIFORNIA COMMISSION ON AGING

Prepared for
PLANNING FOR AN AGING CALIFORNIA: AN INVITATIONAL FORUM
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The Purpose

The purpose of this document is to provide a status report of the work of a stakeholder task team on Mental Health organized around working on implementation of "Planning for an Aging California Population" (Health and Human Service Agency October 2003).

Task Team Members

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Other Invited Participants

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I. Forward

A. Who is the California Commission on Aging?

The California Commission on Aging (CCoA) was established in 1973 by the Burton Act. It was confirmed in the original Older Californians Act of 1980 and reconfirmed in the Mello-Granlund Older Californians Act of 1996.

The Commission serves as "*the principal advocate in the state on behalf of older individuals, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals.*" As such, the CCoA is the principal advisory body to the Governor, State Legislature, and State, Federal and local departments and agencies on issues affecting older Californians.

B. SB 910—Aging Planning Legislation

California is home to nearly four million people over age 65—the largest older adult population in the nation. This number is expected to more than double over the next several decades as the baby boomers begin reaching this milestone. To address this impending reality, Senator John Vasconcellos wrote Senate Bill 910 (Ch. 948/99, Vasconcellos). The bill mandated that the California Health and Human Services Agency develop a statewide strategic plan on aging for long term planning purposes. On October 14, 2003, the *Strategic Plan for an Aging California Population—Getting California Ready for the Baby Boomers,* was completed with the major support of the CCoA and a plan development task team representing 25 older adult stakeholder organizations supported by 15 state departments. The Governor signed the plan in November 2003. (The Strategic Plan can be reviewed at http://www.calaging.org/works/population_files/population.pdf.

C. CCoA's Monitoring Role of the Strategic Plan

SB 910 calls for periodic updates so that it can be continuously improved and reflect new circumstances, new opportunities and the changing socio-political environment. The CCoA agreed to assume responsibility for the monitoring and updating the Strategic Plan. In this capacity, the CCoA is responsible for convening stakeholders, holding meetings, and monitoring the progress of priority action items outlined in the Plan. The CCoA will report to the Legislature the progress of the Plan's implementation, and update the Plan's contents to reflect changing priorities and actions. Reports to the Legislature will be on a biennial basis.

The CCoA's approach to monitoring the Strategic Plan's implementation during 2003-2005 includes:

- Encouraging/facilitating work on Strategic Plan implementation by convening nine new stakeholder task teams, facilitating initial meetings and establishing partnerships with two previously formed stakeholder teams.

- Dialoguing with state officials at the March 8, 2005 Forum on the top 15 priorities in the Strategic Plan.

- Distributing and compiling the results of a baseline questionnaire on the Strategic Plan's 15 Priorities. The questionnaire was distributed to private, public and non-profit providers and aging advocates.

- Reporting to the Legislature by May 2005, on the progress of the Strategic Plan.

D. Stakeholder Task Teams

Eleven Stakeholder Task Teams have been charged with identifying and focusing efforts on several of the top priority recommendations, developing action plans to support or achieve implementation of these priorities and identifying necessary amendments or additions to the original Plan. These volunteer Task Teams have been meeting for the period October 2003 through December 2004, though some Task Teams started their efforts later than others. Written reports have been received from all Task Teams—copies are available from the CCoA office. The focus areas for the 11 stakeholder task teams are: Housing, Economic Security, Elder/Financial Abuse, Transportation, Wellness/Prevention, Mental Health, Oral Health, Long Term Care, Palliative/End of Life Care, Assistive Technology, Provider Workforce.

The choices and actions taken by the Task Teams are solely their own and do not necessarily represent the position of the CCoA.

II. Background on Mental Health

Geriatric mental illness brings together two of the most damaging elements of discrimination in America: the stigma of advanced age and the stigma of mental illness. Worse than being invisible, an older person suffering from depression or dementia is devalued and dismissed.

