2018 Data Notebook Report: Overview of Services in the Mental Health Continuum of Care in California

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The California Behavioral Health Planning Council

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The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resiliency and wellness of Californians living with severe mental illness.

Acknowledgements:

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Survey data in the 2018 Data Notebook were collected in collaboration with the local Behavioral Health Boards and Commissions and their County Departments of Behavioral Health. We thank everyone for their commitment and continued participation in this project.

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Introduction: Purpose and Goals of this Project

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services[1] in each county. The goal of our 2018 Data Notebook is to survey types of services and needs in the behavioral health systems of care for children, adults, and older adults. This topic follows our yearly practice of focusing on different parts of the behavioral health system. However, this year we are taking a survey approach to collect data as the foundation for an overall needs review.

Each year, local behavioral health (BH) boards/commissions are required[2] to review performance data for mental health services in their county and to report their findings to the California Behavioral Health Planning Council (CBHPC). To provide structure for the reports and to make the reporting easier, the Council creates a Data Notebook for local BH boards to complete and submit. Those responses are compiled by Council staff to create a yearly report for policy makers, stakeholders and the general public.

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

- To assist local boards to meet their legal mandates[1] 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 encouraged members of all local behavioral health boards to participate in reviewing and developing the responses for the Data Notebook. This provides an opportunity for the local boards and their county behavioral health departments to work together to identify critical issues that are most important to their county. After analysis, their responses help to guide our advocacy over the following year. That work also can inform county and state leadership plans for behavioral health programs.

The Planning Council perceived a need for greater understanding by advocates of the MH services that are currently required by law in the WIC. Therefore, a different strategy was designed for the 2018 Data Notebook compared to past editions in that it did not provide county-specific data, but instead contained a brief survey about mental health services and needs in each county.[3] As background, we provided a review of the

[1] The specific mental health services addressed are Specialty Mental Health Services for serious mental illness.
[2] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[3] The practice of presenting county-specific data has resumed in the 2019 Data Notebook which, at the time of this writing, is currently under review by the local boards and commissions.

types of mental health services that counties are required to provide, and to whom (summarized in Appendix I).

The 2018 Data Notebook: A Survey of Mental Health (MH) Needs and Services

The objectives of the focus topic of the 2018 Data Notebook are to identify, at the county level, current MH program and service needs, perceptions of barriers to MH services, and priorities for recently-implemented programs in urgent need of sustainable funding. Our methods employed a survey questionnaire to gather information from responses by the local BH boards and commissions, and that analysis forms the basis of this report. Although our current public systems of care have been transitioning to an integrated system of behavioral health (BH) care that provides both MH and substance use disorder (SUD) services, the major focus of this report is limited to MH.

Some of the reasons for the selection of this topic for the 2018 DN have their roots deep in the history of the development of statutes and funding for the public mental health system over several decades of the twentieth century. So how did California come to have our present system of public mental health services?

A Brief Review of Funding for Public Mental Health Programs in California

The early years of the mental health system in California were characterized by state-run psychiatric hospitalization. People with severe mental illness had little hope for recovery as many were placed in these institutions indefinitely. The first such facility – Stockton State Hospital – opened in 1853. By late 1957, California operated 14 state hospitals serving more than 36,000 individuals.[4]

In the early 1950s, however, the introduction of new medications opened up new possibilities for treating severe mental illness outside of an inpatient setting. In 1957, the California legislature enacted the Short-Doyle Act, which called for major changes in the funding responsibility to promote the provision of mental health care in the community rather than in state-run institutions.

In 1968, the Lanterman-Petris-Short Act (LPS) became California's next step in moving away from institutional care toward community-based care. The new law required judicial review before institutional commitment of an individual with serious mental illness, which resulted in a significant reduction in the number of individuals committed. By 1984, the state's institutionalized population had dropped by 84%, resulting in the closing of nine hospitals. This law also required all counties in California, with populations over 100,000, to establish mental health programs, and increased the state

[4] UCLA: Funding Public Mental Health in California. http://histpubmh.semel.ucla.edu/sites/default/files/story-flipbooks/funding_publicmental_health/files/dmh_funding.pdf.

funding match for local programs to 90%. Consequently more individuals were seeking their MH care from the counties.

Unfortunately, the funding needed to serve the individuals exiting state hospitals was denied. Subsequent attempts to address the situation were unsuccessful until 1990 when California lawmakers passed the Bronzan – McCorquodale Act, also known as 1991 Realignment.[5] This law shifted control of mental health programs to the counties, provided counties with a more stable revenue stream from taxes and vehicle registration fees, and changed the state and county cost sharing. This Act also established the minimum array of services that were to be offered, to the extent resources were available. Those services are discussed below.

The 2018 Data Notebook focuses on the array of services that are specified for the various age groups of children/youth, adults and older adults. Some recently published reports and articles assert that California's system is inconsistent and fragmented. We know that the funding from the 1991 realignment fell grossly short in meeting the costs of services needed by individuals discharged from state hospitals. However, it is the array of services that have been in the statutes for almost three decades that this Data Notebook addresses. These services are the foundational core of community MH services. Therefore, the Council asked local boards and commissions about the array of MH services in their county. The following pages describe their responses and our findings.

System of Care: What MH Services are CA Counties Required to Provide?

The California Welfare and Institutions Code (WIC) sets forth a number of definitions, responsibilities, and requirements for the public mental health system. These requirements were codified in law in 1991 and form the basis of today's Specialty Mental Health Services that are funded by Medi-Cal. Below are a few excerpts from the state WIC that were provided to the local advisory boards to provide context for the survey questions presented in the 2018 Data Notebook.

WIC Section 5600.1

The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to

[5] Subsequently, additional funding was supplied in the 2011 Realignment. This is mentioned to indicate that the 1991 realignment is not the only dedicated funding for specialty mental health services.

develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

WIC 5600.4
Community mental health services should be organized to provide an array of treatment options in the following areas, to the extent resources are available:

(a) **Pre-crisis and Crisis Services**. Immediate response to individuals in pre-crisis and crisis and to members of the individual's support system, on a 24-hour, seven-day-a-week basis. Crisis services may be provided offsite through mobile services. The focus of pre-crisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. The focus of crisis services is stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs.

(b) **Comprehensive Evaluation and Assessment**. Includes, but is not limited to, evaluation and assessment of physical and mental health, income support, housing, vocational training and employment, and social support service needs. Evaluation and assessment may be provided offsite through mobile services.

(c) **Individual Service Plan**. Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services. The development of the plan should include the participation of the client, family members, friends, and providers of services to the client, as appropriate.

(d) **Medication Education and Management**. Includes, but is not limited to, evaluation of the need for administration of, and education about, the risks and benefits associated with medication. Clients should be provided this information prior to the administration of medications pursuant to state law. To the extent practicable, families and caregivers should also be informed about medications.

(e) **Case Management**. Client-specific services that assist clients in gaining access to needed medical, social, educational, and other services. Case management may be provided offsite through mobile services.

(f) **Twenty-four Hour Treatment Services**. Treatment provided in any of the following: an acute psychiatric hospital, an acute psychiatric unit of a general hospital, a psychiatric health facility, an institute for mental disease, a community treatment facility, or community residential treatment programs, including crisis, transitional and long-term programs.

(g) **Rehabilitation and Support Services**. Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs. These services may be provided offsite through mobile services.

(h) **Vocational Rehabilitation**. Services which provide a range of vocational services to assist individuals to prepare for, obtain, and maintain employment.

(i) **Residential Services**. Room and board[6] and 24-hour care and supervision.

(j) **Services for Homeless Persons**. Services designed to assist mentally ill persons who are homeless, or at risk of being homeless, to secure housing and financial resources.

(k) **Group Services**. Services to two or more clients at the same time.

Who is eligible for the above services?

The WIC statutes define the specific populations of children, adults, and older adults that are eligible for each of the specialty mental health and related rehabilitation and support services described above (see also Appendix I). Specific modifications or adaptations apply to some services for children and youth compared to services for adults or older adults.

[6] Medi-Cal (or Medicaid) generally does not pay for room and board, which means that other sources of funds are used, if available.

Evaluation of MH Services, Barriers to Access, and Unmet Needs in California

The 2018 Data Notebook contained a series of questions about the MH services in each county regardless of fund source. We asked whether there were barriers to service access, unmet/underserved needs, and whether there was a need to identify sources of sustainable funding for newly-implemented services or programs. We broadly framed these questions and the categories for evaluation based on the types or categories of MH services defined in the WIC statutes.

The purpose of performing this type of survey about the adequacy of the public MH system can help us to identify what are the most frequent unmet or underserved needs, and where we might best direct our advocacy efforts to increase resources to meet those needs. Some of the barriers to service access have been identified in prior Data Notebooks and our ongoing policy efforts seek to address those. We used some of these barriers to access in our questions. We also included an option to give specifics under the category of "other," with the goal of assessing our progress in decreasing or removing as many barriers as possible.

The data summarized in the following sections represents the **responses received in 49 Data Notebook reports, covering 50 counties[7] + Tri-Cities Mental Health Plan** (listed in Appendix II). Those data comprise the basis of this report. We tabulated, for example, how many counties identified service barriers or unmet MH service needs for children (age<18), transition age youth (TAY, ages 16-25), adults, and older adults. (For examples of the questions and exact counts of number of counties that responded, see Appendix III).

The TAY category used here deserves explanation, because it was not defined in the original WIC MH services-related statutes. The TAY categorization is based on the psychological and behavioral development occurring during the age range 16 to 25, and is thought to depend on brain development as well as social and cultural factors. Many in the MH services field find this framework useful for the development and targeting of services in a way that helps these young people to succeed in their MH treatment and life goals. Therefore, we use TAY as one of our age categories in this current project, while understanding that there is overlap with other age groups.

This report has certain limitations. First, due to missing responses from eight counties, the survey data contain an 'undercount' of the number of counties whose clients experience certain barriers, or have unmet needs for specific service types, or have an urgent need to identify sustained funding for newly implemented programs across an

[7] Sutter and Yuba counties are in one combined Mental Health Plan (MHP), as are Placer and Sierra counties.

array of ages and service types. Second, the survey design is intentionally simple, to keep the process manageable by the stakeholders who make up the membership of local BH boards/commissions. Third, although we generated numbers in the categorization and counting of responses, the underlying data are inherently qualitative in nature. And fourth, we made a detailed examination of the raw data counts in an effort to identify any trends that might differ for counties based on population size or geographical location, but the variability among counties made it difficult to ascertain clear trends with certainty.[8] A subsequent analysis based on percentages of the responses within specific categories of counties seems to yield a few differences, but those observations should be treated with caution.

Below, we examine the data for each of the major questions about types of MH services and unmet or underserved needs across each defined age category.

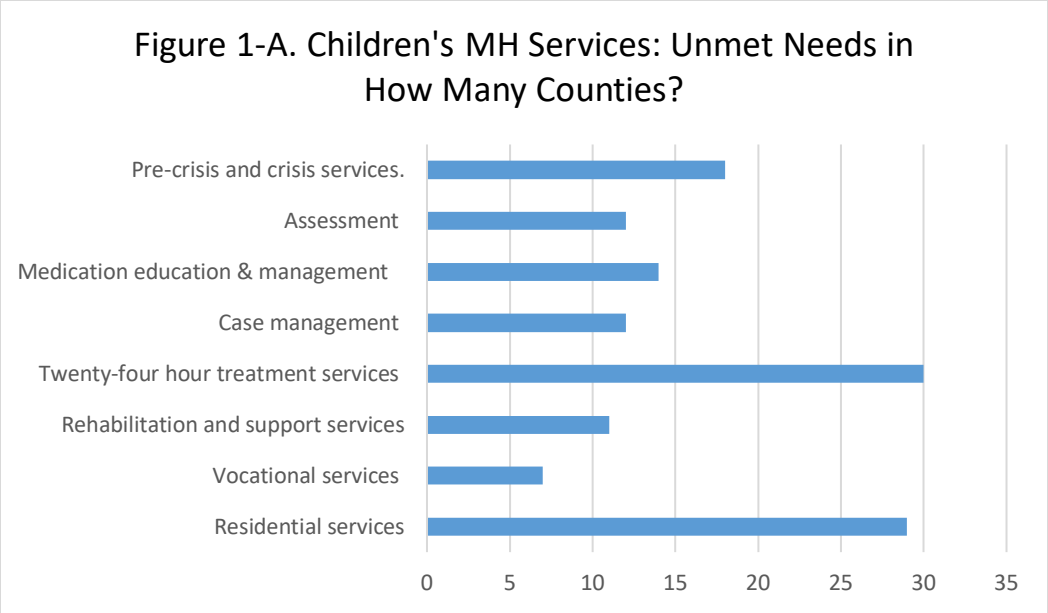
TYPES OF UNMET MH SERVICE NEEDS

First, we asked the local boards to indicate any of the following service areas for which their county had identified populations (child, TAY, adult, and older adult) that are substantially underserved or experience substantial unmet MH needs.

(a) Pre-crisis and crises services.
(b) Assessment
(c) Medication education & management
(d) Case management
(e) Twenty-four-hour treatment services
(f) Rehabilitation and support services
(g) Vocational services
(h) Residential services

As shown in the figure below, the children's MH service areas most frequently identified as being underserved were twenty-four hour treatment, residential services, and pre-crisis and crisis services. However, at least some counties indicated unmet needs in all of the eight services areas listed.

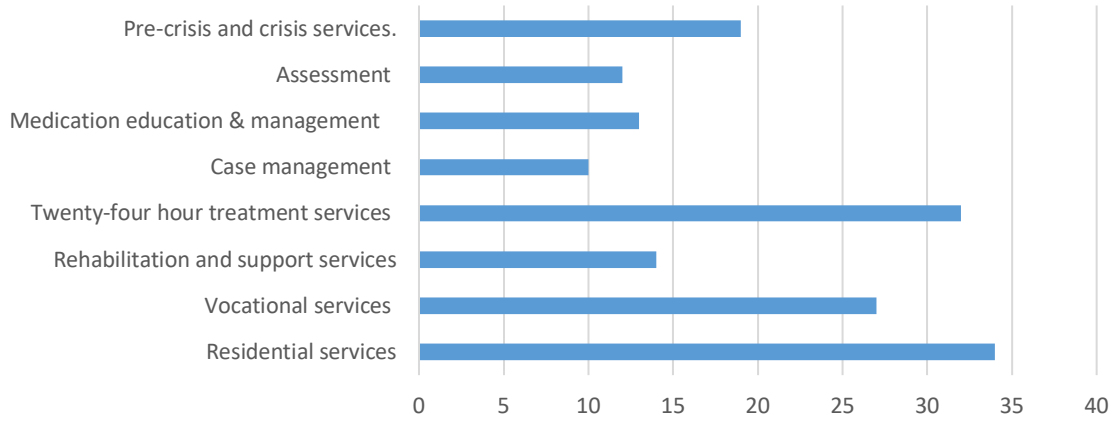
[8] From a statistical perspective, the variability among counties, the large number of service categories evaluated, combined with the relatively small data set of about fifty responding counties, --all these factors taken together—greatly reduce the likelihood of reliability of detecting any trends in any data set, but especially qualitative data.



The stated need for MH-related vocational services for children presents an area for further discussion, as vocational services for children are not listed in the current WIC statutes defining eligible MH services. We speculate that counties which identified these services as an area of unmet need may be addressing the needs of adolescents and teens falling into the age range of 15-17 to help prepare them for transition to their first jobs upon reaching age 18. Such training may be of particular importance for those youth who are receiving MH services and who are not planning to attend college or vocational schools, and for some youth who are emancipating from foster care or from their families of origin. Such training needs also may apply to those seeking to become youth peer counselors.

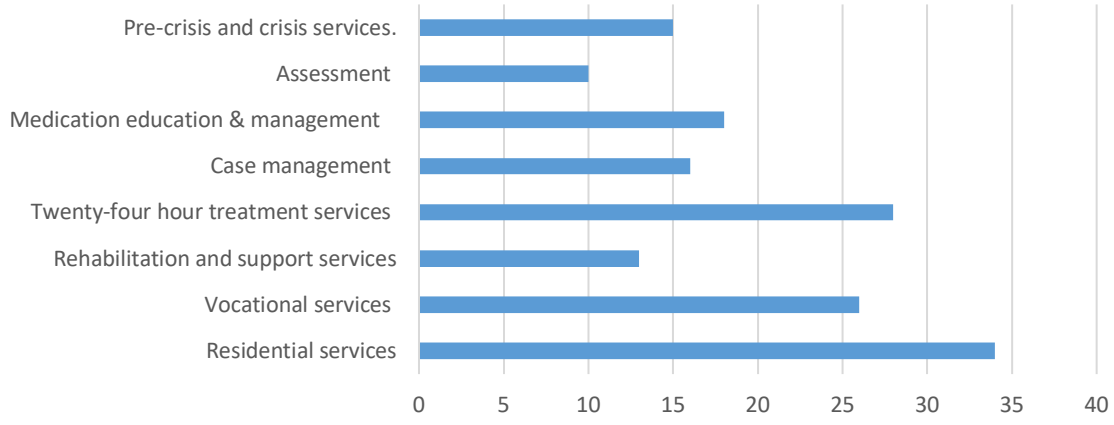
As shown in the next figure below, the MH service areas most frequently identified as being underserved for TAY were twenty-four hour treatment, residential services, vocational services, and services dealing with pre-crisis and crisis situations. However, at least some counties indicated unmet needs in all of the eight services areas listed for that population. With the exception of vocational services, the distribution of TAY service areas perceived as most frequently unmet (or underserved) was similar to the pattern of unmet (or underserved) children's needs.

Figure 1-B. TAY (Age 16-25) MH Services: Unmet Needs in How Many Counties?



