Alameda County: Data Notebook 2018

for California

Behavioral Health Boards and Commissions

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

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.

Table of Contents

Introduction: Purpose and Goals

Continuum of Care: What BH Services are Counties Required to Provide?

Your County: Evaluation of Services, Barriers to Access, and Unmet Needs

Mental Health Services Act (MHSA) and its Program Components

Questionnaire: How Did Your Board complete this Data Notebook?

Reminder: Where to submit your Data Notebook before March 31, 2019

Appendix

This page intentionally left blank.

Introduction: Purpose and Goals

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. The 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.

Local behavioral health boards/commissions are required annually to review performance data for mental health services in their county and to report their findings to the CBHPC. To provide structure for the report and to make the reporting easier, each year we create a Data Notebook for local behavioral health boards to complete and submit to the CBHPC. Afterward, the responses are compiled and analyzed by our 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 encourage members of all local behavioral health boards to participate in reviewing and developing the responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify critical issues that are most important to your county. Your work will help inform county and state leadership plans for behavioral health programs.

We thank everyone for your interest and continued participation.

We are taking a somewhat different approach for the 2018 Data Notebook (DN). The 2018 DN does not include county-specific data but rather is a brief general survey about mental health services and needs in the counties to guide our advocacy in the coming year. It is anticipated that we will resume our practice of presenting county-specific data in the 2019 Data Notebook.

---

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

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

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 questions in this 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 5600.4

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) Precrisis and Crisis Services. Immediate response to individuals in precrisis 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 precrisis 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 services 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 <u>children and youth</u> meeting the target population criteria established in subdivision (a) of Section 5600.3[2] should include the following modes of service in every geographical area, to the extent resources are available:

(a) Precrisis and crisis services.

(b) Assessment.

(c) Medication education and management.

(d) Case management.

(e) Twenty-four-hour treatment services.

---

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

(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 <u>adults</u> 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) Precrisis 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.

WIC 5600.7

The minimum array of services for <u>older adults</u> 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) Precrisis 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.

Your County: Evaluation of Services, Barriers to Access, and Unmet Needs

Below we ask a series of questions about the above services in your county regardless of fund source. We ask whether there are barriers to service access, unmet needs, or lack of continued or sustainable funding for a particular service or program.

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

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

K: Other barrier, specify:
An increase in the rates of homelessness among the TAY population of 18-24 result in barriers to engaging them in services and supports. Also, the revolving door in and out of the Criminal Justice System makes engagement more difficult as well.

3) **Please indicate (X) any 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.	X	X	X	X
(b) Assessment	X	X	X	X
(c) Medication education & management	X	X	X	X
(d) Case management	X	X	X	X
(e) Twenty-four-hour treatment services		X	X	
(f) Rehabilitation and support services	X	X	X	X
(g) Vocational services			X	
(h) Residential services		X	X	X

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

5) **If you could have one new program or facility or resource within the next three years, what would be your highest priority need?**
Please limit your response to 25 words or less.

1) An older adult crisis residential, API crisis residential, and 300-400 transitional living slots, and

2) A targeted approach to community outreach and education that incorporates the natural supports of various communities to accompany traditional clinical models.

3) Stage-matched housing for people who are actively using substances; a harm-reduction focused residential services program.

4) Address the ongoing challenge of the housing market; a barrier to placing folks who are without housing.

5) Additional crisis residential treatment facilities and crisis stabilization units.

Mental Health Services Act (MHSA) Components

Background and Definitions of the MHSA (below) are excerpted from a description contained in the Executive Summary[3] 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.

---

[3] 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 initially funded up front in the early years and are not currently actively funded through MHSA revenues. Although counties can transfer some CSS funds for these purposes each year, essentially, the availability of that upfront funding for Workforce Education and Training, Capital Facilities and Technological Needs ended on June 30, 2018.

6) **Is there still a need for any of these three components in your county?**
   Yes_X__   No___.

   If yes, please rank the following in priority order of need, #1 being highest.

   __1__   **Workforce Education and Training**
   __3__   **Capital Facilities**
   __2__   **Technological Needs**

Optional: In 25 words or less, please specify what those needs are.

Crisis Residential and Board and Care facilities, as well as long-term residential living. We need an Electronic Health Record (EHR) to help improve care coordination.

7) **Do you have a particularly successful program funded by CSS, Innovation, or PEI funds that you would like to share with us? Yes_X__ No___.**

If yes, please describe briefly (maximum one paragraph, 150 words or less).

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 our TAY population. Lastly, the CYASOC has recently invested $1.3 million of CSS funds into School Based and Special Education Services to accompany clinical treatment programs.