Most older adults enjoy good mental health; however, nearly 20 percent who are 55 years and older experience mental disorders that are not part of normal aging. The most common disorders, in order of prevalence, are anxiety disorders, such as phobias and obsessive-compulsive disorders; severe cognitive impairment, including Alzheimer's disease; and mood disorders, such as depression. Schizophrenia is less common. The rate of suicide is highest among older adults compared to other age groups. Based on prevalence rates applied to households under 200 percent of the federal poverty definition, in fiscal year 2002-03 approximately 58,000 persons age 65 and older in California had serious mental illnesses, such as schizophrenia, bipolar disorder, and major depression. This figure represents the older adults who would access mental health services from the public mental health system.[1]

Sadly, many older adults do not receive mental health services for a number of reasons including:

- Stigma associated with identifying oneself with mental illness
- Lack of information about available help
- Lack of outreach about available help
- Lack of financial resources to access private resources and sometimes, too many resources to access public mental health
- Lack of clinicians trained in geriatric mental health
- Lack of transportation to services, especially in rural areas.

[1] U.S. Department of Health and Human Services. (2001). *Older adults and mental health: Issues and opportunities*. Rockville, MD: U.S. Department of Health and Human Services, Administration on Aging.

Overcoming Prejudice

The New Freedom Commission on Mental Health pointed out that "stigma is a pervasive barrier to understanding the gravity of mental illnesses."[2] For example, 61 percent of Americans think that people with schizophrenia are likely to be dangerous to others when, in reality, these individuals are rarely violent.[3] Stigma affects older adults disproportionately, and, as a result, older adults and their family members do not want to be identified with the traditional mental health system.[4] Sue Levkoff, ScD, SM, MSW, Director of the Positive Aging Resource Center, explains that older adults have a different attitude toward mental illness than the younger generation. She points out that "They grew up in an era when having such problems meant you were considered 'crazy.'"[5]

Strategies need to be developed to overcome the prejudice associated with mental illness that prevents older adults with mental health problems from seeking treatment. A campaign to educate the general public about mental illness and to combat the stigma associated with receiving treatment should be directed to the general public. In addition, a focused campaign to educate older adults needs to be implemented. With the enactment of the Mental Health Services Act, the mandate to combat this stigma is now associated with increased fiscal resources.

The Substance Abuse and Mental Health Services Administration (SAMHSA) convened a meeting in 2004 of researchers, advocates, practitioners, media representatives, grant writers, and consumers of mental health services to find ways to combat stigma experienced by older adults. Participants have recommended a two-part strategy. One effort would focus on empowering older adults with mental illness by educating them. A broader effort would use the media to send a positive message about mental health and aging to older persons, their adult children, and the public.[6]

Eliminate the Barriers Initiative (EBI) is a broad effort to send a positive message about mental health and aging. The federal Center for Mental Health Services (CMHS) has developed the EBI to take aim at identifying effective approaches to address stigma and discrimination associated with mental illness. It is a three-year demonstration project being implemented in eight states, including California. The first stage of the project is to collect information about what advocates are already doing to combat the effects of the stigma. The project will then test public education materials, including radio, television, and print public service

[2] Clay, R. (2004, July/August). Improving mental health services. *SAMHSA News, 12,* 1-4. New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (No. DHHS Pub No. SMA-03-3832). Rockville, MD.

[3] Pescolido et al, 2000; U.S. Department of Health and Human Services, 1999

[4] U.S. Department of Health and Human Services, 2001

[5] Clay, 2004

[6] Clay, 2004

announcements (PSAs). After the evaluation of these models is completed, CMHS will expand the campaign nationwide.

In California, the EBI kicked off with placing PSAs in print, radio, and television during Mental Illness Awareness Week, October 3 to 9, 2004. In January 2005, the EBI will target the business sector of the State with the anti-stigma campaign. The expectation is that in 2005 and 2006 the Department of Mental Health and mental health constituency groups at the state and local levels will accomplish the following goals:

- Assist in the development of a strategic marketing plan that addresses stigma and discrimination at the state level.
- Develop a database and build relationships with key stakeholders.
- Use, and when appropriate, adapt EBI materials in state and local public education efforts designed to reduce stigma and discrimination.
- Disseminate EBI messages to the public by gaining public exposure for the PSA campaign.
- Recruit and train a team of public speakers to give anti-stigma/discrimination presentations at schools, congregations, and community centers throughout the State.
- Use the ADS Center website, already devoted to anti-stigma/discrimination education and information, as an intranet for information, materials, and dissemination.