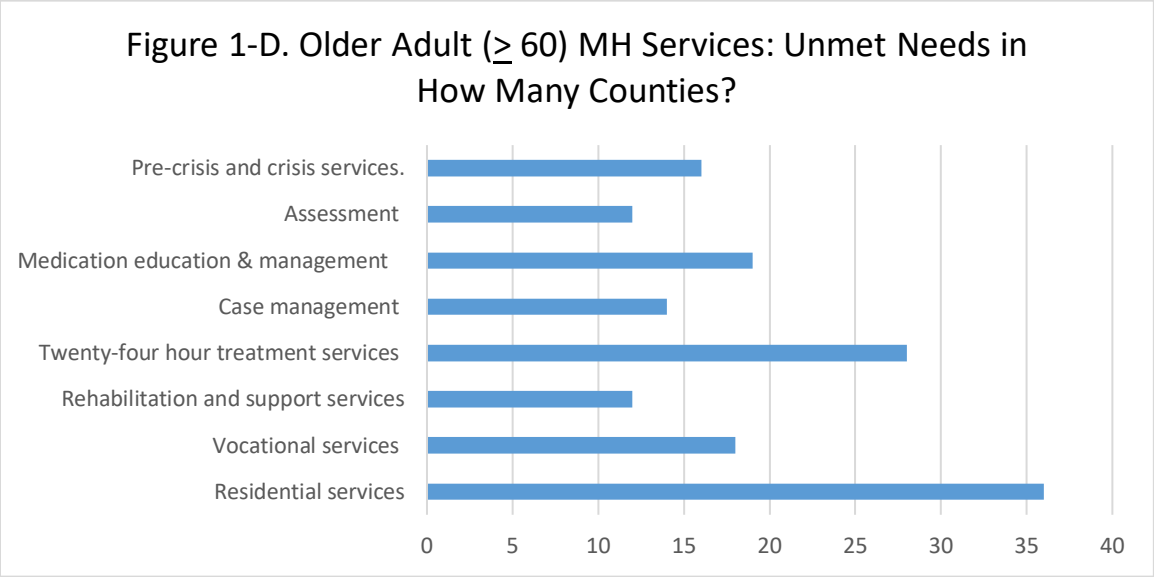
The figure below shows that the most frequently identified areas of unmet (or underserved) adult MH service needs included residential services, twenty-four hour treatment services, and vocational services. However, unmet or underserved MH needs for adults were identified in a substantial number of counties for each of the eight MH service types listed.

Figure 1-C. Adult MH Services: Unmet Needs in How Many Counties?



As shown in the next figure (below), a similar analysis for older adults yielded the finding that counties indicated that the most common unmet (or underserved) older adult MH service needs were residential services, twenty-four hour treatment services, and medication management and education. This pattern was similar to the unmet needs for adults (under 65), with the exception that there was not as great a need for vocational services for older adults (age ≥ 65). However, older adults experienced

unmet (or underserved) needs for each of the eight service types listed, as identified in a substantial number of counties.



In summary, the figures above demonstrate that nearly all counties identified that they were experiencing unmet needs for a broad array of services, and most counties experienced unmet needs for multiple types of services in all age groups.

Next, we analyzed this data in more detail to get a clearer understanding of which groups of counties were experiencing unmet needs for services, and for what types of services. We examined the types of underserved or unmet service needs in groups of counties based on their size of population, using the assumption that population size may correlate to available resources or to resource limitations.

We highlighted mainly those services for which a marked percentage of counties in each group identified unmet needs. Those services that are not highlighted below are of course still very important in those counties for which they are needed.

Small Population Counties (population ≤ 199,999)

- Unmet residential service needs were identified for all age groups in 64 - 76% of the twenty-five small population counties.
- Unmet needs for 24-hour treatment services were identified for all age groups in 56 - 60% of these small counties.
- Unmet needs for assessment, crisis and pre-crisis services were identified for children, TAY, and older adults in 24% of small counties, but for adults in only 12% of these counties.
- Unmet needs for medication education and management were identified for children, adults and older adults in 32 - 48% of small counties, and for TAY in 28% of these counties

- Unmet needs for vocational services were identified for TAY, adults, and older adults in 36 - 56% of small counties.
- Unmet needs for case management for children, adults, and older adults were identified in 24 - 32% of small counties, and for TAY in 16% of these counties.

Medium-sized Counties (population from 200,000 up to 750,000).

- Unmet needs for residential services for children and TAY were identified in 82% of the eleven medium-sized counties, and for adults and older adults in 73% of these counties.
- Unmet needs for 24-hour treatment services for children and TAY were noted in 64 - 73% of these counties, and for adults and older adults in 45% of this group.
- Unmet needs for crisis and pre-crisis services for children, adults, and TAY were identified in 36 - 55% of this group of counties, and for older adults in 27% of these counties.
- Unmet needs for Medication Education and Management for children, adults, and older adults were noted in 27% of these counties and for TAY in 18% of counties.

Large Population Counties (population ≥ 750,000; includes L.A.)

- Unmet needs for 24-hour treatment services for all age groups were identified in 54 - 77% of the 13 large population counties.
- Unmet needs for pre-crisis and crisis services for TAY, adults and older adults were noted in 54 - 62% of large counties, and for children in 46% of this group.
- Unmet residential service needs for adults and older adults were noted in 62 - 69% of large counties, and for children and TAY in 31 - 46% of these counties.
- Large counties had unmet needs in all age groups for most other services:
    - Case management in 31 - 46% of these counties
    - Medication education and management in 23 - 46% of this group,
    - Rehabilitation and support for 23 - 46% of this group, and
    - Vocation services in 31 - 69% of this group.
    - The percentages of large counties experiencing these types of unmet needs were generally greater than for the medium-sized counties.

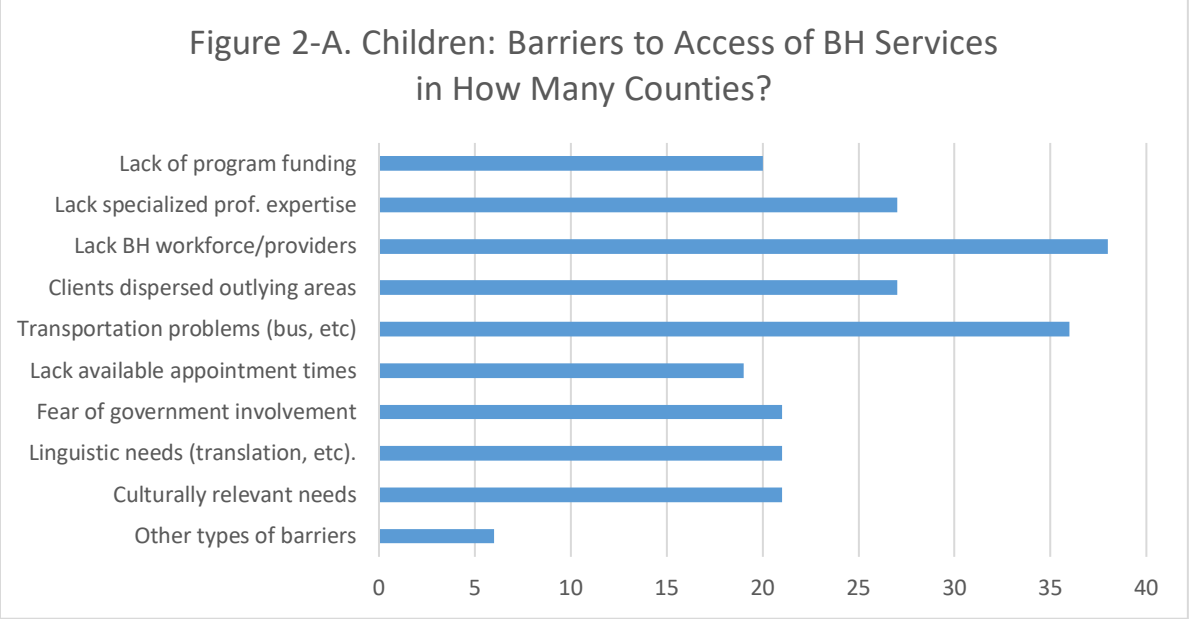
BARRIERS TO MH SERVICE ACCESS

Second, we asked the local boards to identify the major barriers to MH service access for persons who are in need of these services, for each age group listed (child, TAY/youth, adult, and older adult). Respondents were invited to mark as many options as they perceived to be applicable to their county.

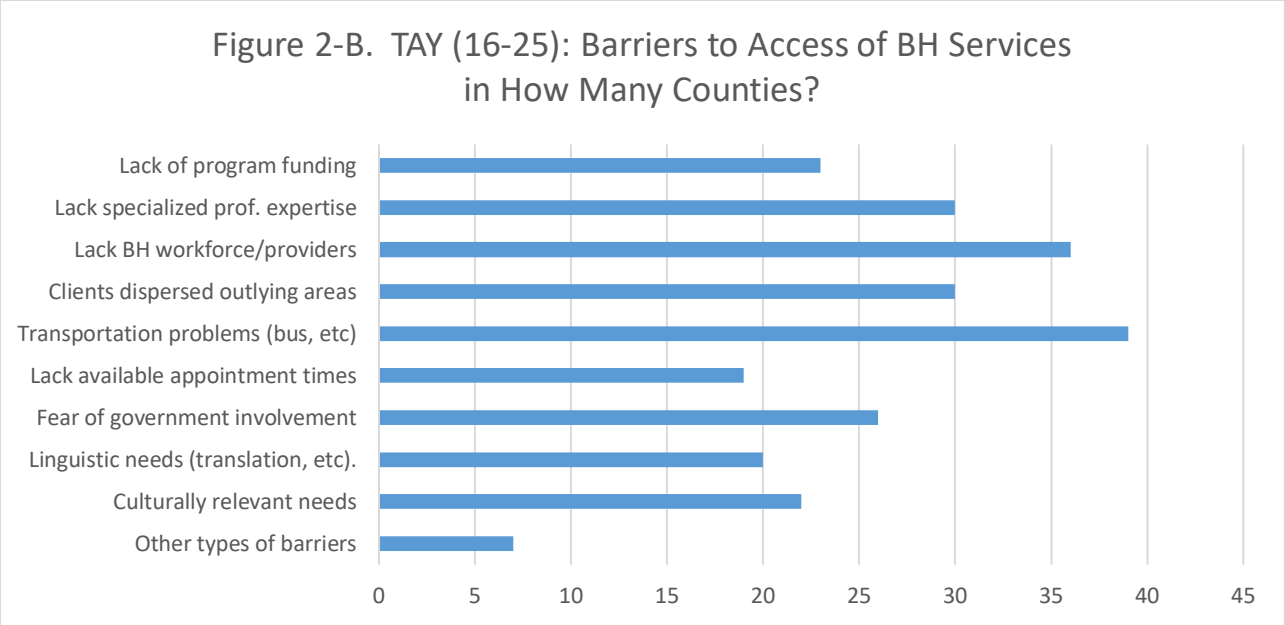
A. Lack of program funding
B. Lack of specialized professional expertise

C. Lack BH workforce/providers
D. Clients dispersed in outlying areas
E. Transportation problems (bus, etc.)
F. Lack available appointment times
G. Fear government involvement
H. Linguistic needs (translation, etc.)
I. Culturally relevant needs
J. Other barrier, specify.

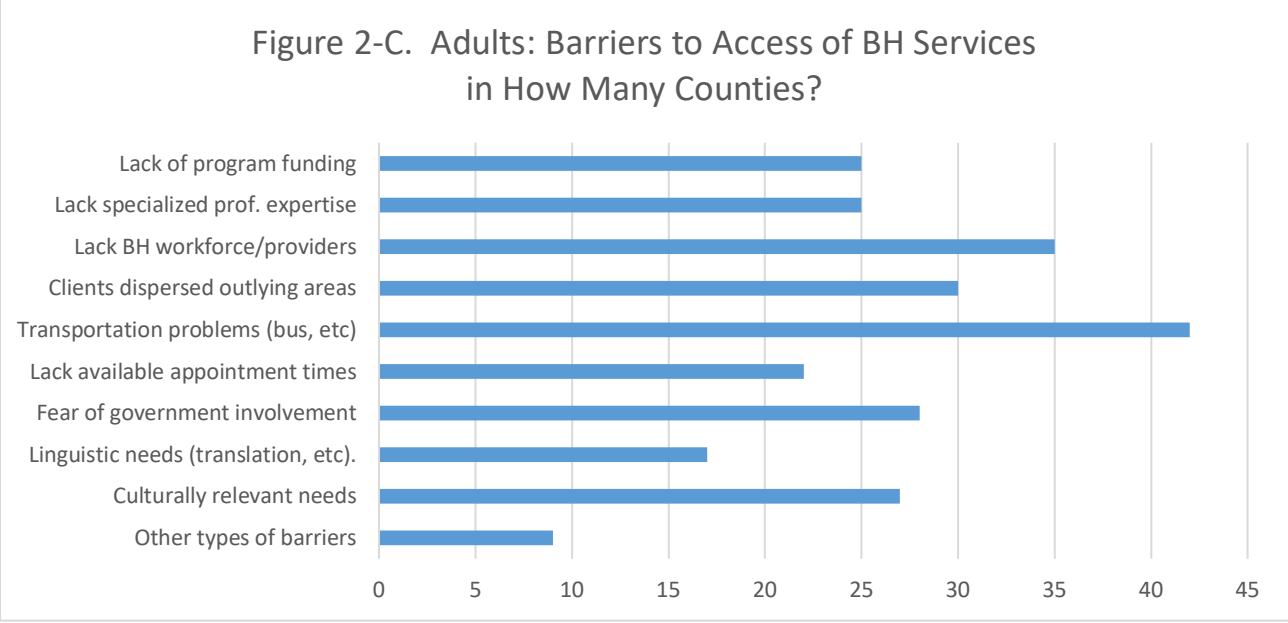
As shown in the figure below for access to children's MH services, the most frequently identified barriers included a lack of workforce and providers, with a related problem being the insufficient number of specialized workforce. The next most common barriers to service are transportation problems likely related, at least in part, to geographic distribution of clients and families in outlying areas. However, many counties identified multiple factors as potential barriers to service access for children.



Substantial numbers of counties identified multiple barriers to MH services for TAY, as shown in the figure below. The most commonly identified barriers for TAY were similar to those identified for children: lack of workforce and providers, lack of specialized professional expertise, and transportation problems that included the geographic distribution of clients in outlying areas.

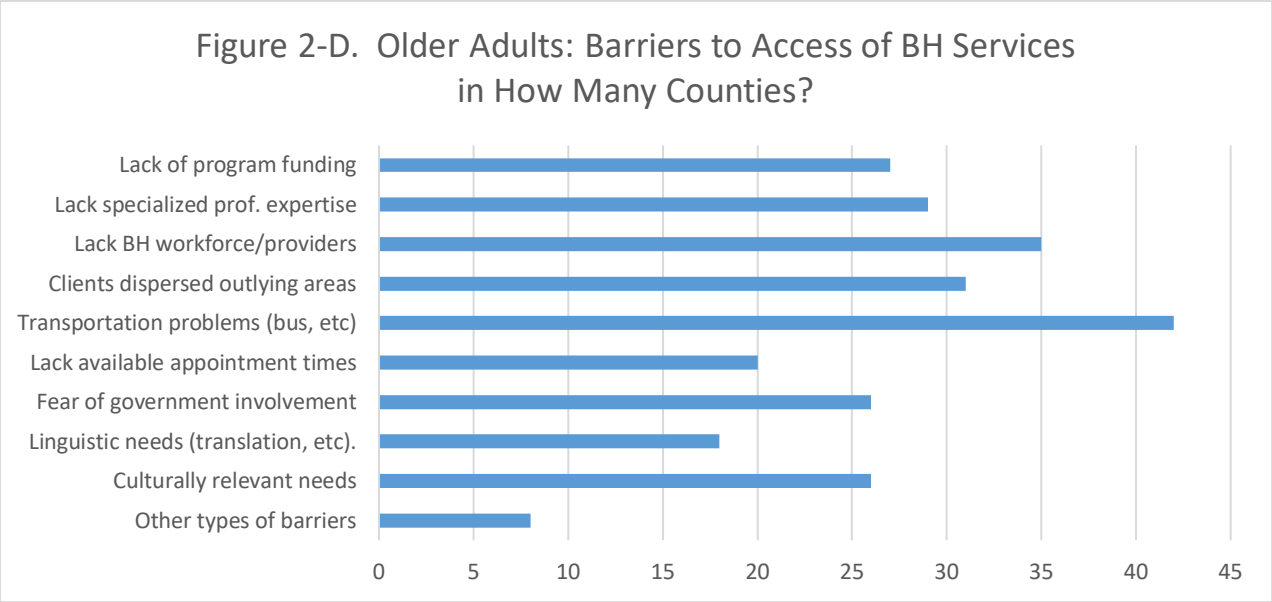


The figure below shows that the barriers to service access for adults are similar to those for children and for TAY, in that the top three items were lack of workforce and providers, transportation, and that clients tend to be distributed in outlying geographic regions. Culturally relevant needs and fear of government involvement were identified in at least half of the counties as being important barriers to access.[9]



[9] Additional barriers that were identified in responses to the "Other" category are discussed on the next page.

As shown below, older adults encountered barriers to service access in many counties in all categories listed, in addition to other types of barriers involving age-related disabilities or challenges, and factors such as stigma and social isolation. The most common barriers cited were transportation, lack of BH providers--especially those with specialized professional expertise, and the geographically scattered locations of clients.



We summarized barriers to service access that were listed by counties under the category of "other." Common items applied broadly to most age groups and included:

- Homelessness and the lack of affordable or supportive housing
- Unmet needs for substance use disorder (SUD) treatment
- Unmet service needs for specific cultural groups including LGBTQ, veterans, and Native Americans
- Lack of acute psychiatry beds, or beds in institutions for mental disorders (IMD), or residential beds in (or near) to the county
- Shortages of MH workforce including psychiatrists, registered nurses (RNs), shortages of therapists trained for specific age groups (age groups in greatest need varied by county)
- Shortages of both multi-lingual and multi-cultural therapists, and
- Stigma regarding MH and/or SUD-related issues.

Next, we examined whether groups of counties (based on population size) perceived different items or issues to be their top barriers to accessing MH services. Most of the small population counties tend to have populations scattered in outlying areas due to the rural nature of the county. This distribution is also characteristic of some mid-sized population counties, many of which are located in agricultural areas of the central valley

and in some of the foothill regions adjoining mountain ranges. Larger population counties tend to have dense urban and suburban core population areas, but may also have some population dispersed in rural or agricultural areas.

Small Population Counties (population ≤ 199,999)

- Lack of BH workforce/providers was perceived as a major barrier to MH access for all age groups in 68 - 76% of these twenty-five small counties.
    - A closely related issue was a lack of specialized professional expertise in 48 - 56% of these small counties.
    - Lack of appointment times affected all ages in 20 - 28% of small counties.
- Transportation problems were a barrier to access for all age groups in 80 - 88% of these small counties.
    - A closely related issue is that clients in all age groups were dispersed in outlying areas in 64 - 68% of these small counties.
- A lack of program funding was a barrier for accessing services for all age groups in 36 - 48% of these small counties.
- Fear of government involvement was experienced as a barrier to access for all age groups in 40 - 64% of these small counties.
- Culturally relevant needs were seen as a barrier to access for all age groups in 24 - 36% of these small counties.
- Linguistic needs were a barrier for children and TAY in 20 - 24% of the small counties but affected adults and older adults in only 8% of small counties.