The data collection stage is already complete. The following anti-stigma programs are already operating at a statewide or local level:

- California Coalition for Mental Health, a statewide advocacy organization comprised of 32 mental health constituency groups, is leading the effort to disseminate EBI material to both the general public and the business community.
- California Network of Mental Health Clients provides materials that are consumer-driven and focus on offering community solutions to reducing stigma.
- California Council of Community Mental Health Agencies is a clearinghouse of many nonprofit community-based providers, linking organizations working to reduce stigma.
- National Alliance for the Mentally Ill (NAMI) California supports StigmaBusters, a national program to fight inaccurate and hurtful representation of mental illness found in television, film, print, or other media. StigmaBusters speak out to challenge stereotypes in an effort to educate society about the reality of mental illness.

- *StampOut Stigma* is one of the nation's most recognized consumer-run speaker's bureaus of people with mental illness.
- The Contra Costa Mental Health Division maintains a Stigma Public Awareness Committee addressing stigma towards persons with mental illness in the media and in cases of employment and housing discrimination.

On a national level, these groups have published campaign materials on their websites.

- ADS Center: Resource Center to Address Discrimination and Stigma www.adscenter.org
- National Mental Health Consumers' Self-Help Clearinghouse www.mhselfhelp.org
- National Mental Health Association www.nmha.org
- Open Minds Open Doors www.openmindsopendoors.com

Cultural Diversity

Among ethnic groups, mental illness is even more highly stigmatized than among whites. In *Mental Health: Culture, Race, and Ethnicity–A Supplement to Mental Health,* the Surgeon General reports that stigma associated with mental illness is a significant barrier to seeking treatment. One study found that only 12 percent of Asians would mention their mental health problems to a friend or relative versus 26 percent of Whites; only 4 percent of Asians would seek help from a psychiatrist or specialist versus 13 percent of Whites.[7] Materials and treatment approaches that address the needs of ethnic groups will need to be developed.

Even if older adults obtain accurate information about mental illnesses, they may still be reluctant to obtain mental health services from traditional mental health providers, such as psychiatrists, in traditional mental health settings.

Senior Peer Counseling Programs

Senior Peer Counseling Programs is an approach that has been successful in reaching out to older adults in need of mental health services. These programs are not perceived by older adults in the same way as are traditional mental health services and, thus, older adults are more willing to access these services. According to the staff at the Center for Healthy Aging in Santa Monica, California, these programs reframe mental health issues as "stage of life" issues and loss

[7] U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity--A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Page 29.

issues, making them more acceptable to discuss and reduces the feelings of stigma for older adults.

Senior Peer Counseling programs are offered in many counties throughout the State. The type of services depends on the focus of the individual program. Programs train volunteer counselors, who are typically 55 or older, to work in individual, couple, family, or group settings. Some programs also offer support groups on various topics, including bereavement and caregiving. Senior Peer Counseling programs can be a way to identify older adults in need of referral to specialty mental health services.

Depression and Suicide Prevention

According to the National Institute on Mental Health (2003), "of the nearly 35 million Americans age 65 and older, an estimated 2 million have a depressive illness and another 5 million have…depressive symptoms that fall short of meeting full diagnostic criteria for a disorder."[8] Depression in older adults often looks different than depression in younger people. Usual symptoms of depression include: persistent low mood, irritability, fatigue, poor or changing appetites, inability to concentrate, and lack of interest or satisfaction in activities an individual would normally find interesting.

In older adults, more often than not, depression is often displayed as persistent and vague physical complaints, confusion and memory problems. Doctors treating older adults frequently do not identify the last group of complaints as depression for a number of reasons including:

- Lack of education to properly diagnose depression in older adults.
- Lack of understanding that just because an older adult may have a chronic condition such as diabetes, heart disease, or Parkinson's disease, depressive symptoms are not necessarily a part of the disease and should be recognized as separate and treatable.
- Myth that depression is a natural part of aging.

77 percent of older adults (defined as 55 years of age and older) had contact with primary care physicians in the year prior to their death. These rates are higher than those who had contact with mental health professionals since persons with mental health problems are more likely to seek services in the primary care sector.[9] These findings points to the need for better screening and assessment by primary care physicians.

[8] Older Adults: Depression and Suicide Facts, National Institute on Mental Health, 2003 NIH Publication No. 03-4593

[9] Luoma, Jason; Martin, Catherine; and Pearson, Jane; Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence, American Journal of Psychiatry, June 2002.

Behavioral Health Professionals in Primary and Outpatient Settings

Treatment for mental health disorders traditionally has been separate from primary care treatment. The linkage of mental health services and primary care services is logically the next progression of care for the growing number of older adults in California. Historically about 60 percent-70 percent of psychotropic medications are prescribed, sometimes inappropriately, in the primary care settings. Data indicates that more than 50 percent of mental health services are provided in the primary care setting. The medical visits have little or no confirmable medical or biological diagnosis with co-occurring medical, psychiatric and addictive disorders.

The previously referenced Surgeon General's Report of 1999 as well as the first three speakers who presented to this Task Team indicated that the first point of entry with the health care system is through the primary care practice. The patient has more familiarity with primary care then the specialty care of mental health. Primary care practices offer the patient the possibility of cost effective treatment, the potential for early identification of the symptoms and the linkage of the two services that provides for effective and immediate coordination and continuity of care for the patient. Primary care is where the patient, as well as their family members receives most of their care. The primary care practitioner establishes relationships with family members that are critical in the care of older adults, thus allowing the provider to have a greater advantage of tapping the family for support. These relationships are key for serving the older adult population. Primary care is where most of the patients want to receive their mental health services since it is perceived as less stigmatizing than the specialty mental health sector.

While there are potential benefits to increased use of primary care physicians, there are also concerns. Older adults who receive mental health care from primary care practitioners are often misdiagnosed or improperly treated. As a result, they continue to suffer from depression and other mental illness that complicate their medical conditions and lead to physical disability. One in five older adults is given inappropriate prescriptions. Older adults are less likely to be treated with psychotherapy even though the combination of anti-depressant medication and psychotherapy has been found in numerous studies to be the most effective form of psychotherapeutic treatment.

The successful integration of mental health and primary care services would provide many benefits such as:

- Services could be provided in one location, thus eliminating the burden of multiple appointments with multiple providers in multiple settings.
- Integrated services in a single location would lessen transportation constraints often experienced by older adults.
- Linkage of the two services provides for potentially effective coordination of services and continuity of care.

- Studies over the years have indicated a significant improvement in treatment response rate for older adults who receive coordinated mental health care integrated with primary care sites.

Training for First Responders

Communities throughout California vary in how they provide emergency response services. A private ambulance company that specializes in transporting older adults from assisted living centers and other types of older adult residences spoke to the Task Team. The employees of this particular company receive specialized training on mental health problems including dementia management, manners, and "what not to do" strategies. The first responder staff who serve the senior population learn that they may not be able to make the patient "better" on the spot as would be the case when they stabilize a physical injury or problem at the scene of an accident. Instead, they have to learn that their success in serving an older adult with a mental illness comes by being able to perform medical clearance at the scene, which then avoids the need for an ambulance trip to the hospital to get a medical clearance.

Often, by providing the medical clearance at the scene, the patient only needs to be transported once if they then need to go to a mental health facility. Also, success comes through being able to mitigate negative reactions from patients by using the specialized skills developed through training.

When public EMS receives calls from older adults living at home, they make an assessment; they note the person's physical balance and gait as well as check off any hazards in the home that could pose a danger to the older adult. If the older adult does not live at home, the EMS will make such an assessment of the facility where the patient resides.

III. Current Status of Mental Health Task Team

The Mental Health Task Team (MHTT) was comprised of advocates, representatives from provider organizations, state government, and the private sector. Task Team members are listed on page i of this document. They met a total of six times, plus three conference calls, in 2004. The Task Team began its work by reviewing the *Strategic Plan on an Aging California* including the full list of Mental Health recommendations. The Task Team worked through a selection process to identify four implementation priorities. The priorities represent what the Task Team members felt could be reasonably accomplished in the current environment. For each of these priorities, an Action Plan was created. As a final step, the Task Team compiled a list of barriers that hinder implementation.