Medium-sized Counties (population from 200,000 up to 750,000).

- Lack of BH workforce/providers was perceived as a major barrier to MH access for all age groups in 82 - 91% of these eleven medium-sized counties.
    - A closely related issue is a lack of specialized professional expertise to serve children, TAY, adults, and older adults in 45% of these counties.
    - Another closely related issue is the lack of available appointment times for all age groups in 45% of these counties.
- Transportation problems were a major barrier to accessing MH services for all age groups in 64 - 82% of the medium-sized counties.
    - A related issue is that many clients (in all age groups) are dispersed in outlying areas in 45 - 55% of these counties.
- Both linguistic needs and culturally relevant needs were experienced as barriers to access for children and TAY in 55% of this group of counties, and for adults and older adults in 64% of these counties.
- Lack of program funding was a barrier to MH service access for children and TAY in 36 - 45% of these counties, and for adults and older adults in 55 - 64% of these medium-sized counties.
- Fear of government involvement was experienced as a barrier to accessing services across all age groups in 36 - 45% of the medium-sized counties.

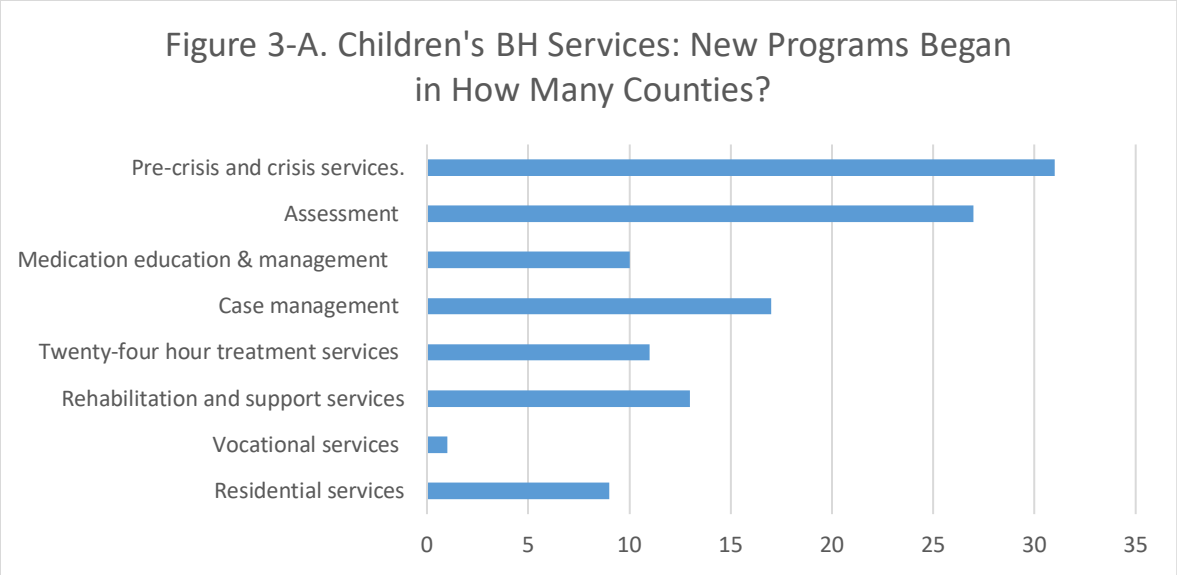
Large Population Counties (population ≥ 750,000; includes L.A.)

- Lack of BH workforce/providers was perceived as a major barrier to MH access for TAY, adults, and older adults in 69% of the thirteen large counties, and for children in 77% of these counties.
    - A closely related issue is a perceived lack of specialized professional expertise for children and adults in 62% of large counties, and for older adults and TAY in 77 - 85% of these counties.
    - Similarly, a lack of available appointment times was a barrier to service access across all age groups in 69 - 77% of the large counties.
- Transportation problems were a major barrier for TAY, adults, and older adults in 85% of the large counties, and for children (or their families) in 62% of this group.
    - A closely related issue is that clients who are TAY, adults, or older adults are distributed in outlying areas in 62% of large counties, but this is also a problem for children (or their families) in 38% of these counties.
- Linguistic needs were a barrier for all age groups in 62 - 69% of large counties.
- Culturally relevant needs were barriers to access for children and TAY in 69% of these counties and for adults and older adults in 85% of these counties.
- Fear of government involvement was experienced as a barrier to access for all age groups in 77% of large counties.
- Lack of program funding was a barrier to services for TAY, adults, and older adults in 62 - 69% of large counties, and for children in 54% these counties.

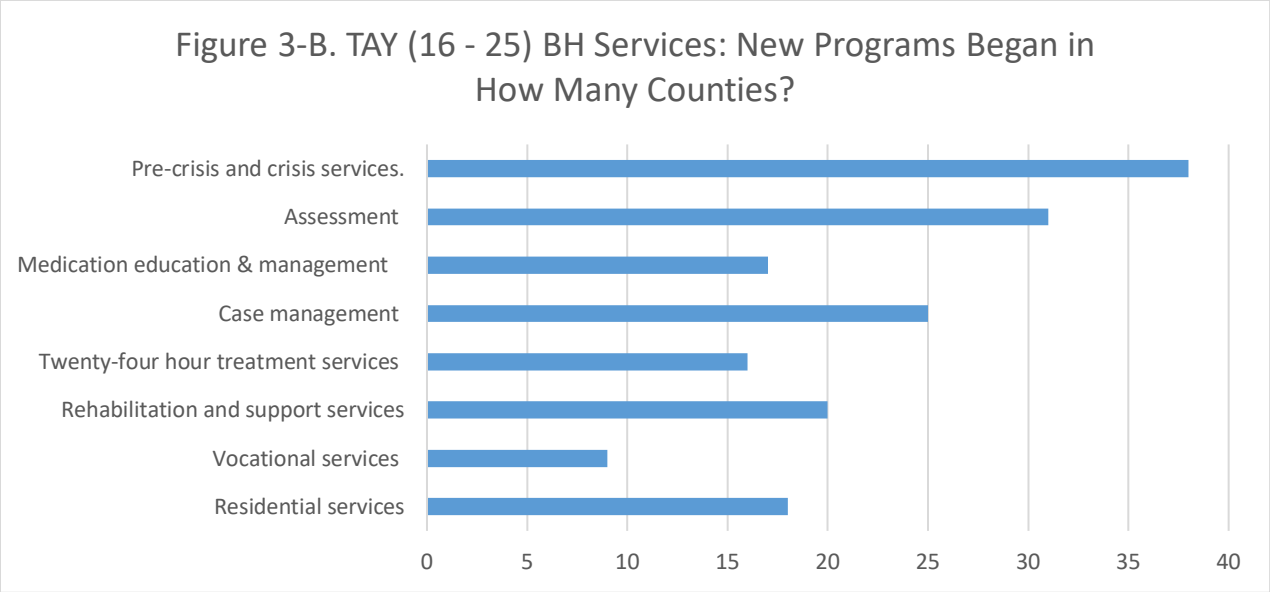
NEW MH SERVICE PROGRAMS

Third, we asked local boards to indicate those service areas for which their county had implemented new programs within the last 3 years, for each age group listed (child, TAY, adults, and older adults).

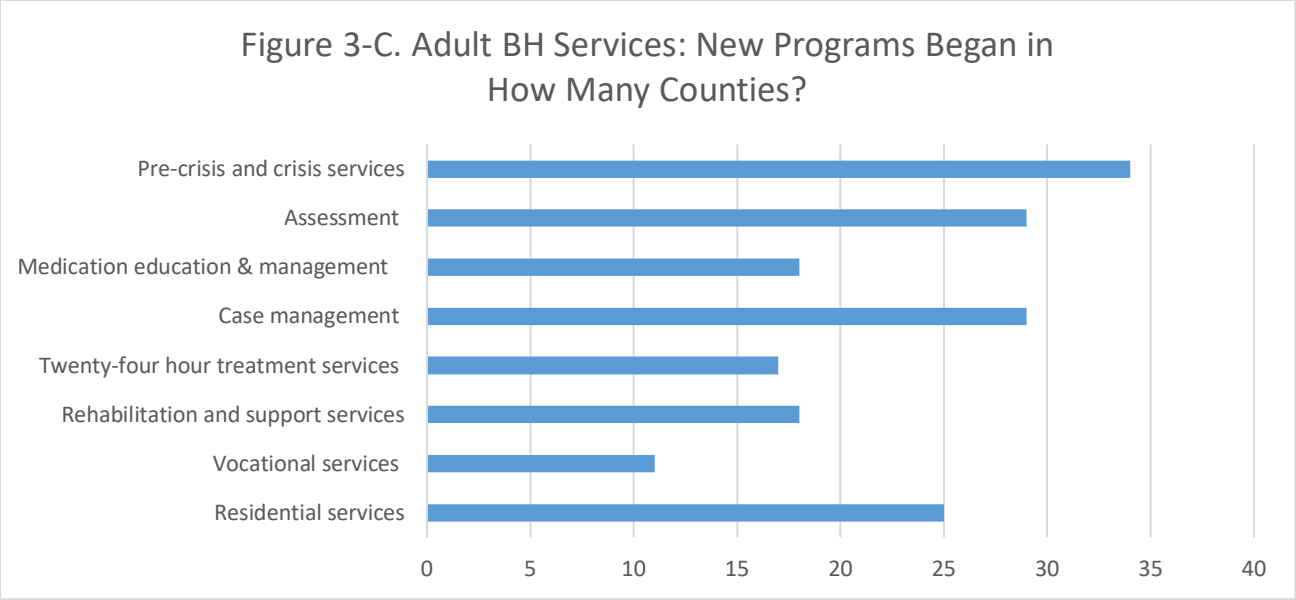
As shown below, new programs in children's services were begun in seven of the categories listed. The most commonly-implemented new programs were in pre-crisis and crisis services, assessment, and case management. Only one county identified new services for vocational training of children or youth under age 18.



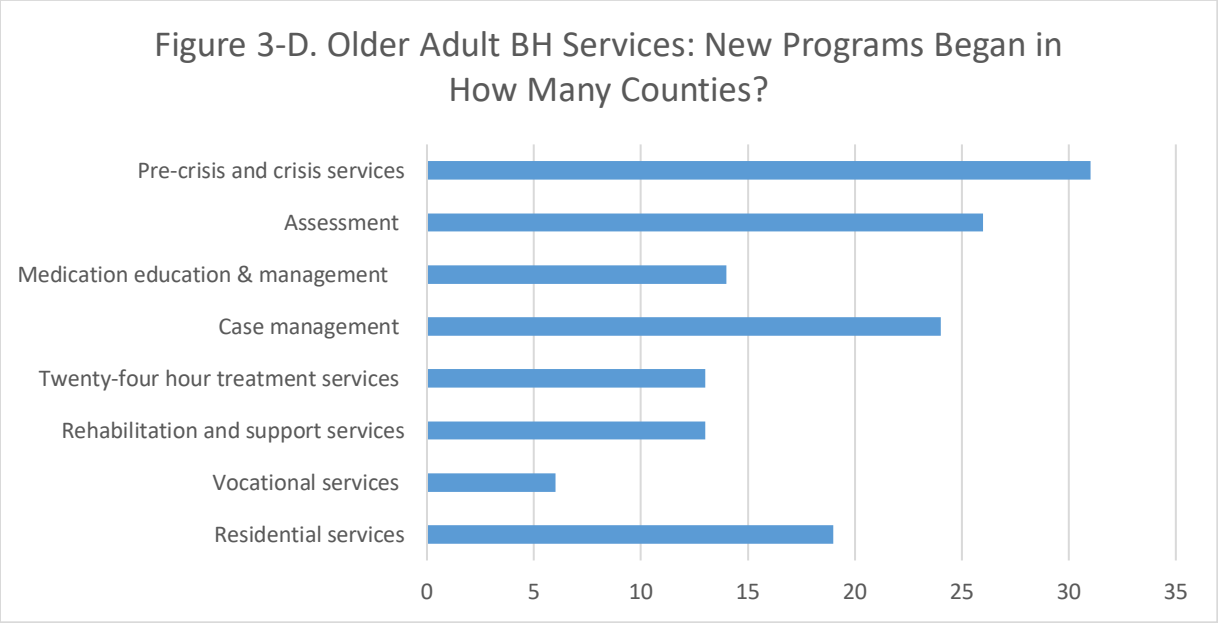
The figure below shows that new programs were begun in numerous counties for TAY in all eight MH service categories listed. The most frequently-implemented new programs were in pre-crisis and crisis services, assessment, and case management. New residential services began in nearly half of the responding counties.



New programs in adult BH services were implemented in multiple service areas, as summarized in the figure below. The most common new adult programs included crisis and pre-crisis services, assessment, case management, and residential services.



The figure below shows that older adult service programs implemented new programs most commonly in the same service areas noted for adults: crisis and pre-crisis services, assessment, case management, and residential services. New programs began in each of the eight service types. However, slightly fewer total counties initiated new programs targeted for older adults, compared with those for adults of any age.



In summary, the above series of figures illustrates the significant extent to which new programs in crisis and pre-crisis services, assessment, and case management were organized and implemented during the prior three years for all age groups. Residential services were initiated to meet the needs of adults, older adults, and TAY with chronic

and/or severe mental illness in multiple counties, indicating the importance of providing residential services across the state. Also, a few counties started to provide residential services for children. Local county-level implementation of all these new programs targeted for various age groups--each of which has differing service needs-- represents a major accomplishment for such a brief, three-year span of time.

Next, we examined the array of new services begun in groups of counties based on their size of population, using the assumption that population size may correlate to available resources or their limitations. We highlight only those services which a notable number (or percentage) of counties in each group implemented as new programs. Those services not highlighted are of course very important in those counties in which they are provided, and may serve as a resource for other counties.

Small Population Counties (population ≤ 199,000)

- About 50% - 65% of the twenty-five small population counties implemented new assessment, and pre-crisis and crisis services for each age group (children, TAY, adults and older adults).
- New services for 24-hour treatment were begun in 20% of small counties for TAY, and adults, but in only 16% of these counties for children or older adults.
- About 30 - 50% of the small counties began new case management services for each age group.
- New rehabilitation and support services were begun for children, adults, and TAY in 16 - 28% of these counties, but only 12% of small counties targeted those services for older adults.
- New residential services were initiated for TAY, adult, and older adults in 25 - 36% of the small counties.

Medium-sized Counties (population from 200,000 up to 750,000).

- Between 70 - 85% of the eleven counties in this group implemented new pre-crisis and crisis services for each age group (child, TAY, adult, and older adults).
- New assessment services were begun in 25 - 35% of counties in this group.
- New case management services for TAY, adults, or older adults were initiated in 25 - 55% of these counties, but began for children in only 18% of this group.
- New services for rehabilitation and support and for 24-hour treatment were begun for TAY, adults, and older adults in 27% of these counties, but new programs in these categories were begun for children in only 9% of this group.
- New residential services were begun for adults in 64% of these counties, for older adults in 45% of these counties, and for TAY in only 18% of these counties.

Large Population Counties (population ≥ 750,000; includes L.A.)

- New services for pre-crisis and crises were initiated for TAY in 90% of the thirteen large counties, and for children, adults, and older adults in 60 - 77% of these counties.
- New 24-hour treatment services for all age groups began in 46 - 70% of large counties.
- New services for assessment of each age group were implemented in 70 - 92% of large counties.
- New case management services for each age group were initiated in 54 - 85% of the large counties.
- New rehabilitation and support services were begun for children, TAY, and adults in 60 - 77% of large counties, but for older adults in only 54% of the large counties.
- New residential service programs targeted for each age group were begun in 45 - 70% of the large counties.

To summarize the above findings, we found it remarkable that so many counties of all sizes, and in all parts of the state, were able to implement new programs in multiple age groups and service areas within the last three years. Greater percentages of large and medium-sized population counties initiated new programs and services, compared to the small population counties. Further study is needed to ascertain whether there are substantial unmet needs in small counties, how many people are affected, and exactly what those needs are. However, we may draw some conclusions from the answers provided to question number one about under-served and unmet needs in small counties, compared to those for counties with large or medium-sized populations.

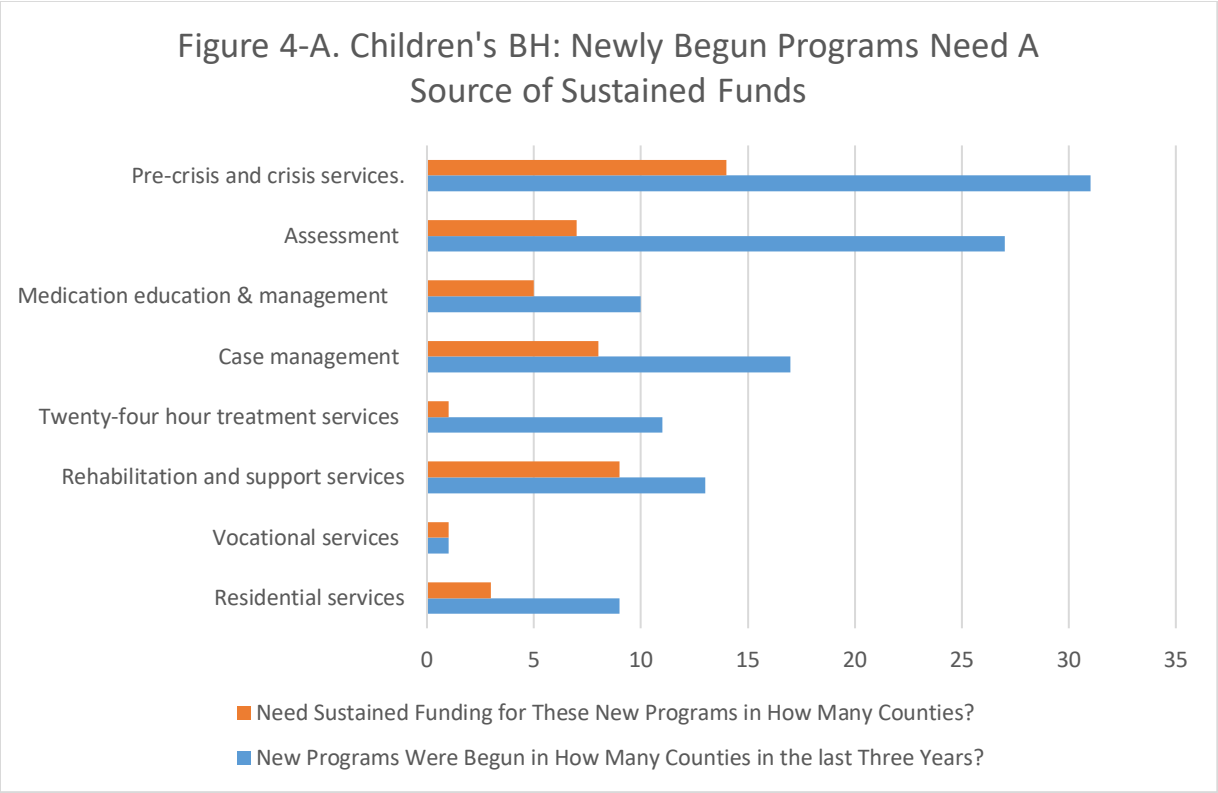
TEMPORARY FUNDING OF MH PROGRAMS

Fourth, we asked local boards to indicate whether any of the services (for any of the age groups listed) are funded with temporary (one-time, time-limited) funding for which their county is seeking a sustainable fund source to continue services (for children, TAY/youth, adults, and older adults).