The group chose a leader for each implementation priority selected to more evenly share the Mental Health Task Team workload. Leaders researched their topics through the internet and community resources in order to identify speakers to

provide education to the task force in a face-to-face meeting. Conference calls were arranged in order to hear speakers from out of the area and to accommodate the Task Team members from out of the area. At the end of each topic presentation, implementation strategies and barriers to implementation were discussed.

IV. Mental Health Implementation Priorities and Action Plan

Priority	Action Plan
Public Information Campaign to Combat Prejudice	• In conjunction with the California Mental Health Planning Council, convene a task force to develop an implementation plan to empower older adults with mental illness to access mental health services. a) Developing the theme for the anti-stigma campaign and contract for the production of materials b) Obtaining buy-in from stakeholders c) Develop a dissemination plan d) Obtain funding from a variety of sources including financial and in-kind contributions, pursuing grants, and obtaining funds from the Mental Health Services Act • Develop partnerships between and among public sector mental health, public sector aging, older adult advocate organizations at both statewide and local levels to disseminate educational information. Potential activities include: a) Distribute materials, conduct an outreach and education campaign at Area Agencies on Aging sponsored programs serving older adults b) Disseminate information to local chapters of older adult advocate organizations such as local AARP chapters, the Older Women's League of California chapters, and other community-based organizations serving older adults
Depression and Suicide Prevention	• Develop better screening and assessment by primary care physicians. • Include suicide prevention, general prevention and early intervention services as a focus area for the Mental Health Services Act (effective January 1, 2005). • Advocate for the development and adoption of a state plan for suicide prevention.

Priority	Action Plan
Depression and Suicide Prevention (continued)	• Develop recommended objectives for implementing the 11 goals of the California Strategy for Suicide Prevention (see Attachment 1) • Promote the concept of giving primary care physicians training on suicide prevention. • Develop evidence-based diagnostic and screening tools for depression and suicide specifically for older adults. • Promote the concept of giving primary care physicians training on suicide prevention. a) Develop evidence-based diagnostic and screening tools for depression and suicide specifically for older adults
Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings	• Linkages: Mental health providers (LCSW, MFT, Ph.D. and M.D.) would provide assessment and behavioral health counseling at the primary care site through formalized, ongoing agreements. • Training: • Primary care providers: a) Train primary care providers to identify and treat mental disorders, and promote mental health wellness and prevention. b) Train primary care practitioners to determine the severity of the disorder and when referral to mental health specialty care is needed. c) Train primary care providers on the availability of local mental health resources and how patients can access care from the mental health system. • Mental Health Providers: a) Train mental health providers to treat a range of diagnosis. b) Train mental health providers in crisis management. c) Train mental health providers to work in a shorter time frame (from 10-20 minutes) that emphasizes working with behavioral interventions.

Priority	Action Plan
Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings (continued)	d) Train mental health providers to serve as support to the nursing and other staff members who need support and occasional specific skill development in dealing with challenging patients. • Funding Issues: a) Link the funding sources of mental health and primary care so both will share equally in the funding of positions. b) Lobby legislators to raise mental health funding to the level it shared with general health services in the past decade. c) Advocate to health plans that they discontinue carve out mental health services and move to collaborative care across disciplines in order to encourage and develop a team approach to patient care. d) Insure that provider reimbursement rates reflect the cost of providing services and the time spent on care coordination. e) In fee for service arrangements, payers should develop billing codes that allow providers to be compensated for longer patient visits, when needed, and for the time it takes to collaborate with other health professionals. f) In managed care plans, payers should provide higher capitation rates for individuals with serious mental disorder and co-occurring health conditions. Any increased costs would be offset by reduced hospitalizations and office visits. • Program Evaluation and Outcome Measurement a) Develop programs linking public and private sector delivery systems in California to measure quality of service that integrates mental health and primary care services. b) Evaluate whether programs and policy initiatives regarding integration of services leads to the elimination of racial and ethnic health disparities and promote equal access to high quality health care.

Priority	Action Plan
Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings (continued)	• Quality and outcome measures should be standardized across systems and levels of care. Data gathering would include: a) Use of emergency rooms for physical health care issues (pre-post integration) b) Admissions to psychiatric facilities and average length of stay (pre-post integration). c) Review of patient charts to confirm signed consent forms and indication that communication between mental health and primary care providers has occurred. d) Review of patient charts to confirm that medication prescribers have exchanged pertinent information on medications. e) Review of consumer and provider satisfaction surveys. • Report findings on a regular basis to determine outcomes and evaluate needed changes. • Mental health consultation availability: develop capacity for mental health providers to provide support to primary care physicians through the use of psychiatric phone consultations, mobile mental health teams and telepsychiatry to rural areas.
Training for First Responders	• Support the continuation of the elder death reviews now taking place in Sacramento County, and advocate for implementation of this plan in every county in California • Support training for both public and private emergency medical responders to meet the special needs of older adults with mental health concerns, dementia and other problems associated with aging. • Suggest a pilot program to use master level clinicians in training to assist emergency responders to complete accurate mental health assessments. • Study the feasibility of establishing a pilot program to provide on call social workers to ride along with first responders. • Recommend that a social worker familiar with older adult mental health issues be on call to support first EMS responders when needed.

Priority	Action Plan
Training for First Responders (continued)	• Advocate for county regulation and program oversight of EMS services to be in place in every county. • Study the feasibility of public EMS contracting with private EMS services that have staff trained in handling mental health problems.

V. Barriers to Mental Health Priorities Implementation

Public Information Campaign to Combat Prejudice

- Obtaining adequate funding.
- Achieving consensus among stakeholders for the theme and messages of the anti-stigma campaign.
- Achieving a cohesive collaboration between mental health and aging stakeholders.
- Developing and following through on a sufficiently extensive dissemination plan so that the message really reaches enough older adults.

Depression and Suicide Prevention

- Establishing new medical school curricula in suicide prevention and intervention may be met with resistance. Mandatory continuing education units (CEU's) on this subject may be an option. The support of medical, nursing, and mental health provider groups would likely be necessary.
- Funding for prevention efforts in public mental health has been historically limited. The Mental Health Service Act is so new that criteria for use of funds are still largely unknown.
- Generating enthusiasm for development of a State Plan for Suicide Prevention and Intervention.

Staffing of Behavioral Health Professionals in Primary Care/Outpatient Settings

- Lack of training and practice guidelines: primary care providers are often not trained to identify those suffering from untreated mental health disorders and to provide appropriate treatment or referrals.
- Lack of guidance about treating mental disorders in primary care including which disorder and what level of severity can be effectively treated in primary care settings.
- Lack of time: most primary care practitioners are set up to deal with acute conditions, rather than chronic ones and primary care physicians often lack sufficient time to identify and treat mental disorders.

- Lack of adequate funding: payers have limited motivation to reimburse for integrated treatment programs when cost offsets are either uncertain or would benefit other service sectors. There is also limited financing from other sources for incorporating evidence based practice into most primary care practices. Insurance plans may not pay primary care providers for the additional time required to provide care to their patients with mental disorders.
- Research gaps: A body of research is being built on the treatment of depression in primary care. Little research, however, exists on the treatment of other mental disorders in primary care settings or on integrated services for people with severe mental illness.
- Lack of specialty providers: There is a shortage of specialty mental health providers who can serve as consultants or referrals for patients whose needs cannot be met solely by their primary care practitioners.
- Stigma of mental health
- Lack of treatment designed to meet the needs of age, gender, race and culture.
- Some patients are unable to follow through on their own with recommended services from mental health professionals.\
- Partnership between primary care and mental health providers have met with some issues based on different culture of care, including styles of communication and duration of office visits.

Training for First Responders

- County and city union contracts may prohibit contracting with private EMS firms that can provide specialized services to the aging population.
- Lack of "floating" mental health provider who could be available to go out with EMS personnel on calls where a mental health assessment is needed.
- Lack of training of EMS personnel and 911 dispatchers to identify calls where assessment of mental health issues is needed.
- Lack of funding for training of EMS personnel and 911 dispatchers to identify calls where assessment of mental health issues is needed.