The next series of figures show the numbers of counties that implemented new programs in each service category (as shown in the previous section) and indicate the number that identified a need to find sustainable funding to replace one-time funding.

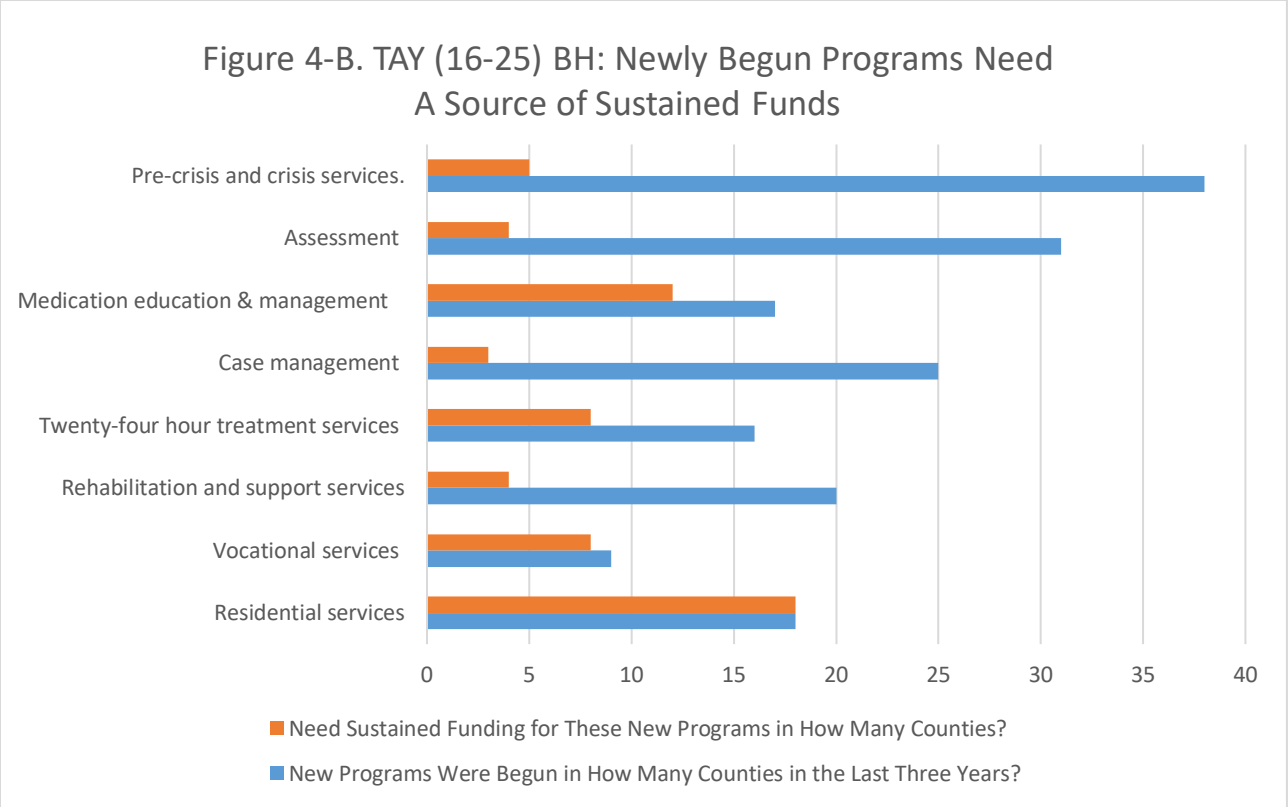
The figure below shows the MH service programs that were begun in the last three years for children in each of the eight selected categories and indicates which of those need a source of sustained funding. The most frequently identified new programs in

need of sustained funding are pre-crisis and crisis services, followed by rehabilitation and support services and case management.



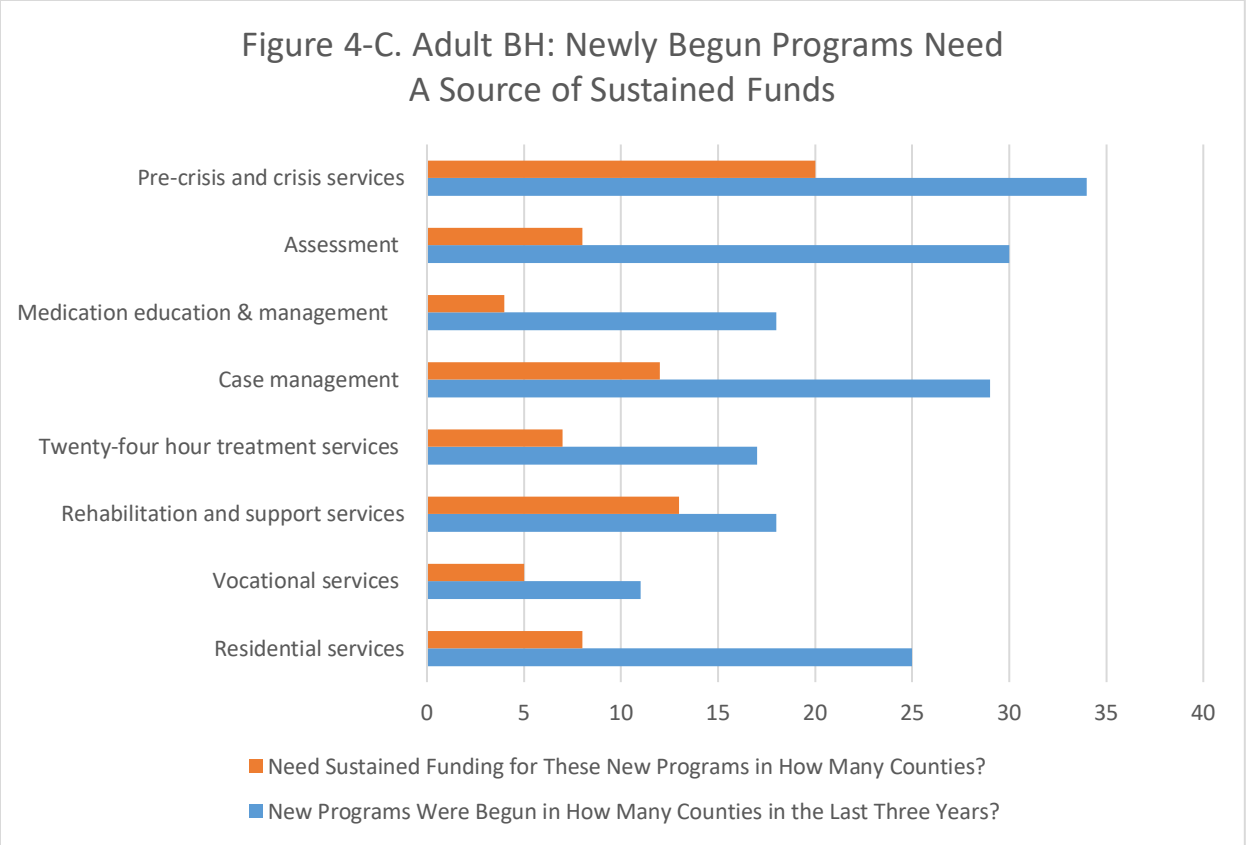
Next, we examine comparisons for MH programs for other age groups. The figure below suggests an even greater need for sustained funding for all eight categories of MH services for TAY. Sustained funds are definitely needed for 100% of both vocational and residential services currently provided. Many counties have only recently increased their capacity to provide crisis and pre-crisis services, assessment, and case management for TAY, including mobile crisis teams that are able to meet the youth wherever they are in the community.

A source of sustained funding is needed for TAY programs in all eight categories shown that were begun within the last three years. The greatest number of counties identified residential services, medication management and education as in need of sustainable funding, followed by twenty-four hour treatment services and vocational services. In summary, sustained funding is needed in all eight service areas shown, but are urgently needed for 100% of both vocational and residential services currently provided for TAY.

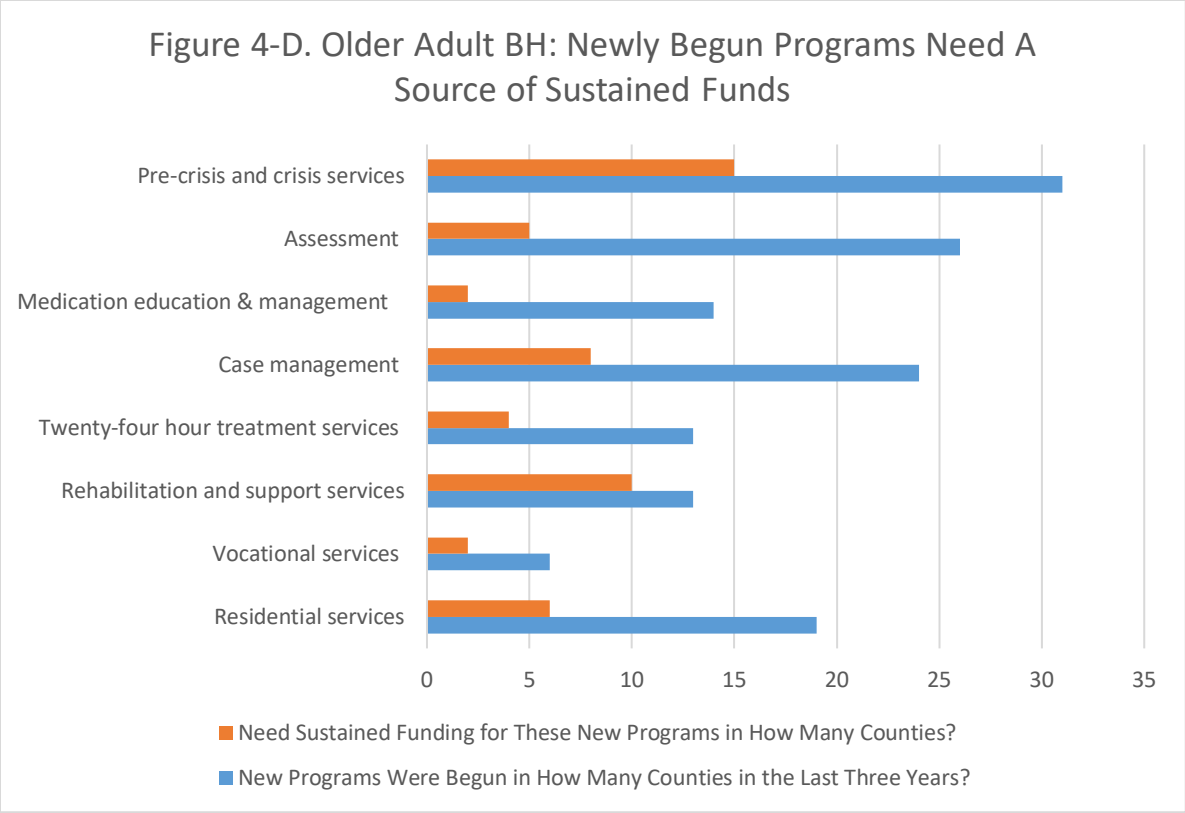


Similarly, the figure below shows that newly implemented programs for adults in all eight service categories need sustained funding. The greatest number of counties identified residential services, medication management and education, followed by twenty-four hour treatment services and vocational services.

Furthermore, at least twenty counties indicated that newly-implemented adult BH programs for pre-crisis and crisis services need sources of sustained funding. In addition, there are significant needs to continue funds for rehabilitation and support services, followed by case management. But all eight categories of adult BH services were identified as needing sustained funding for the future, including residential services. Residential services and housing are much in the news lately due to substantial statewide needs for Adult Residential Facilities (ARFs) and other forms of housing for those with chronic or severe mental illness.



Next, we can make an approximate comparison of adult programs (shown above) and those for older adults (shown below). There are similar types of services for which new programs were instituted, in similar numbers of counties and which also need to obtain sources of sustained funding. Crisis and pre-crisis services, assessment, case management, and medication management are all areas which have increased to meet MH needs of adults and older adults. Other unfunded or underfunded critical needs include residential services for both adults and older adults with MH needs.



In recent years, older adults' MH needs have been found to be under-served and in need of services designed to meet the specific needs of older adults. Therefore a number of new programs were funded and implemented across the state. All eight categories of MH services for older adults need a source for continued funding, with the greatest number of counties identifying needs for continued funding of pre-crisis and crisis services, rehabilitation and support services, and case management.

Not surprisingly, there is a substantial need for various forms of residential services for older adults with chronic mental illness. And there is great need for both increased and sustained sources of funding, as there have been many instances of seniors (those with and without MH challenges) being forced out of their long-term homes and other living arrangements by rising rents and related costs. The numbers shown above may be 'undercounts' of the true needs,[10] taking into account the increasing numbers of elders.

One surprise may be that the need for vocational services for older adults may be greater than previously expected, but few older adults are able to live on social security or disability alone, particularly in California. And, some older adults are not eligible for social security due to having contributed little or no lifetime earnings to their eligibility for

[10] Undercounts likely are attributable to non-response from eight counties, including some with large or medium-size populations and a few small-population counties.

social security, because of factors such as BH (or other) disabilities that prevented gainful employment, or non-U.S. resident status earlier in life.

In conclusion, we can see from the data in the above series of figures that a large proportion of newly begun BH services or programs, in many counties, did not have an identified (or secure) source of sustained funding for programs serving clients in any age group. The limitations of this data are that it's possible that not all counties have fully recognized that some of their new programs will need additional funding to continue operating, due to the complexities of county budgeting processes or other 'in-process' pending application for new funding.

One explanation for some of these findings (depending on the individual county) is that a county did not implement new programs that are in need of sustained funds, but that their population still has important, unmet service needs in those areas, so they may (or may not) need additional funding. Or, a particular county may indeed have adequate funding for their new programs, and/or their existing programs. Only one county, Los Angeles, made statements that indicate adequate funding for their current services, and that no current services were likely to be terminated due to lack of funds. Their experience many be unique.

All of these limitations may contribute to a significant underestimation in our data summary regarding the full range of needs for sustainable funding to continue providing these important MH programs and services. These findings lead to a policy statement supporting a compelling and urgent need for the legislature to continue funding for these vital programs and for MHSA[11]-funded programs. It is essential to ensure the continuity of services and programs for the highly vulnerable populations of individuals affected by serious mental illness and serious emotional disturbance and for the sake of their families and loved ones.

IDENTIFICATION OF MH PROGRAM PRIORITIES

Fifth, we asked local boards to answer the following question regarding their county's highest priority need (in 25 words or less). "If you could have one new program or facility or resource within the next three years, what would be your highest priority need?"

The most frequently-received answers involved some type of physical facilities for placement of mentally ill persons, running the entire continuum of community-based supportive housing, emergency housing for those who abruptly lost their housing, adult residential facilities, board and care, respite care, with the range to include facilities capable of providing more direct and intensive BH care, whether short or long-term.

[11] MHSA = Mental Health Services Act program, enacted in 2004. See pages 31-34 of this report for information.

More BH care-providing facilities are needed that linked with (or within) hospital emergency departments, crisis stabilization units, crisis residential units, psychiatric hospital facilities (PHF), either freestanding, or as part of a residential substance use treatment facility, or associated with the local general hospital.

Some of the facilities needed are those that can assist populations with special BH needs; e.g. foster youth with MH treatment needs appropriate to a Short-Term Residential Treatment Program (STRTP)[12], or older adults with physical medical challenges or disabilities who also have chronic or severe mental illness. The major emphasis stated over and over again is the need for all of these facilities to be situated within the county, or within a manageable driving distance given the local geography and winter weather conditions. Some comments elaborated on where the desired services and facilities need to be located to serve specific communities of that county.

Aside from facilities, other comments emphasized the importance of providing MH services where they are most needed within a county, and when they are needed (especially when existing crisis assessment services are not available 24/7). Hence, there are needs for: mobile psychiatric emergency response teams (PERT), assisted outpatient treatment (AOT), provision of jail treatment services and court-ordered diversion programs, including Behavioral Health Treatment Courts. These programs bring MH services to the person in crisis wherever they are found in the community.

All of these needs were described in small population counties as being areas of urgent and compelling priority for their populations. Many commented on the lack of crisis treatment or in-patient treatment facilities for children and adolescents under 18. Many of the medium and large population counties also specified priority needs in all of the forgoing service and facility needs described for small and rural population areas.

Many counties identified their top priority was to fill positions for psychiatrists and MH nurse practitioners capable of prescribing and evaluating client responses to medications for children, adults and older adult populations. Some responses indicated that tele-psychiatry and tele-health applications were not adequate to the need and may not provide the most effective delivery of services for those who prefer or respond better to services provided on a personal, face-to-face basis.

Several counties also described a need for more addiction treatment providers and programs in their counties. Others described a need for more coordination between the provision of MH/BH services in schools and those provided to youth outside of school.

[12] Group homes for foster youth were largely transitioned into a new facility type named Short-Term Residential Treatment Programs (STRTP), which are designed to provide short-term, specialized, and intensive treatment and intended to be used only for children whose needs cannot be safely met initially in a family setting.

Mental Health Services Act (MHSA) and Its Program Components

Background and Definitions of the MHSA (below) are excerpted from a description contained in the Executive Summary[13] of a 2018 Report by NAMI California.

Proposition 63, the Mental Health Services Act, was passed by voters in 2004. At the time, California was struggling to meet the mental health needs of its residents. A 2003 report by the California Mental Health Planning Council estimated that as many as 1.7 million Californians were not receiving the mental health services they needed. As many as 80% of children with mental health needs were undiagnosed or unserved. The consequences of untreated mental illness were seen through health systems, school systems, and the criminal justice system. Therefore, the Act was designed to reduce homelessness, incarceration, and preventable hospitalizations, and to increase access to behavioral health services.

The Act imposes a 1% tax on personal income over $1 million and places revenues into the Mental Health Services Fund. Counties receive annual distributions from the Fund, and are responsible for providing community-based mental health services. Program expenditures align with the five core components of the Act:

Community Services and Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, and wellness focus. This programming applies concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. [Full Service Partnerships are another example of CSS-funded programs].

Prevention and Early Intervention (PEI) is intended to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs.

Innovation (INN) projects aim to increase access to underserved groups, increase the quality of services, and promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan.

[13] 2018 MHSA County Programs: Services That Change Lives. A report created by NAMI California 2018, pages iii-iv. Downloaded from: https://static1.squarespace.com/static/5ab2d59489c1724bd8a2ca78/t/5b7de7d370a6adca27a8a959/1534978017856/NAMI+CA+2018+MHSA+Rept_072318_03_FINAL.pdf

Capital Facilities and Technological Needs (CFTN) works toward the creation of facilities that are used for the delivery of MHSA services to mental health consumers and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and most cost-effective services and supports for clients and their families.

Workforce Education and Training (WET) is intended to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes. They work collaboratively to deliver client- and family-driven services, provide outreach and services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

The CSS, PEI and INN components are funded through ongoing revenue into the MHSA Fund. Per provisions of the MHSA, the Workforce Education and Training, Capital Facilities and Technological Needs components were funded in the early years and at present are not actively funded through MHSA revenues. Although counties can transfer some CSS funds for these programs each year, essentially the availability of any funding has ended for Workforce Education and Training and Capital Facilities and Technological Needs.

We asked local boards whether there is still a need for any (or all) of these three components in your county?

All but one of the 50 counties replied in the affirmative.

We also asked them to rank these MHSA components in priority order of need, #1 being highest.

____ Workforce Education and Training
____ Capital Facilities
____ Technological Needs

Of 25 'small-rural' and 'small' population counties, eighteen counties identified Workforce Education and Training as their #1 priority, seven counties identified Capital Facilities as their #1 priority, and 5 counties identified Technological Needs as #1. A few counties gave #1 priority ratings to all three categories. The remaining votes for the

second and third priorities were roughly evenly divided among Capital Facilities, Technology, and Workforce needs.

The numbers were combined for the 10 'medium' sized counties and the 12 'large' counties, because there were no discernable differences between the responses from either of these two groups, and the numbers in each group were relatively few. The priority rankings from this combined group of counties were almost evenly divided among the three MHSA components, with a slight lead for WET funding priorities.

The major take-home conclusion, as evidenced in supplemental comments, were that all three MHSA components are still urgently needed in nearly all counties. The most useful part of this exercise was getting the local boards and stakeholders to evaluate their community needs and priorities for these MHSA programs. Their responses emphasized the ongoing importance of all three of these MHSA components and a compelling need for their continued funding.

We then provided the option for respondents to give examples that illustrated the specific needs for continued funding under those MHSA program components (in 25 words or less). Details of these responses are provided in Appendix IV. Brief summaries follow.

Workforce, Education, and Training Needs

For counties generally, including those designated as 'Health Provider Shortage Areas', loan assistance programs under WET facilitate recruitment and retention of qualified clinical and administrative MH/BH professionals.

One county responded: "We are unable to keep up with the rate of technological advancement in terms of costs and government red tape." Others commented that "there is a dearth of workforce qualified to implement the technological and capital facilities components and put them into service. Therefore, we need to support ongoing training of staff, with continued enhancement of information technology capacity."

Orange County quoted the California Future Health Workforce Commission's report, Meeting the Demand for Health:[14] "California is in a real crisis shortage of mental health professionals including prescribers and non-prescribers. We see a real need for continuing with community training on evidence-based and community-defined practices to 'treat to target', specialist training, including peer certification and primary care providers to expand the primary care integration to the whole person care approach. We need to have a robust training system to meet the demand." This conclusion was also supported by comments received in Data Notebooks from several other counties.

[14]This report was released in February, 2019, by a statewide commission of 24 health experts that was co-chaired by Janet Napolitano (President, University of California) and Lloyd Dean (Dignity Health CEO and President).

Capital Facilities Needs

Several counties identified a need to improve "our facilities to expand crisis and triage services" including crisis stabilization unit expansion, and crisis residential services. Multiple counties identified needs for all types of residential care, including adult residential facilities, permanent supportive housing, 'Board and Care' programs, and facilities for older adults, and emergency housing.

Some counties described a need to locate newer buildings suitable for offices and other service delivery needs that met accessibility and ADA requirements and other zoning or legal criteria. "Capital Facilities funds can be extremely valuable when leveraging other funding for building projects."

Technological Needs

Fully two-thirds of the comments received identified challenges related to the software for electronic health records (E.H.R.)[15], such as lack of flexibility or ease of use, lack of ability to easily gather information for mandated reports, problems with access, timeliness, and the need for interoperability so that different systems "can speak across departments" and facilitate BH integration. The rate of technological advancement is perceived as a challenge to county information technology capability in terms of costs and government "red tape." Others described their needs for technological assistance to improve productivity and decrease barriers (e.g., tele-psychiatry/ tele-health, dictation software, direct messaging to E.H.R. and treatment submission). One large county identified a need for a centralized phone system that can better assist individuals with referral to appropriate services and making appointments with providers in different service specializations.

EXAMPLES OF SUCCESSFUL MHSA PROGRAMS

Finally, we asked local board members if they had a particularly successful program funded by CSS, Innovation, or PEI funds that they would like to share in this report.

We asked respondents to keep their responses brief (<150 words), as there are literally hundreds of MHSA-funded programs in counties across the state, and a comprehensive inventory is published elsewhere every year by NAMI-California.

We received a total of 44 'Yes' responses from Data Notebook reports representing 45 counties plus the Tri-Cities Mental Health Plan.[16] They provided a multitude of varied examples of programs that are succeeding. (See Appendix V for detailed listing). Types

[15] We abbreviate this as E.H.R. because omitting the period results in autocorrect changing it to HER.

[16] Out of a total of 49 Data Notebook reports received that represent 50 counties and the Tri-Cities MHP. A few chose not to provide examples of their MHSA programs. See Appendix V for detailed examples, separated by groups according to county population size (small, medium, and large, as previously defined.

of MHSA-funded programs and services varied from initiating (or expanding) mobile crisis response teams, graduated housing programs that had the goal of moving the person eventually to independent living, 'Strengthening Families' (A First Five program), outreach and support programs that included community gardens, animal assisted therapy, and many other types of programs. In brief, all of these programs seemed designed to help fill a variety of needs specific to the community.

These programs have been developed to meet local needs and local cultures, and many are 'innovative' and flexible approaches regardless of whether the program was supported by "Innovation" funds or not. Successful programs represent accomplishments that we should celebrate and share across the state so that other communities can learn from—and perhaps implement—features of these successes.

SUMMARY OF MAJOR FINDINGS AND CONCLUSIONS

The Data Notebook for 2018 took a close look at impediments to accessing the MH services that are required by law in WIC section 5600.4. The Planning Council asked Advisory Boards of each county to work with their local Behavioral Health Director in all fifty-eight counties and the two city-based MH programs to review their MH services. The objectives were to identify unmet needs, barriers to access, and potential gaps in program funding. The Planning Council asked a series of survey questions so that the counties and the local boards could give their feedback. The outcome was that fifty counties and one city program submitted responses in their 2018 Data Notebooks. During the course of evaluation and study of those results, we came to several conclusions which have important policy implications. Subsequently, members of the Planning Council identified potential solutions and policy recommendations which will be discussed in the conclusions. First, the major findings and results of our analyses will be summarized below.

Categories of MH Services Most Frequently Noted as Unmet and Underserved

Our strategy for evaluating unmet MH needs was organized by the categories of service that California counties are required to provide by California's Welfare and Institutions Code (WIC)[17]. The WIC statutes further defined the specific populations of children, adults, and older adults that are eligible for each of the required specialty mental health and related rehabilitation and support services listed below:

(a) Pre-crisis and crises services	(e) Twenty-four-hour treatment services
(b) Assessment	(f) Rehabilitation and support services
(c) Medication education, management	(g) Vocational services
(d) Case management	(h) Residential services

[17] W.I.C. 5600.1, 5600.4, and other sections; as established in 1991.

The summarized county response data showed that there are substantial unmet and underserved MH needs for multiple service categories and for most age groups. The categories of MH services that were most frequently identified as unmet or underserved were analyzed according to major age groups that showed similar needs.

The unmet MH service needs were similar for children and TAY, as shown below, in order with the most frequently identified needs first:

- twenty-four hour treatment
- residential services
- pre-crisis and crisis services
- vocational services (for TAY only).

The unmet MH needs for adults and older adults were similar and include the following, shown in order with the most frequently identified needs first:

- residential services
- twenty-four hour treatment
- vocational services
- medication management and education
- pre-crisis and crisis services.

In addition, unmet needs for crisis-related services for both adults and older adults were identified in more than half of the responding counties. Unmet needs for vocational services were noted for both older adults and adults in at least half of the counties.

Including the information volunteered from comments or 'other' items, our survey found substantial unmet or underserved needs in nearly all counties for the continuum of care[18] for serious mental illness and those in crisis. This continuum includes needs for respite care, crisis-stabilization, crisis-residential, and various types psychiatric hospital facilities able to meet needs of specific age groups (children, adolescents, adults, and older adults with complex needs), and adult residential facilities (ARFs).

New Programs: Good News and Bad News

One important conclusion of this report is that, using targeted program funding, a truly remarkable number of new programs have been implemented within the last three fiscal years in counties large and small across the state. That represents a substantial undertaking of personnel, policy, inter-agency coordination, and administrative support

[18] Although we use this terminology, strictly speaking there is not a well-defined or standardized continuum of care established for specialty mental health services. In contrast, for example, for the Drug Medi-Cal Organized Delivery System (DMC-ODS), there is a continuum based on the American Society of Addiction Medicine (ASAM) criteria which are nationally recognized and based on extensive research.

at both the state and local level. The successful implementation of all these new programs should be celebrated as major accomplishments.

New programs were initiated in all of the major MH service categories previously defined. The answers most commonly received from the responding counties showed that they had begun new programs for all age groups. These new programs generally corresponded to the population and MH service needs identified as unmet or under-served in the previous section. The most frequently-cited new programs provided the following categories of MH services:

- pre-crisis and crisis services
- assessment services
- case management, and
- residential MH services (with the exception that only a few counties had begun such services for children).

However, those new services and programs are at risk, because funding which was allocated on a time-limited basis is running out (or will run out) for many new programs, particularly crisis and pre-crisis services, assessment services, and case management programs that were implemented with grants or other funds. For example, initial start-up funds from the Investment in Mental Health Wellness Acts of 2013 and 2017 provided funding for crisis services[19] for adults and children, respectively. Other types of services found to be at risk due to funding concerns included recently-begun programs for rehabilitation support, residential services, medication management, and vocational services for TAY, adults, and older adults.

The responses from counties of all sizes indicate that there is an urgent, compelling need for the state legislature to establish or identify continued, sustainable funding for each of these critical MH service areas—perhaps as part of a state-county partnership. Intervening early in serious mental illness not only helps the individual begin to recover earlier and avoid an exacerbation of the illness, but in the long run saves money for the state and local agencies, especially if hospitalization can be avoided. The need for sustained funding for crisis services signals an impending statewide emergency in the public BH system if immediate steps are not taken to address funding issues. Of similar concern, stable funding is essential for the case management, residential treatment, and rehabilitation services that are key supports for many individuals in MH recovery.

These findings need to be considered in the context of the larger picture. Several factors challenge the capacity of the public MH system to meet the demand for services, including changes in state population. Most significantly, Medicaid expansion[20]

[19] Note that provision of crisis and pre-crisis services has been mandated in the WIC since 1991.

[20] Affordable Care Act, 2010.

increased the numbers of people who became eligible for Medi-Cal and those newly eligible for Medi-Cal funded Specialty Mental Health services, thereby stressing an already resource-strained system. Furthermore, many advocates believe that MH services have been substantially underfunded for at least the last half century when compared to traditional physical health services. All these factors, taken together, lead to the conclusion that our new programs, though much needed and laudable, are still not sufficient to meet all the needs nor to mitigate the overall impact to society in lost productivity and quality of life due to untreated mental illness.

Therefore, it is not surprising that that the data and findings of our present report can be summarized in the following 'take-home' message.

> After several years of implementing new services, programs, and funding across the state public BH system, there are still multiple unmet needs and underserved populations across all age groups and for all service types in most counties.

Identification of Major Barriers to Mental Health Access

Our survey further endeavored to determine the perceived barriers to accessing MH services. We examined a number of factors, and gave respondents the opportunity to volunteer other items not specified under the major headings. We broke down the analysis by age groups. Perhaps surprisingly, the answers were nearly identical across all age groups, with priorities shifting only slightly between the different age groups for some of the less frequently chosen items.

For all age groups, and in most counties, workforce issues and transportation problems were identified as being among the top two barriers to accessing MH services. Closely related to lack of sufficient numbers of BH workforce is that there is a lack of specialized expertise of several types. For example, specialized expertise is important for meeting the needs of specific age groups that have unique developmental or medical challenges, or to meet the needs of cultural groups. Other barriers to access included the lack of program funding for a variety of types of programs, and the problem that parts of a county's service population is distributed in outlying or rural areas. These problems are both closely related to the transportation issues mentioned and to a potential decision to open satellite offices for some services.

Fear of government involvement was another barrier that deterred a potential client's seeking of MH services. These fears were noted in comments regarding concerns about a client's or family member's potential involvement with immigration authorities, past involvement with police, and other fears related to prior experience with governmental authorities, including past involuntary holds.

Several barriers to MH access were volunteered under the 'other' category, and can be considered 'crosscutting issues' under unmet MH service needs:

- homelessness and the lack of affordable or supportive housing
- lack of adult residential facilities (ARFs)
- lack of SUD treatment facilities and programs, and
- lack of psychiatric hospital, institutions for mental disease (IMD), and other acute care facilities within the county.

Some of these items under barriers to access need to be considered separately and in more detail because they further contribute to unmet MH service needs. Several of these issues draw on a variety of complicating factors related to social policy and decisions related to how governmental programs are funded. There are areas of potential competition for resources of personnel, expertise, and for specially designated fund sources.

Continuum of Need for Housing with BH Supports and for Affordable Housing

When a person recovering from serious mentally illness is discharged from an acute care facility, that individual (or their family, or a case manager) faces immediate challenges to identify where they can or should live, including how to pay for it. The range of need includes housing facilities for those who need more supportive care as in adult residential facilities (ARFs), and those preparing for independent living.

But what happens when an individual recovers sufficiently to be ready to live in housing which does not provide BH services (and therefore is not part of the BH system)? Then the person 'in recovery' encounters limited options due to the statewide shortage of affordable housing. Safe and affordable housing is essential for an individual to maintain their recovery. It seems that the continuum of need for safety and shelter, does not always match the actual continuum of care systems. California's housing crisis presents substantial additional challenges to this situation.

BH Workforce Needs and Challenges

Our survey findings refined and underscored our understanding that there is a shortage of BH professionals in multiple categories in counties across the state. Many of these professionals are aging, and some plan to retire. Thus, there is an urgent need to continue recruiting and training their replacements. That process takes years of preparation, up to nearly a decade for the most specialized BH professionals such as psychiatrists with subspecialty certification. These shortages of behavioral health professionals prevail in a state already suffering from insufficient numbers of physicians, therapists, advanced practice RNs, and other health care workers in nearly all specialties. These shortages are expected to worsen in the next decade.

And, if long-established trends continue, rural and small-population counties likely will continue to be critically underserved, as many small counties already are technically identified as being both medical specialty shortage areas (MSSAs) and health provider shortage areas (HPSAs), with corresponding shortages of BH professionals. Such shortages not only impact the ability to provide services across multiple areas of professional expertise, but adversely affects the ability to provide well-coordinated care between primary care and behavioral health for optimum client recovery.

One concern is that, at a time of projected BH workforce shortages, our aging population may present increased numbers in need of BH services. Often, these older clients may have MH and/or substance use treatment needs within a context of physical health challenges and disabilities. There are relatively few practitioners available with geriatric expertise to meet both the physical and behavioral health needs of older adults.

Another workforce category emerged as an area of concern in responses to the MHSA questions about 'Workforce' and 'Technological Needs.' Some counties do not have adequate numbers of staff who have the professional expertise for the administrative, medical-billing intensive, data-intensive, and information technology-intensive tasks necessary to meet state and federal regulatory requirements and the related compliance and audit procedures. This leads to another 'cross-cutting' issue: procedures that counties must implement are so complex that not only do they require a highly specialized workforce, but reform of the overlying system should be examined.

<u>Management of Data Collection, Billing Procedures, Audits, and all the Regulations</u>

At present, billing procedures for most BH services requires documentation <u>for every minute billed</u>. Not only are such procedures tedious, but they are so complex that some services are disallowed years after they were initially approved and paid. This is part of an opaque and laborious audit system which takes up substantial county staff time with repeated audits. Not all state or federal-level audit staff have expertise in either MH or substance use treatment services, nor with the complex medical and social needs of BH clients.

County budgets are much less predictable when previously billed 'paid-claims' are disallowed, resulting in the counties (or other providers) having to return significant amounts of the money received. It would be far preferable if there were time-limits to such reversion, that the intertwined finance and regulatory systems could be simplified, and that sufficient technical training were provided to staff so that the complex billing documentation could be done correctly. These are important issues for understanding how much funding—and sustainable or reliable sources of funding—are needed for BH services and programs to operate.

Furthermore, counties are required to collect increasingly large amounts of data items about each client, their diagnoses, and the services received due to state or federal regulations. These data and documentation demands are separate from the actual expertise and qualifications to provide clinical and therapeutic services, but are part and parcel of the human skills infrastructure (as well as hardware and software) necessary in our modern society for the operation of our departments of behavioral health. As such, these are unavoidable costs to the system, and should be adequately funded up front. Otherwise, unplanned costs will vitiate funds intended for direct client services.