VI. Proposed Revisions to the *Strategic Plan for an Aging California Population*

The Mental Health Task Team does not recommend any changes, additions or deletions to the *Strategic Plan for an Aging California Population* at this time.

Attachment 1

CALIFORNIA STRATEGY FOR SUICIDE PREVENTION

This document is the first iteration of a California Strategy for Suicide Prevention. It is based on the work of participants at the SPAN-California Suicide Prevention Planning Conference - Furthering the National Strategy in California, convened in Sacramento, California, May 2004. It sets forth a list of recommended objectives for implementing the 11 goals of the National Strategy for Suicide Prevention[10] within California in order to initiate and direct activities statewide to significantly reduce the rate of death by suicide. The contents will require refinement through an inclusive process that invites critical examination by government leaders, scientific and clinical professionals, and the general public alike.

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GOAL 1: Promote Awareness that Suicide is a Public Health Problem that is Preventable

Objective 1.1
Develop and implement a public awareness program that destigmatizes suicide by changing social norms.

Objective 1.2
Develop annually a suicide media awareness kit that can serve as a reference for statistics, referrals and other relevant information.

Objective 1.3
Consult suicide survivors, suicide attempt survivors, and consumers of mental health services in the development of all public awareness strategies.

Objective 1.4
Tailor public awareness campaigns to the communities they are intended to serve.

Objective 1.5
Build relationships between interested parties and the local media to enhance suicide prevention messages.

[10] U.S. Department of Health and Human Services (2001). National strategy for suicide prevention: Goals and objectives for action. Rockville, MD. U.S. Department of Health and Human Services, Public Health Service. Available at http://www.mentalhealth.org/suicideprevention or http://www.surgeongeneral.gov/library/reports.htm

GOAL 2: Develop Broad-based Support for Suicide Prevention

Objective 2.1
Develop a statewide public-private task force, appointed by the Governor and Legislature through a legislative mandate, to coordinate and implement the California Strategy for Suicide Prevention.

Objective 2.2
Delegate responsibility for suicide prevention programs and policies to the California Secretary of Health and Human Services.

Objective 2.3
Identify funding resources to establish collaborative partnerships to advance suicide prevention.

Objective 2.4
Develop a California-specific resource guide for suicide prevention that includes data, literature, and training curricula.

Objective 2.5
Identify a lead organization in every California county to coordinate suicide prevention activities.

GOAL 3: Develop and Implement Strategies to Reduce the Stigma Associated with Being a Consumer of Mental Health, Substance Abuse, and Suicide Prevention Services

Objective 3.1
Develop a strategy to communicate social norms for discussing suicide with sensitivity.

Objective 3.2
Implement programs that promote help-seeking behavior.

Objective 3.3
Require primary care providers in California to screen for mental illness.

Objective 3.4
Conduct outreach to employers to implement suicide prevention programs for their workforce.

Objective 3.5
Conduct outreach to higher education centers to implement suicide prevention programs for their students.

Objective 3.6
Pass mental health parity legislation in California.

GOAL 4: Develop and Implement Suicide Prevention Programs

Objective 4.1
Implement a suicide prevention curriculum for all personnel who come in contact with youth who are preschool age to age 18.

Objective 4.2
Disseminate best practice suicide prevention programs.

Objective 4.3
Develop programs that build upon individual and community-level suicide protective factors.

Objective 4.4
Develop programs that target individual and community-level modifiable suicide risk factors.

Objective 4.5
Require effectiveness evaluations for all funded suicide prevention programs in California.

GOAL 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

Objective 5.1
Require all gun owners to undergo annual certification for gun safety.

Objective 5.2
Require all healthcare professionals to screen for the presence of lethal means and to inform clients and their families about the importance of restricting access to lethal means.

Objective 5.3
Pass legislation that would require all elevated bridges in California to install suicide prevention barriers.

Objective 5.4
Promote collaboration among suicide prevention advocates and gun safety advocates to reduce access to and availability of firearms (e.g., gun shows, shooting ranges).

GOAL 6: Implement Training For Recognition of At-Risk Behavior and Delivery of Effective Treatment

Objective 6.1
Establish suicide prevention training resources for healthcare providers in California.