Policy Recommendations of the California Behavioral Health Planning Council

The following recommendations are offered from our analysis of the cumulative responses.

ADULT RESIDENTIAL FACILITIES AND OTHER HOUSING

When an individual has a likely possibility of going into an acute setting, or has completed an inpatient psychiatric stay, the individual may need an extended stay in a lower level of care such as an Adult Residential Facility. While the individual may not meet medical necessity for a high level of inpatient care, they may not yet be ready to go back home, or he/she may have no home to go to. If adult residential beds were more available across the state, the level of homeless persons with mental illness would surely drop.

One current issue is the number of, and funding for, Adult Residential Facilities (ARFs). Generally these are six-bed facilities with staff who provide care and supervision 24 hours a day. The ARFs are licensed by the Department of Social Services Community Care Licensing. Unless the ARF is a Medi-Cal Certified Social Rehabilitation Program (which most are not), they are extremely underfunded. The only source of revenue for these facilities is the Social Security benefit of the resident which amounts to about $1,000 a month. Typically a bed in one of these facilities will cost $3,500 a month due to the 24/7 care.

Because of this financial inequity, more and more ARFs are closing their doors. Unless a source of funding is identified to fill the gap, this crucial housing option will become extinct. The Planning Council and Los Angeles County have been working on this issue for some months and have issued both a report and a letter to the Governor asking for assistance in solving the problem that many of these facilities are closing due to lack of

revenue. This is a critical need for individuals with serious mental illness who need an augmented level of care and supervision.

In order to help sustain this essential housing resource, the Planning Council recommends to the Legislature and the Governor an increase in the State contribution of an individual's monthly Social Security benefit by $1,250 so that the number of beds can be maintained and perhaps even expanded. The counties would still need to match this new revenue dollar for dollar in order to ensure the full cost of $3,500 a month is covered. This tri-pronged approach, to ensure the necessary funding to cover the actual cost, is the best option.

These new State General Funds would be offered only for persons with severe mental illness living in licensed Adult Residential Facilities and would address this residential crisis. The new funding stream would offer some incentive to both counties and private providers to enhance these ARF beds. Though this would be a new fiscal obligation to the State, this action would reduce State fiscal obligations in other arenas such as the costs of criminal justice involvement/recidivism, ER visits and of homelessness. An appropriate level of housing is a key social determinant of good health.

A broader issue is the continuum of residential options for persons with mental health or substance use treatment challenges. There are many residential options needed by the individuals in the behavioral health system. Housing supports differ by diagnosis (mental health, substance use), by age, by family supports, by culture, by funding availability and more. Housing is expensive in CA and programs that provide housing must be adequately funded for both start-up and ongoing costs.

Additional needed housing options include permanent supportive housing for individuals who can reside independently with support for behavioral health issues, temporary shelter, respite care, less formal congregate housing that provides minimal care and supervision (board and care homes, etc.) and more. Housing has to be able to support families as well as single people.

Recent estimates published by the New York Times[21] for California, indicate that at present, building any form of publicly-supported affordable housing costs an average of $450,000 per unit. These estimates assume that units are basic, no-frills, one or two bedroom apartments. The costs are even greater for some urban areas such as San Francisco. The factors contributing to these costs are complex, and outside the scope of this review. However, cost factors present a limiting reality for any housing policy.

[21] Why $4.5 Billion from Big Tech Won't End California Housing Crisis, by Conor Dougherty, NY Times, Nov. 6, 2019. https://www.nytimes.com/2019/11/06/business/economy/california-housing-apple.html?te=1&nl=california-today&emc=edit_ca_20191107?campaign_id=49&instance_id=13676&segment_id=18599&user_id=2581d26c8fb7d50c95e8442ae7529e3e&regi_id=40289810

TRANSPORTATION

Transportation is both a barrier to access and the second most common area of unmet need identified for MH clients. When a consumer is unable to make it into the clinic for services due to transportation shortages, the result is that the consumer may not receive the critically needed services. The end result may be more frequent visits to the local emergency room, there may be a spike in inpatient psychiatric admissions, and there likely will be increases both in criminal justice incarcerations and homelessness. Clearly if counties could afford to provide a transportation system for consumers, they would not be identifying transportation as an unmet need. Unquestionably, this is a matter of funding.

Because county mental health programs mostly serve Medi-Cal beneficiaries, the Planning Council recommends, as a solution, that the Department of Health Care Services (DHCS) mandate in their contracting with physical health Medi-Cal Managed Care Plans a requirement to offer and provide transportation for all Medi-Cal-funded appointments. The Managed Care Plans can decide how to best fulfill this obligation, so there will be flexibility from county to county and community to community. There is a precedent for this model, as Partnership Health Plan does offer this transportation service in several counties of Northern California. Better treatment and outcomes can be assured if there is clearly defined responsibility by the Managed Care Plan for providing this critical resource.

WORKFORCE SHORTAGES

Every county in California expresses the need for adequate staffing to provide the MH services required by the Welfare and Institutions Code. There simply are not enough trained staff to fill all the existing vacancies. In addition, the workforce often does not have enough training or the right training for the job they are doing. When there are not enough qualified staff to serve the Medi-Cal population, service capacity is strained, and both network adequacy and access are compromised. When individuals do not get needed care, the state ends up paying through other indirect costs due to incarceration, court costs, emergency room visits, and homelessness.

The needed workforce includes psychiatrists, physicians, registered nurses, physician assistants, individuals with training in counseling (MSW, MFT, etc.), peers who are certified and capable of providing services. The workforce must have adequate initial and ongoing training through continuing education and experience. They must be able to work in either rural or urban areas. In order to retain staff, the BH workforce must be able to earn a reasonable salary and work in settings that provide adequate space, equipment, and human and technological support.

The Planning Council recommends that the State of California establish a sustainable fund source to support the Five-Year Plans as developed by the Office of Statewide Health Planning and Development. In the past, the Five-Year Plans were funded by designated Mental Health Service Act dollars, but the designation has ended. As mentioned earlier, the issue is about funding. If the counties could make this happen, they would have done so long ago. This is an area where the State must step in to assist the Behavioral Health System reach full capacity.

DATA COLLECTION AND MEDICAL CLAIMS/BILLING PROCEDURES

In order to make the 'right' changes in our system, we must have adequate data about the types of services needed and the demographics of those in need of services. This is a basic principle of quality improvement: what is not measured does not get done (or changed). Data presents a challenging issue for BH for a few reasons:

- California has both a public and a private behavioral health care system. The public system collects limited data. The private system does not collect data in an organized way. But those using the private BH system impact the public system by competing for many of the same resources, including BH workforce, affordable housing, transportation and so forth.
- Data is not collected systematically by service providers in a consistent, organized way.
  For example, BH data from the Medi-Cal-funded Specialty Mental Health Services represent the major source of our data about the types of MH services provided and the demographics of those persons who received them. These data are derived from the billing and paid claims files. The adequacy of this data depends on the quality of the data as entered, data is incomplete due to delays or because the entry is awaiting corrections when sent back due to errors, omissions, or issues such as client not being approved or apparently not eligible for claimed services.
- Improvements in quality and types of data collected at present depend on the billing and paid claims systems. Whether that could change in the future would depend on what system or entity would do the complex data collection and processing, and whose responsibility it would be to collect, enter, and validate the data. It would be necessary, as part of a state planning process, to define, fund, and implement any new data system, regardless of whether it is independent of billing or not.

An ongoing area of urgent concern for providers of Medi-Cal-funded BH services is a perceived need for changes in the state regulations governing the current payment and billing procedures. At this time, it is unclear which of these procedures are mandated by the state (and therefore potentially fixable) and which fall under federal regulations. The

current processes under Medi-Cal are an antiquated system for managing payments. Some of the problematic features include:

- Billing for same day services generally are not allowed
- Billing minute by minute that must be documented in detail
- Rigid standards for records that set the recordkeeping level apart from the client treatment and services
- On-going audits that are not reasonable nor useful, and often cover records from several years ago making it difficult to produce records that could substantiate challenges to audit findings
- Lack of partnership with facilities providing services to individuals who qualify for Medi-Cal services.

The public BH system likely will be hobbled by this antiquated and burdensome system unless the state partners with counties, and other service providers, to review and revise these procedures. This system is so complex that considerable expertise is needed to understand the system and to define realistic, pragmatic solutions. Therefore, the Planning Council recommends that the State establish a Blue-Ribbon Commission to study and propose workable solutions that could be implemented within a five-year time frame.

APPENDIX I

California's Welfare and Institutions Code (WIC) sets forth a number of definitions, responsibilities and requirements for the public mental health system. Below are a few excerpts from the WIC to provide context for some discussion and survey questions in the 2018 Data Notebook.

WIC Section 5600.1

The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

WIC 5600.3

To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a)(1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations .

(b)(1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B)(i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services.

(A) No eligible veteran shall be denied county mental health services based solely on his or her status as a veteran.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

WIC 5600.4

Community mental health services should be organized to provide an array of treatment options in the following areas, to the extent resources are available:

(a) Pre-crisis and Crisis Services. Immediate response to individuals in pre-crisis and crisis and to members of the individual's support system, on a 24-hour, seven-day-a-week basis. Crisis services may be provided offsite through mobile services. The focus of pre-crisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. The focus of crisis services is

stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs.

(b) Comprehensive Evaluation and Assessment. Includes, but is not limited to, evaluation and assessment of physical and mental health, income support, housing, vocational training and employment, and social support service needs. Evaluation and assessment may be provided offsite through mobile services.

(c) Individual Service Plan. Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services. The development of the plan should include the participation of the client, family members, friends, and providers of services to the client, as appropriate.

(d) Medication Education and Management. Includes, but is not limited to, evaluation of the need for administration of, and education about, the risks and benefits associated with medication. Clients should be provided this information prior to the administration of medications pursuant to state law. To the extent practicable, families and caregivers should also be informed about medications.

(e) Case Management. Client-specific services that assist clients in gaining access to needed medical, social, educational, and other services. Case management may be provided offsite through mobile services.

(f) Twenty-four Hour Treatment Services. Treatment provided in any of the following: an acute psychiatric hospital, an acute psychiatric unit of a general hospital, a psychiatric health facility, an institute for mental disease, a community treatment facility, or community residential treatment programs, including crisis, transitional and long-term programs.

(g) Rehabilitation and Support Services. Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs. These services may be provided offsite through mobile services.

(h) Vocational Rehabilitation. Services which provide a range of vocational services to assist individuals to prepare for, obtain, and maintain employment.

(i) Residential Services. Room and board and 24-hour care and supervision.

(j) Services for Homeless Persons. Services designed to assist mentally ill persons who are homeless, or at risk of being homeless, to secure housing and financial resources.

(k) Group Services. Services to two or more clients at the same time.

WIC Section 5600.5

The minimum array of services for children and youth meeting the target population criteria established in subdivision (a) of Section 5600.3[22] should include the following modes of service in every geographical area, to the extent resources are available:

(a) Pre-crisis and crisis services.

(b) Assessment.

(c) Medication education and management.

(d) Case management.

(e) Twenty-four-hour treatment services.

(f) Rehabilitation and support services designed to alleviate symptoms and foster development of age appropriate cognitive, emotional, and behavioral skills necessary for maturation.

WIC 5600.6

The minimum array of services for adults meeting the target population criteria established in subdivision (b) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:

(a) Pre-crisis and crisis services.

(b) Assessment.

(c) Medication education and management.

(d) Case management.

(e) Twenty-four-hour treatment services.

(f) Rehabilitation and support services.

(g) Vocational services.

(h) Residential services.

[22] See attached Appendix for presentation of the full definition of the target population criteria set forth in Welfare and Institutions Code Section 5600.3.

WIC 5600.7

The minimum array of services for older adults meeting the target population criteria established in subdivision (b) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:

(a) Pre-crisis and crisis services, including mobile services.

(b) Assessment, including mobile services.

(c) Medication education and management.

(d) Case management, including mobile services.

(e) Twenty-four-hour treatment services.

(f) Residential services.

(g) Rehabilitation and support services, including mobile services.

APPENDIX II

Summary of 2018 Data Notebooks Received:

Received Reports (07-31-2019): 49 reports, covering 50 counties[23] + Tri-Cities

Small population: (24 county MHPs, 25 counties + 1 non-county)	**Medium: (11 county MHPs, 12 counties)**	**Large: (13 county MHPs)**
Alpine	Butte	Alameda
Amador	Marin	Contra Costa
Calaveras	Merced	Fresno
Del Norte	Monterey	Kern
El Dorado	Placer/Sierra	Los Angeles
Glenn	San Joaquin	Orange
Humboldt	Santa Barbara	Riverside
Imperial	Santa Cruz	Sacramento
Inyo	Sonoma	San Bernardino
Kings	Stanislaus	San Diego
Lassen	Tulare	San Francisco
Madera		San Mateo
Mariposa		Ventura
Mendocino		
Modoc		
Napa		
Nevada		
Plumas		
San Benito		
Shasta		
Siskiyou		
Sutter/Yuba		
Trinity		
Tuolumne		
Other: Tri-Cities MHP		

These are presented in groups according to population size, because that was one basis on which we analyzed the results for the MHSA-related questions and some of the other questions.

[23] Sutter and Yuba counties are in one combined Mental Health Plan (MHP), as are Placer and Sierra counties.

APPENDIX III

Details of the Survey Questions #1 -- #4 and Counts of the Numbers of Counties Providing Specific Responses to the 2018 Data Notebook

The data summarized below represents the responses received in 48 Data Notebooks, representing 49 counties and the Tri-Cities MH Plan. The tables below summarize, for example, how many counties identified barriers or unmet BH service needs for children (age<18), transition age youth (TAY, ages 16-25), adults, and older adults. The TAY category includes BH clients who are children (age<18) or young adults (age 18-25).

1. **Please indicate (X) any service areas for which your county has identified that persons are substantially underserved or experience substantial unmet BH needs.**

For each age Group:	Child	TAY (age 16-25)	Adult	Older Adult
(a) Pre-crisis and crisis services.	18	19	15	16
(b) Assessment	12	12	10	12
(c) Medication education & management	14	13	18	19
(d) Case management	12	10	16	14
(e) Twenty-four-hour treatment services	30	32	28	28
(f) Rehabilitation and support services	11	14	13	12
(g) Vocational services	7	27	26	18
(h) Residential services	29	34	34	36

2. **What are the major barriers to BH service access for persons who are in need of these services? Indicate any reasons; mark as many as apply.**

For each age Group:	Child	TAY (age 16-25)	Adult	Older Adult
A: Lack of Program Funding	20	23	25	27
B: Lack specialized prof. expertise	27	30	25	29
C: Lack BH workforce/providers	38	36	35	35
D: Clients dispersed outlying areas	27	30	30	31
E: Transportation problems (bus, etc.)	36	39	42	42
F: Lack available appointment times	19	19	22	20
G: Fear government involvement	21	26	28	26
H: Linguistic needs (translation, etc.)	21	20	17	18
J: Culturally relevant needs	21	22	27	26
K: Other barrier, specify below.	6	7	9	8

3. **Please indicate (X) any service areas for which your county has implemented <u>new programs</u> within the last 3 years.**

For each age Group:

	Child	TAY (age 16-25)	Adult	Older Adult
(a) Pre-crisis and crisis services.	31	38	34	31
(b) Assessment	27	31	29	26
(c) Medication education & management	10	17	18	14
(d) Case management	17	25	29	24
(e) Twenty-four-hour treatment services	11	16	17	13
(f) Rehabilitation and support services	13	20	18	13
(g) Vocational services	1	9	11	6
(h) Residential services	9	18	25	19

4. **Indicate (X) whether any of the following services are funded with <u>temporary</u> (one-time, time-limited) funding for which you are seeking a sustainable fund source to continue services?**

For each age Group:

	Child	TAY (age 16-25)	Adult	Older Adult
(a) Pre-crisis and crisis services.	14	18	20	15
(b) Assessment	7	8	8	5
(c) Medication education & management	5	4	4	2
(d) Case management	8	8	12	8
(e) Twenty-four-hour treatment services	1	3	7	4
(f) Rehabilitation and support services	9	12	13	10
(g) Vocational services	1	4	5	2
(h) Residential services	3	5	8	6

APPENDIX IV

Current Needs for MHSA Funds for Workforce Education and Training, Capital Facilities, and Technological Needs Projects (Responses to Question #6)

In Question #6, we asked local boards whether there is still a need for any (or all) of these three components in your county? (Yes___. No___.)

All but one county replied in the affirmative. For those who responded 'yes,' we asked them to rank those MHSA components in priority order of need, #1 being highest.

A few counties ranked each component as being equally important. A representative comment is that "All three components are essential for an accessible, responsive and effective public mental health system. Our county continues to fund all three."

We then provided the option for respondents to give examples that specified the needs for continued funding under those MHSA program components (in 25 words or less). Typical responses are summarized as follows.

Workforce, Education, and Training: sample comments

- Our county would benefit from loan repayment programs and MHSA stipend programs that were available through the WET component that are no longer available. The WET component currently uses CSS funding for peer employment and job specific training, so demand for these initiatives continues.
- County has difficulty recruiting qualified MH professionals. WET funding allows us to develop local individuals and provide needed training to existing workforce.
- Investing in higher education for local workforce and recruitment efforts to hire workforce.
- Improved ability to recruit and retain staff.
- Significant staff development and cultural competency trainings, peer development, and incentives to hire more psychiatrists.
- Support countywide MH trainings and workshops for community members, partners, and providers in the MH field. Also we support staff to participate in evidence-based trainings and reimburse continuing education units/expenses for courses in the MH field.
- Recruiting and training of qualified staff, specifically psychiatrists and Vietnamese clinicians.
- Loan Assistance programs under WET to facilitate recruitment and retention of qualified professionals, including both administrative and clinical professionals is critical and necessary for small counties to secure expertise and mastery of public MH systems.
- Peer development and scholarships.

- We need to continue building a diverse workforce and provide ongoing professional staff development and training.
- There is a dearth of workforce qualified to implement the technological and capital facilities components and put them into service.
- Throughout the state of California, there is a shortage of qualified individuals to work in government. The areas particular to Behavioral Health are Psychiatrist, Registered Nurses and Mental Health Clinicians I/II/III.
- Support ongoing training of staff, with continued enhancement of I.T. capacity.
- We are unable to keep up with the rate of technological advancement in terms of costs and government red tape.
- Our county is a designated 'Health Shortage Area;' so WET is need to fund efforts to bring and keep staff here.
- We need to recruit, train, and retain more staff who provide culturally-relevant healing practices and staff who ethnically/ culturally represent the demographics being served.
- WET funds for staffing, system transformation, for/by consumers and family members, including career pathway programs, including stipends and loan forgiveness.
- "According to the California Future Health Workforce's report, Meeting the Demand for Health, California is in a real crisis for shortage of mental health professionals including prescribers and non-prescribers. We see a real need for continuing with community training on evidence-based and community-defined practices to 'treat to target', specialist training, including peer certification and primary care providers to expand the primary care integration to the whole person care approach. We need to have a robust training system to meet the demand." [Orange County].