Objective 6.2
Mandate suicide prevention training in schools preparing school counselors and health professionals (e.g., nurses, physicians, social workers, mental health workers).

Objective 6.3
Require suicide prevention training as part of the certification process for first responders (e.g., firefighters, EMTs).

Objective 6.4
Provide suicide prevention training for faith-based professionals.

Objective 6.5
Require suicide prevention training for professionals working in institutional settings and state sanctioned institutions.

Objective 6.6
Provide training for teachers and other education staff on identifying and responding to persons at risk for suicide.

GOAL 7: Develop and Promote Effective Clinical and Professional Practices

Objective 7.1.
Develop and enhance existing core competencies of health and mental health professionals for the recognition, assessment and initial management of suicidal behavior (e.g., primary care providers, medical students, school counselors, psychologists, psychiatrists, emergency department personnel).

Objective 7.2
Establish basic skills for other disciplines that promote the recognition of emotional distress, assessment of suicide risk, and (where indicated) referral to mental and/or health professionals.

Objective 7.3
Promote the coordination of services and a multidisciplinary approach among those who assess and intervene with individuals at risk for suicide and substance abuse.

GOAL 8: Increase Access to and Community Linkages with Mental Health and Substance Abuse Services

Objective 8.1
Provide no cost and/or affordable mental health and substance abuse services.

Objective 8.2
Implement effective utilization management guidelines for suicide risk in managed care and insurance plans.

Objective 8.3
Develop and disseminate tools (e.g., web sites, resource guides) for accessing mental health and substance abuse services for professionals and the public alike.

Objective 8.4
Develop and support innovative ways to deliver crisis services (e.g., mobile, telephonic, Internet) to individuals who otherwise would not receive services.

Objective 8.5
Ensure that everyone at risk for suicide is linked to mental health and substance abuse services. These services should be accessible, timely, culturally appropriate, clinically appropriate, and age appropriate.

Objective 8.6
Develop guidelines for support programs for suicide survivors.

Objective 8.7
Develop support programs for suicide attempt survivors.

GOAL 9: Improve Reporting and Portrayals of Suicidal Behavior, Mental Illness, and Substance Abuse in the Entertainment and News Media

Objective 9.1
Provide and promote guidelines for responsible suicide reporting to practicing professionals and professionals in training who are involved in entertainment, news media and public relations.

Objective 9.2
Establish a state council comprised of entertainment and news media representatives, mental health professionals, and suicide prevention experts to serve as a resource and provide guidance to the media on the depiction of suicide and mental illness.

Objective 9.3
Provide a mechanism to offer public recognition for exemplary portrayals of suicidal behavior in the entertainment and news media.

GOAL 10: Promote and Support Research on Suicide and Suicide Prevention

Objective 10.1
Develop a California suicide research agenda that reflects state population needs.

Objective 10.2
Advocate for more research funds within California for research on suicide and suicide prevention.

Objective 10.3
Evaluate existing suicide prevention programs and promote implementation of effective programs.

Objective 10.4
Create a California suicide prevention research consortium to facilitate communication and collaboration among researchers involved in suicide and suicide prevention research.

Objective 10.5
Create a statewide database of suicide prevention programs operating in California.

Objective 10.6
Promote and expand research on suicide and suicide prevention in California universities, colleges, and other organizations.

GOAL 11: Improve and Expand Surveillance Systems

Objective 11.1
Pass state legislation implementing mandatory reporting of suspected suicide attempts.

Objective 11.2
Increase the number of death review teams in California which address suicide across the life span.

Objective 11.3
Increase linkages among data systems that collect data on suicidal behavior.

Objective 11.4
Examine and expand existing behavioral risk surveys to include additional suicide, mental health and substance abuse questions.

Objective 11.5
Conduct behavioral risk surveys in non-traditional settings (e.g., juvenile detention facilities, homeless shelters) to better reach persons at risk for suicide.

Objective 11.6
Develop and implement standardized protocols for death scene investigations.

Objective 11.7
Develop and implement statewide criteria for the determination of suicide by medical examiners and coroners.