Capital Facilities: sample comments

- Expand our facilities to expand crisis and triage services.
- A multi-suite facility that provides MHSA services such as a step-down facility, and more housing needed for individuals with MH needs.
- Emergency housing room or rooms (small—rural county).
- A 24/7 multi-use crisis facility with a specific wing to serve youth separate from adults that includes overnight care, spaces for programming, and other resources.
- Facilities for older adults.
- Need funds for an adult residential facility.
- Our county's top need is Capital Facilities funding for all types of residential care.
- Increased housing options through our Capital Facilities funding.

- In-patient facility, with satellite centers in outlying areas.
- Crisis Stabilization Unit expansion (CFTN).
- This component helps our county with building infrastructure and providing services in a welcoming environment that assist with an integrated service experience and stigma reduction.
- Acquisition of facilities to develop residential programs.
- Need help with the rising costs of available business buildings with accessibility to ADA requirements.
- Additional permanent supportive housing.
- Crisis Residential and Board and Care facilities, and long-term residential living.
- Identification, renovation, and acquisition of facilities to aid in service delivery.
- Capital Facilities funds can be extremely valuable when leveraging other funding for building projects.

Technological Needs: sample comments

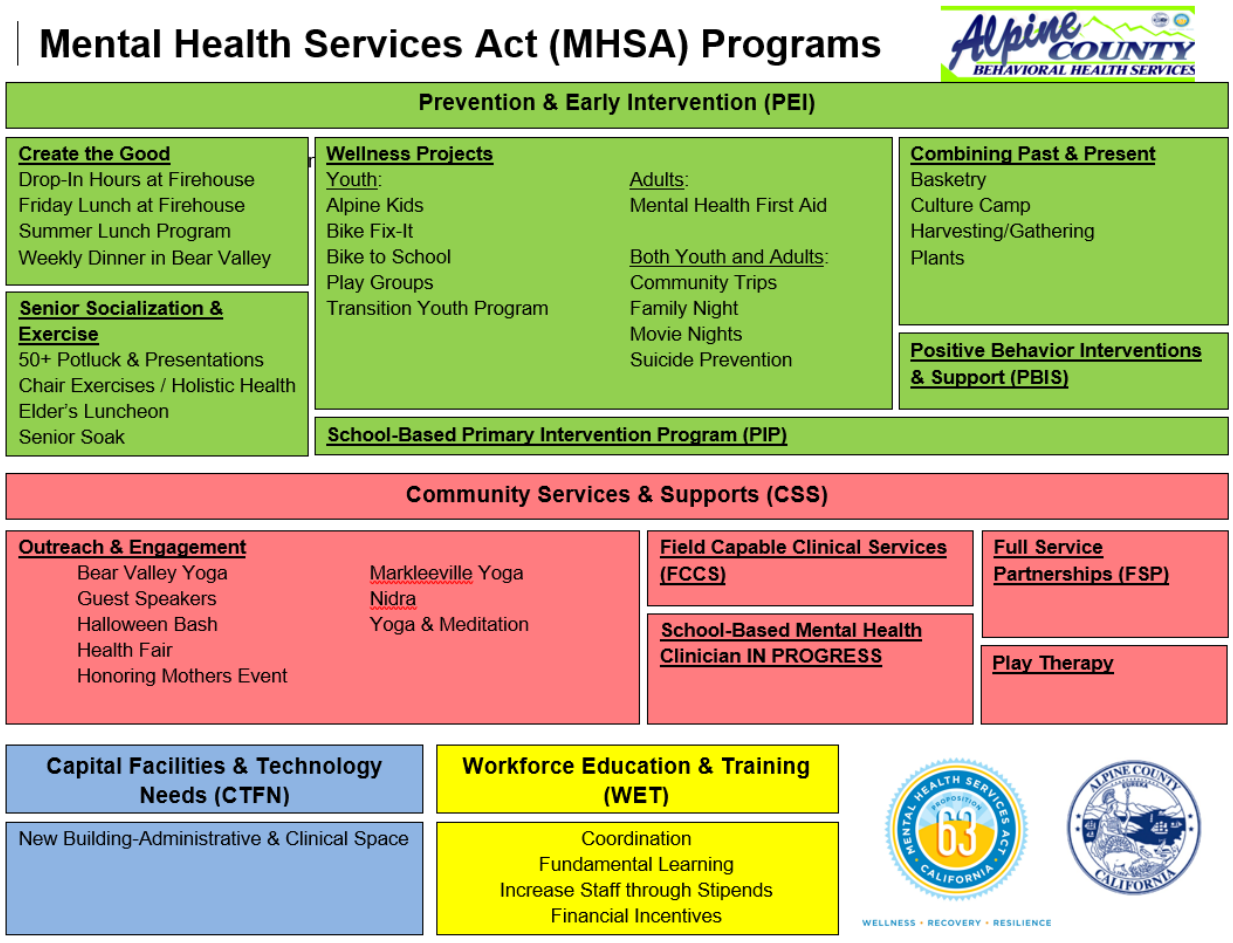
- Electronic Health Record (E.H.R.) to improve care coordination.
- Needs are related to improving productivity and decreasing barriers (tele-psychiatry/ tele-health, dictation software, E.H.R. direct messaging, treatment submission).
- Enhanced and new Technology Tracking Systems.
- E.H.R. capable of gathering information for and producing mandated reports.
- Further integration efforts by developing systems that can speak across departments.
- TN to assist us in trying to keep up with the rate of technological advancement in terms of costs and government red tape.
- Electronic Health Records and continued support of the E.H.R.
- Continued enhancement of I.T. capacity.
- This component is needed to provide an up-to-date E.H.R. system that is easy to access, timely, and operates efficiently.
- Upgrade/replace E.H.R.
- TN funds help support our migration to electronic health records and to maintain our electronic health care database, software, and I.T. support for this purpose.
- Needed: upgrading I.T. for staff, upgrading Tele-med equipment, and establishing Tele-med for outlying areas.
- We will need to purchase a new E.H.R. when Anasazi sunsets.
- Ongoing challenges with E.H.R.
- Associated costs of E.H.R. conversion to ‘Millenium’ and transitioning contractors to the new system.
- Upgrading E.H.R. to share information across systems.
- Technology to serve our isolated, rural community.

APPENDIX V

Examples of Successful Programs funded by CSS, PEI, or Innovation Projects: (Responses to Question #7), Grouped by County Population Size

DN 2018 Question # 7 All SMALL Population Counties' Responses

Alpine –Yes



Amador

CSS- Mobile Support Team: The Mobile Support Team, fully implemented in FY 16/17, provided 107 total appointments to 73 individuals in its first year. Of all of these clients seen, 2 were re-hospitalized. In FY 17/18 there were a total of 140 mobile appointments to 90 individuals. Of all clients seen, there were 0 re-hospitalizations.

CSS- Sierra Wind Wellness & Recovery Center: Sierra Wind is a peer-led self-help wellness center that served 1,039 individuals in FY17/18.

PEI- Youth Empowerment Program/Project SUCCESS: This program's approach uses interventions proven effective in reducing risk factors and enhancing protective factors in Amador County youth.

PEI- Promotores de Salud: The Promotores de Salud is a Latino Peer-to-Peer program. The goal of this program is to promote mental health and increase access to services. The Promotores are instrumental in the quarterly Latino Engagement Committee meetings and in providing access to mental health services and supports.

Calaveras

'**First 5 Strengthening Families' Program**:

Based on the independent evaluation report for FY 2017/2018, the First 5 Calaveras MHSA-PEI Countywide Education & Support Program for Parents, Caregivers and Educators for all services offered in FY 17/18**,** 445 adults (unduplicated) participated. (66% parents/caregivers/grandparents and 34% educators or other service providers). This program continues to provide strong leadership in program planning, coordination, and implementation. The program met and exceeded the service expectations while continuinig to build on fresh and interesting approaches to keep parents and educators engaged. The leadership demonstates a high degree of effort and capacity in coordination. This program continues to be a valuable investment in mental health prevention and early intervention with a broad and deep community coverage in Calaveras County.

Del Norte

Del Norte County maximizes its MHSA CSS and PEI dollars for the utmost outreach to historically underserved populations. 51% of our CSS dollars goes to support our Full Service Partnership program. We have been able to help clients with a variety of non-traditional mental health needs such as rental assistance and higher education costs. We have also been able to hire additional case managers and masters level clinicians to support our robust FSP program.

With PEI dollars we target youth who are in need of vital services but might feel stigmatized by accessing mental health treatment in a traditional county setting. With Innovation funds we developed a TAY center that is now funded through PEI. At the center, youth are able to get preventive mental health services, psycho-educational group services, vocational training, and peer support.

El Dorado

Psychiatric Emergency Response Team (PERT) is a PEI program that partners a mental health clinician and a sheriff deputy to respond to crisis calls with the goals of crisis de-escalation. Since the program's inception in early 2018, the program has

dramatically reduced the number of unnecessary 5150 holds being written, increased the number of safety plans written, and has allowed for greater follow-up with individuals and families contacted during the crisis call.

Glenn

Glenn County's Behavioral Health Treatment Court (BHTC) is a successful program that helps individuals living in Glenn County and charged with non-violent, BHTC-eligible offense(s) to achieve positive outcomes. This is a comprehensive treatment and supervision program that will help individuals become drug-free, crime-free, and self-sufficient members of the community. Through coordinated Behavioral Health Treatment Court and Substance Use Treatment services, individuals will reduce jail recidivism, develop healthy behaviors, achieve sobriety and be substance-free.

Humboldt

Mobile Intervention and Services Team (MIST)--DHHS mental health clinicians and case workers work with local police departments full-time to assist with segments of the homeless population. Specifically, the main goal is to help homeless people who have frequent contact with both the police department and DHHS Mental Health Staff.

Imperial

First Step to Success (FSS) is an early intervention program utilizing Positive Behavioral Interventions and Support (PBIS). ICBHS has implemented this model under the MHSA Innovation Project with the intention of developing and sustaining a strong collaboration with education staff in efforts to provide early intervention services to children ages 4 to 6. FSS is designed to help children at risk for developing aggressive or antisocial behavioral patterns.

The program is implemented by mental health staff who are trained on FSS and who work on a one-to-one basis with each student, his/her class peers, teacher, and parents for approximately 30 school days. FSS includes three interconnected modules: screening, classroom intervention, and a parent intervention. FSS is currently being implemented in 44 classrooms in 14 schools, in 7 cities in Imperial County. The plan for school year 2018/19 is to continue expanding the FSS program to the cities of Imperial, Calexico and El Centro.

Inyo

The most successful strategy has been to implement the 'Strengths' model. Training was out of WET funds, but this is an innovative project that is being anchored in all aspects of work with adults and older adults.

Kings

The Collaborative Justice Treatment Court program continues to turn out successful graduates. This program, run by Kings County Behavioral Health, consists of four courts: behavioral health court, co-occurring court, drug court, and veteran's court. Participants proceed through treatment that promote increasing personal responsibility for daily life functions. This program is a collaboration between Behavioral Health, Probation, the Sheriff's Department, and the Kings County Supreme Court.

Madera

Prevention and Early Intervention (PEI) has grown tremendously from 2012 to 2018. In 2012, PEI consisted of two Wellness Centers and a Health Educator. PEI served 1,854 individuals in 2012. In 2017 PEI served an unduplicated count of 4,454 individuals (a 42% increase from 2012). Later, we added a program specifically for school age children/youth.

The largest PEI community intervention included all PEI staff, but also included one of our Innovation Projects, and a few clinical employees. It started our new **Trauma-Informed Community Initiative**. This initiative included:

- Served 1,379 participants
- 33 agencies
- 3 all day trauma trainings
- A social psychology intervention
- A World Café with our partner agencies
- Adverse Child Experiences screening with homeless individuals and at-risk youth
- Screening three formal documentaries (more than one)
- Maternity Fair and
- Parent conference

The Trauma-Informed and Resilience Coalition (TIRC) came from this initiative. It is a collaboration of agencies that reduce the impact of community trauma. It builds positive community level social connections that build social resilience.

Mariposa

Mariposa County has utilized Innovation funds to implement use of the Adult Team Meetings (ATM). The county has captured the strategies in the Innovation Model and implemented these strategies to improve the quality of life of our clients. These strategies have increased our client's overall success and have moved them through the clinical processes of therapy while creating a safety net for accomplishing client directed services and goals.

Mendocino – We have an Innovation program in progress, but the data are not yet available on its success.

Modoc

Workforce Education and Training (WET): This funding has been a most outstanding opportunity for our staff and clinicians to utilize the tuition assistance in earning degrees in every level of our organization, even to doctorate degrees. Those funds have helped entry-level employees become licensed clinicians, thus expanding the scope and breadth of the County services.

PEI program: PBIS in all Modoc County Schools including Tulelake and Big Valley utilizing positive behavioral interventions and supports.

Innovation: Tech Suite is a collaborative innovation program with 14 additional counties utilizing a growing suite of technological applications available to clinicians, clients, and peers to provide enhanced quality of care, increased accessibility to care, and decreased isolation. This program, supported by Modoc County Behavioral Health, includes Sunrays of Hope, a peer-run wellness center for education and outreach.

Napa

(1) The **Kids Exposed to Domestic Violence program (KEDS)** provides services specifically for children exposed to domestic violence to prevent the onset of Post-Traumatic Stress Disorder (PTSD), depression, anxiety or other mental illness. The program offers tutoring, support groups (using specific curriculum), communication with schools, and referrals as appropriate to other services in the NEWS office and at the shelter. The KEDS children's support group has about 20 kids with ages that range from 2-13 years who participate on a regular basis (parents have to call ahead of time to sign up). There is currently a wait list for the support group. The support group meets once per week and works on a variety of activities, including, but not limited to art therapy. Parents (generally moms) are also using this time to learn about protective factors.

(2) The **Court and Community Schools Student Assistance Program (SAP)** includes staff who offer mental health services and counseling as needed along with a wide range of services including academic assistance in order to support students, reduce suspension rates, and increase school attendance.
Students are referred to the community school for reasons of truancy, disciplinary issues or through expulsion. The majority of students are performing well below

grade level and all come from a history of neglect, abuse, trauma, substance abuse, and/or diagnosed or undiagnosed mental health conditions.

The multidisciplinary SAP Team meets weekly to discuss and organize services to all students participating in the program. The SAP Team provides students access to brief individual therapy or group support, check-ins and crisis intervention.

Successes:

- An average of 42% of students showed improvement in FY 16-17.
- Attendance is at 86% for those students receiving SAP services.

Nevada County

Moving Beyond Depression Program

'Moving Beyond Depression' is a voluntary, evidenced-based program for low-income, underserved women experiencing prenatal or postpartum depression (i.e., perinatal depression; PND) who are enrolled in a home-visitation program. Moving Beyond Depression offers In Home-Cognitive Behavioral Therapy (IH-CBT) in 15 weekly sessions and a one (1) month follow-up booster session. Therapy is provided in the clients' homes by two (2) licensed therapists and supervised by a psychologist. Individuals receiving services complete an Edinburgh Postnatal Depression Scale (EPDS) at intake, during ongoing services, and at discharge from the program. Individuals receiving services also complete the Interpersonal Support Evaluation List-Short Form (ISEL-SF) to assess perceived social support at intake to, and discharge from, the program. The vast majority of 'Moving Beyond Depression' participants see an improvement in both the EPDS and ISEL measurements.

Plumas

Under PEI, a partnership was developed with Plumas Unified School District (PUSD) for programs such as **Positive Behavior Intervention Support** (PBIS), which includes: prevention, intervention, and referral to Behavioral Health.

San Benito

The **Esperanza Center** is a drop-in center that offers a welcoming environment to clients and others needing supportive services. Services are available in English and in Spanish and offer a wide range of wellness activities. In addition, Case Managers are available to offer supportive services and provide transportation, when needed.

In the past year, we have developed an LGBTQ program that utilizes the center on Saturdays. This has created a supportive and safe environment to bring people together and provide the resources to help meet the needs of these high-risk youth.

The Center is located in downtown Hollister, so it is easy to access, and public transportation is available. This CSS-funded resource has been utilized by both Transition Age Youth and adults, sharing the building on different days and/or times. Telemedicine Services are also available on Fridays and offers a Spanish-speaking psychiatrist.

Shasta

The **Counseling and Recovery Engagement** (CARE) Center opened in March 2017 and is open 7 days a week, 365 days a year, in the afternoons and evenings. Services include:

- After-hours pre-crisis clinical assessment and treatment
- Case management and linkage
- Treatment groups
- Warm line
- Community outreach
- Buddy/mentor system for youth and adults
- Transportation
- Connection to respite care and transitional housing
- A peer-staffed resource center which provides resources and information, assistance with linkage to benefits, resource materials, referrals, education and support groups

The goal is to improve access to services, reduce mental health crises, bridge service gaps and help support families. The center is performing well above expectations, serving more than twice the number of clients we anticipated, and is clearly filling a significant gap in our community mental health service continuum.

Sutter/Yuba

The FSP (Full Service Partnership) program which is funded by CSS has been very successful in providing services to clients, especially those in the TAY (Transitional Age Youth) program. This also ties into many community based organizations (CBO) such as the ‘Youth for Change’ organization which works directly facing clients.

Trinity

PEI-funded efforts provide a program to our high school students in Weaverville that falls in line with the Comprehensive Juvenile Justice Plan, looking at outcomes for all youth, not just those in the juvenile justice system. With the full-time Prevention Services Liaison on-site, the numbers of youth in Juvenile Hall or truant have decreased significantly and there have been no suicides in this current school year. Having a greater presence at the school has allowed the liaison to develop partnerships and meaningful relationships with the youth. The departments work together to assist you in a wrap-around manner that either program on its own would not be able to accomplish.

Tri-Cities Mental Health Plan & Mental Health Commission

The **Therapeutic Community Garden** (TCG) is a Prevention and Early Intervention program that facilitates support groups for all ages and developmental stages. It is a supplemental service that can be added to a client's already existing treatment, or act as a "step-down" option for those graduating from services and wanting to maintain their wellness.

TCG groups are also available to non-clients where 45% of participants are local community members and engage in garden groups that provide unique interventions that include Therapeutic Horticulture, mindfulness, and metaphor therapy. This unconventional form of therapy helps individuals to process everyday life challenges in a non-threatening environment while learning the basic skills to grow their own fruits and vegetables.

This successful approach has resulted in an increase in participation of 58.5% from FY 2016-17 to FY 2017-18. In addition, 55% of participants requesting additional support or services were successfully connected to appropriate clinical programs.

DN 2018 Question #7 Medium-sized Counties, by Population

Butte—Yes

The Iversen Wellness and Recovery Center was created to serve those with mental illness. They offer the chance to work and develop the skills needed to pursue goals, such as attending school, or acquiring and maintaining employment in the community. The Iversen Center also offers support through groups and socialization in an environment free from stigma and judgement. A variety of groups are offered that are geared toward helping individuals with day to day issues, as well as other issues related to their illnesses. Assistance is also provided in creating a Wellness Recovery Action Plan™ which provides a tangible program to ensure client's success in life and recovery. The center also provides services related to needs such as housing and job placement which is done through networking and computer access.

Embedded in the Iversen Center is the Northern Valley Talk Line; a free, consumer-run, peer support telephone service that offers non-emergency, non-crisis support and referrals. The majority of calls pertain to problem solving, help with coping, and conflict management. Callers that are in crisis or that are at risk of harm to themselves or others are referred to crisis services. The Talk Line is open 7 days/week, 4:30 PM to 9:30 PM.

Marin

One of our very successful programs is our "Client Choice Hospitalization Prevention" program which has developed into Casa Rene, our home-like Crisis Residential Unity. This program was developed using Innovation funding and has been sustained with CSS funding. This last year they streamlined their referral process, forged stronger partnerships with other organizations, and increases their utilization rate significantly. Our clinical Performance Improvement Project (PIP) produced positive client outcomes following treatment at Cases Rene including reduced presenting symptoms and a better sense of recovery (based on client self-reported measures). Additional, clients had decreased re-admission rates to our Crisis Stabilization Unit and to inpatient psychiatric hospitals as measured 60 days post-treatment.

Merced

The Strengthening Families Program is a Prevention and Early Intervention program designed to develop healthy children and family relationships that lead to secure bonding and attachments and early intervention in life transitions.

The program continues to serve the following communities in Merced County: El Nido, Le Grand, Planada, Gustine, Santa Nella, South Dos Palos, Dos Palos, Winton, Atwater, Livingston, and Franklin Beachwood.

The program is implemented by a Community Development Partner (CDP). The CDP is a 'Caring Adult,' who works to strengthen families by providing linkage to support,

information, resources, and services, to restore self-esteem and self-worth by building on cultural identity strengths and wisdom. Each CDP builds a network of contacts in their assigned communities, with individuals such as school principals, counselors, community leaders, law enforcement, parents, etc. Through this network, service needs are identified and the CDP works with the requesting agency or individual.

Key objectives:

- Decrease stress-related issues in families
- Provide support during life transitions
- Improve access to serves and to provide the needed services.
- Provide culturally specific community engagement and intervention.
- Increase early detection of mental health problems.

Monterey

OMNI Program Description

OMNI is a peer and family member operated mental health wellness center operated by Interim, Inc. and funded by Monterey County Behavioral Health Bureau. The Center provides a wide range of services to anyone in the community who is interested in participating in the activities offered. The Center is free and open to all mental health consumers; no referrals are necessary.

The Center serves to assist members in pursuing personal and social growth through self-help groups, socialization groups, and peer support groups in order to specifically address issues of personal growth, and recovery. Consumers come together to socialize and interact with others who are going through the same challenges. Support groups are offered for Spanish speakers at the OMNI Center and in East Salinas for unserved and underserved individuals. Many seasonal events and celebrations are held throughout the year. Additionally, the center offers skills and tools to those who choose to become leaders among their peers and take an active role in the wellness and recovery movement.

Placer/Sierra

Placer's Whole Person Care pilot is funded in part with Innovations funding. This highly successful program provides care coordination services to chronically homeless individuals experiencing a physical health condition to help house, provide medical respite, and link to necessary services. This group also shares data and reporting functions with the ERs/Hospitals to better outreach and engage individuals who frequently use medical services. This partnership has been very successful between County and our Medical Services.

Placer County in partnership with Advocates for the Mentally Ill Housing developed a 19 unit apartment complex using MHSA funding. The project houses FSP and other adults with mental illness in 18 of the units, one unit is for the on-site property manager. The 100 year old building went under rehabilitation before purchase, updating the units, adding two ADA units and a lobby area. The property is leased up with support services provided by county staff, and Turning Point.

San Joaquin

Progressive Housing is a shared housing program for homeless individuals with serious mental illness and co-occurring disorders. Progressive Housing offers a tiered approach to housing and recovery services that is designed to support individuals at different stages of the recovery process with the goal of "graduating" participants into independent living programs.

Assessment and Respite Center.

PEI: NAMI Signature programs PEI: NAMI Signature Programs –reaching many people (clients as well as family members) that otherwise would not be. With additional funding for 'coordination' could be even more successful.

CSS: The Wellness Center of SJC –serving nearly 1,000 individuals each year, averaging 60+ participants daily, 20 groups and classes weekly, one on one peer counseling, and many other services. With expanded facilities, in Stockton and satellites throughout county, could be even more successful.

Riverside county has been highlighted as successfully utilizing Peer Specialists (family members and individuals with lived experience) –and might be a model worth looking at.

Santa Barbara

RISE- the launch of a CSEC program three years ago that partners and collaborates with Probation, Social Services, Public Health, Rape crisis, and community partners.

PEI- Access Adult program- our access program allows for designated staff that focus on allowing timely access to care for all new clients and linkage to crisis/urgent services to existing and new clients. Our department monitors timely access monthly. This program has allowed for our access timeliness to improve over time to where clients wait between 1-10 days for routine services, 24 hours for urgent, and 2 hours for crisis.

PEI- Community Health Centers of the Central Coast (CHC) – CHC is contracted to provide outreach and engagement services to underserved communities in the Santa Maria and Lompoc areas. Community health educators, or *promotores*, provide support groups in familiar, un-stigmatized locations – including primary health clinics and apartment complexes – to ensure greater accessibility to care. In recent years, CHC

began collaborating with local radio stations to do lunchtime “meet and greets” at local orchards and agricultural fields. This strategy offers a more casual environment in which *promotores* can build relationships and develop trust with low-income workers. Over time, these relationships can be leveraged to link workers to a range of behavioral health care services.

Santa Cruz

Integrated Housing Supports Program funded by Innovation works with individuals who have a serious mental illness, co-occurring health condition, who are homeless or at risk for homelessness and provides funds for housing, peer support services in the community, and telehealth monitoring devices in their homes to support improved behavioral health and health outcomes.

Sonoma

- Mobile Support Team (MST)
- Goodwill Industries (Peer-run Programs)
  - Wellness & Advocacy Center
  - Interlink Self-Help Center
  - Petaluma Peer Recovery Center

- West County Community Services (Peer-run Program)
  - Russian River Empowerment Center

Stanislaus

RAIZ *Promotores* Mental Health Prevention Program is funded by MHSA PEI. Stanislaus County defines RAIZ (“roots) as *Realizando Alianzas e Inspirando Sabiduria*, which translates to “Creating Alliances and Inspiring Wisdom.” *Promotores* play a critical role in promoting community-based health education and prevention, particularly in communities historically underserved by behavioral health and well-being to reduce the risk for developing a potentially serious mental health condition and to build protective factors. *Promotores* are generally from the communities they serve and represent a risk spectrum of characteristics that facilitate access and linkage for underserved individuals into needed mental health care services and/or natural communities of support. They help address multiple barriers such as those related to transportation, availability, culture, language, stigma, and mistrust. As leaders in their communities and non-clinical providers, *Promotores* are the bridge between health care institutions, professional providers, and community residents. RAIZ *Promotores* are currently active in twelve communities throughout Stanislaus County.

Tulare

The ‘My Voice Media Center’ (MVMC) was an Innovative project from 2012 through 2015, and continues under CSS as it was deemed to have successful outcomes. The purpose of the MVMC is to provide adult individuals with lived experience with the opportunity and resources to express themselves through a variety of artistic media.

Through participation in community events, displaying art of participants, MVMC continues to have a positive impact on participants, and the community at large, reducing stigma. Some of the sessions held at MVMC include poetry, drawing, photography, and videography. Over 350 participants have created works of art that have been shared on PBS, as well as in local publications.

DN 2018 Question #7 Large-sized Counties, by Population

Alameda

Mobile evaluation team that has a police officer and clinician respond to crisis calls together. This saves an average of 20 minutes of officer time, clients get to treatment facilities quicker and are assessed much more quickly because the scene safety is maintained throughout.

The Child and Young Adult System of Care (CYASOC) currently has a number of PEI programs in our school-based services. Additionally, the CYASOC has two Innovations Grants that fund services to school-aged children and the other four serve our TAY population. Lastly, the CYASOC recently has invested $1.3 million of CSS funds into School-Based and Special Education Services to accompany clinical treatment programs.

Contra Costa

Innovation project currently being stood-up: The Center for Recovery and Empowerment in Point Richmond, CA.

The Center for Recovery and Empowerment is an intensive outpatient treatment program offering three levels of care; intensive, transitional and continuing care to adolescents dually diagnosed with substance use and mental health disorders. Services that are provided include a multi- disciplinary team, and include individual, group and family therapy, and linkage to community services.

Fresno

Our First Street Center program operated by Turning Point, for our AB109 program for the persons we serve that are on Post-Release Community Supervision (probation), is a special program that we are proud of. This program consists of an FSP delivery system, consisting of mental health outpatient services along with drug Medi-Cal outpatient services with a capacity to serve individuals 247. This program was recently visited by an outside independent agency that was working with UCLA to learn more about this program and review the model. This program is unique in that it has several braids of funding that assist the department with serving individuals involved with the justice system. In addition, this program has both mental health and substance use disorder certifications (co-occurring).

Kern

Freedom, Recovery, Empowerment, with Dogs (F.R.E.D.).

The program was developed to incorporate therapy dogs and a Canine-Assisted Interventionist into client services. 'F.R.E.D. integrates a dog and interventionist into 'Seeking Safety' groups run by Kern Behavioral Health and Recovery Service facilitators. Groups currently run in two locations with two different programs, focusing on dually diagnosed individuals addressing trauma issues or who have a history of incarceration.

Pre- and post-test measures are used to assess the dog's effects on group participation and client symptoms. During the groups, clients appear comforted by the dog's presence. Successful outcomes reported have included improved client symptoms, treatment engagement, communication with staff, and improved attendance. Clients participating in the groups shared these comments about working with Luka, the dog:

> *"You always make me feel better, Luca. That's why I come to group"*
> *"I almost didn't come to group today, but I wanted to see Luca, so here I am."*

Los Angeles

Our FSP and PEI programs have been independently evaluation by RAND Corporation. The link to that evaluation report is:
https://www.rand.org/pubs/research_reports/RR2327.html

LA's own evaluation data and analyses continue to find that our early intervention programs result in significant reduction in symptoms associated with trauma, depression, anxiety, severe behavioral misconduct, parenting difficulties and improvements in parenting skills. Our FSP programs reduce homelessness, psychiatric hospitalizations and incarcerations while increasing independent living opportunities.

Orange

Strong Families – Strong Children (SFSC): Behavioral Health Services for Military Families serves all members in the military family, including veterans, service members, spouses, partners, and children. SFSC increases access to military-connected families and utilizes trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family.

Clinicians provide short-term individual and family therapy to address the impact of traumatic events on children and family members.

Peer navigators provide one-on-one peer support, case management, and linkages to community resources.

Additional services include outreach and engagement, screening and assessment to encourage appropriate referrals to, and enrollment in programs services; workshops

and education support grou0ps for families; and counseling using the evidence-based practice 'Families Overcoming Under Stress' (FOCUS) program.

Based on demonstrated effectiveness, this Innovation project will be continued through Prevention and Early Intervention funding beginning July 1, 2019.

Riverside

CSS: Crisis System of Care. Mobile teams, urgent care centers in each region, crisis and adult residential treatment as alternative to acute hospitalization. Peer-oriented Navigation Center intervention engages consumers during crisis service delivery to better connect to outpatient behavioral health care. The results were that 77% of law enforcement contacts and 36% of contacts originating from hospital ED were diverted from more acute level of care. The Navigation Center improved care connection by nearly 20% for consumers who were formerly disengaged.

PEI: Strengthening Families Program (SFP) is an EBP for children ages 6-11 and their families. Parents and children participate in SFP, separately and together. Since 2013, SFP has served over 900 families; 70% of families graduated. About 80% of families identify as Hispanic.

Evaluation revealed decreased behavioral, emotional, and social problems, and increased parenting skills, parent supervision, building family strengths, enhancing school success, concentration skills, and prosocial behaviors. Participant surveys indicate satisfaction and families see the program as an important tool for healthier families and communities.

Sacramento

Innovation Project: The Mental Health Urgent Care Clinic, certified as a Medi-Cal outpatient clinic, provides voluntary and immediate access to short-term crisis intervention services including integrated services for co-occurring substance abuse disorders to individuals of any age who are experiencing a mental health crisis.

Services are designed to provide an alternative to emergency department visits for individuals who have immediate mental health needs. Services focus on wellness and recovery as well as linkage to ongoing community services. Interventions assist in decreasing unnecessary and lengthy involuntary inpatient treatment while increasing access to care in a voluntary setting.

San Bernardino

The MHP has several successful programs:

• Full Service Partnership:

- field-based services for individuals diagnosed with severe mental illness or serious emotional disturbance who would benefit from intensive service program
- differs from traditional, clinic-based outpatient care

• Recovery Based Engagement and Support Teams:
- voluntary, client-centered project providing field-based services to individuals with untreated mental illness through assisted outpatient treatment model
- holistic approach to the needs of the consumers, are highly flexible and unencumbered by traditional limits of services

• Child and Youth Connection; Screening Assessment Referral and Treatment:
- access and linkage to treatment, connecting children with severe emotional disturbances to medically necessary care and treatment
- Screening, Assessment, Referral, and Treatment
  - serves at-risk children (0-6) experiencing social, physical, behavioral, developmental, and/or physiological issues
- Early Identification and Intervention Services
  - Children (0-8) who experience social, physical, behavioral, developmental, and/or psychological issues not requiring intensive interventions.

<u>San Diego</u>

The County shifted CSS funds into Capital Facilities to finalize a building project in FY2017-2018: a multi-purpose facility in North San Diego County. This is especially noteworthy because the funds were leveraged with other local resources to open a center which will house behavioral health treatment and recovery services, as well as public health functions and a military and veteran component.

Three distinct mental health programs will operate out of this new building, and there will also be a large conference room available for community use.

Once fully operationalized, the facility will be a health hub where north county families can access multiple services and programs under one roof. This is an excellent use of funds because it allows the County to maximize return on expenditure instead of wasting money on overhead by operating multiple similar County services nearby.

<u>San Francisco</u>

The Senior Drop-in Center at Curry engages socially isolated seniors, 55 years of age and older, in Wellness and Recovery activities in a supportive, peer-based environment. This program refers and links seniors to wrap-around services including primary care, behavioral health, and case management services, as well as socialization opportunities. A consumer Advisory Panel meets monthly to provide feedback to the leadership team.

IN FY17-18, significant changes were made to the program including: increasing drop-in program days from 6 to 7 days per week, expanding program hours from 6 to 8 hours per day, and increasing wellness group programming. Seven new groups were started in 2018. Outcomes: 139 seniors attended peer-led, wellness-based activities; 88% reported an increase in socialization: 88% of participants agree with the statement: "My culture and lifestyle are respected in the Drop-In Center".

Other successful programs include the Transgender focused programs and significant increases in Peer staff and the Full Service Partnership program.

A Full-Service Partnership (FSP) program is full spectrum of community services, funded by the California Mental Health Services Act, to serve individuals who have been diagnosed with a severe mental illness and would benefit from an intensive service program. The foundation of Full-Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness. Full Service Partnerships embrace client-driven services and supports with each client choosing services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and consumers. FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have a co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community, and other locations. Peer and caregiver support groups are available. Embedded in Full Service Partnerships is a commitment to deliver services that are culturally and linguistically competent and appropriate.

<u>San Mateo</u>

CSS – California Clubhouse

The California Clubhouse gives those whose lives are disrupted the opportunity to experience meaningful work and relationships. Research shows participation in the Clubhouse leads to reduced hospital visits, stays, and re-admission; reduced recidivism and incarceration; reduced suicide; better employment rates (double the rate for non-participants), improved Well-Being compared with non-participants receiving psychiatric services, and better physical and mental health.

"I could not imagine that any employer, seeing the gaps in my resume, would take a chance on me; but California Clubhouse saw my willingness to work and my ability to stay on task. I was matched with a retail store; they vouched for my readiness, with more confidence than I could muster." -- Riley, Clubhouse Member

PEI –Storytelling

The storytelling program empowers community members to share their stories of recovery and wellness to heal and to address community issues, including stigma.
In FY 17-18, housing was prioritized by sharing client stories with housing stakeholders

(property managers, board of supervisors and commissions, etc.) and at two landlord appreciation events. The result was long term and reduced rent housing to people who were formerly unhoused, which improved their path to recovery. Months after, the same tenants are now peer support workers.

Stigma reduction outcomes included:

1. Stigma Reduction: “I see people with mental illness as capable people.” **Strongly agree** increased by **17%**.
2. Empowerment/Self-Stigma Reduction “Because I have a mental illness, I am dangerous.” **Strongly disagree** increased by **54%**

Ventura

Rapid Integrated Support and Engagement (RISE) is a program designed to outreach to people who tend to slip through the cracks or have difficulty accessing services.

Since RISE began in 2015, it has assisted 4,158 individuals connect to Ventura County Behavioral Health (VCBH) and other services. And, 35% of these individuals had some type of contact or had been enrolled in a VCBH clinic in the past. Fully 1,612 individuals enrolled in RISE, with 41.5% remaining enrolled with a VCBH clinic, with an average length of stay of 263 days.

Individuals who received services from RISE had decreased jail days by 76%, decreased IPU stays by 27%, and decreased crisis team contact by 14%. The success of RISE has allowed for increased collaboration with community partners, which has helped in forming the RISE Expansion, working alongside Law Enforcement.