CALBHB/C Issue Briefs

CA Association of Local Behavioral Health Boards / Commissions

Issue briefs and 35+ issue pages are available at www.calbhbc.org

Revised January 29, 2024

See Page 2 for Data, Funding, and a "Call for Immediate & Long-Term Solutions"

California Association of Local Behavioral Health Boards and Commissions

Rev. 7 June 2023 www.calbhbc.org

ISSUE BRIEF: Adult Residential Facilities

ADULT RESIDENTIAL FACILITIES (ARFs) — The critical need for "Board and Care" facilities.

Adult Residential Facilities (ARFs) are a **critical component of CA's housing continuum.** Lack of ARFs (and RCFEs) impacts families, local communities, and most of all, it impacts individuals with severe mental illness (SMI) who for health and/or physical reasons cannot live independently. **The social and financial costs are high** as individuals enter revolving doors between crisis facilities, psychiatric facilities, emergency rooms, homelessness and incarceration. Local budgets are impacted due to crisis management, expensive placements and incarcerations.

What is an ARF?

Names and acronyms include:

- ARF: Adult Residential Facilities
- RCFE: Residential Care Facility for the Elderly (for ages 60 and older)
- Board & Care (often called "Enhanced" or "Augmented" Board & Care)
- Assisted Living

ARFs are licensed to provide care and services sufficient to support needs resulting from an inability to perform Activities of Daily Living or Severe Cognitive Impairment. ARFs provide services that allow people to maintain independence and receive individualized care in a home-like environment, to include:

1. 24 Hour Care
2. Trained Staff
3. Three meals/day (must accommodate special dietary needs)
4. Access to a physician/nurse in case of emergency
5. Assistance with managing medications

Three Key Challenges

1. **Financial:** ARFs cannot survive on a small scale without substantial subsidies. On a larger scale (45+ beds), a supplemental rate (known as 'patches') from counties ranging from $64/day to $160/day is required for fiscal stability.[1]
2. **Staffing:** Providing and retaining a professional, trained and experienced staff requires proper management, appropriate salaries and ongoing training.
3. **"Not In My Backyard"** (NIMBY) opposition from communities for new construction or attempts to rezone a property for ARF (required for more than 6 beds).

Costly Consequences

- Psychiatric hospitals/facilities range from $350 - $775/day.
- Prison costs appr. $291/day[2]
- County jail costs appr. $194+ per day vera.org/downloads/publications/price-of-jail.pdf [3]
- Transitional Programs cost appr. $150/day per resident.

Thousands of Beds Needed

CA counties who responded to the 2021 CA Behavioral Health Planning Council survey [4] estimate that their need for ARF beds for individuals with serious mental illness totals **4,052** persons (for **27 counties out of 58**).

CA Department of Social Services unpublished reports show **488 licensed ARFs and RCFEs serving individuals with SMI closed in 2021** (excluding those that closed due to a change of location or ownership, resulting in a new license being issued). **Losses reported in 2021 total 3852 beds**.

Legislation

Data: AB 1766 requires data collection and reporting for ARFs/RCFEs that serve individuals with SMI, and anticipated closures.

Closures & Purchase: AB 2377 requires notification of ARF/RCFE proposed closures, and gives the city/county the first opportunity to make an offer to purchase the property and continue operation.

A Call for Immediate & Long-Term Solutions

Current ARF/RCFE funding is insufficient for adults with severe mental illness. It is limited to the SSI rate, approximately **$1,325 per month**. Some counties bolster this rate, providing "patches" to large-scale ARFs/RCFEs, often located hours away from an individual's community. These patches range from $64/day to $160/day. [6]

A Tiered Model: It is worth examining a different funding model, such as the one for adults with intellectual and developmental disabilities (IDD). The IDD model provides **several tiers of funding based on the needs of the consumer.** Funding ranges from **$1,325 to $11,736.45 per month per consumer**, allowing for community-based, appropriately staffed ARFs and RCFEs. Dept of Dev. Services Community Care Facility rates: www.dds.ca.gov/rc/vendor-provider/vendorization-process/vendor-rates

Workforce, Training & Education: Funding and resources are necessary to sustain the ARF/RCFE workforce. This includes a living wage, technical assistance, training and support for staff and owners to:

a) Provide trauma-informed, culturally relevant, recovery-focused services and supports to individuals with SMI (including SMI with co-occurring Substance Use Disorder.)
b) Provide services and supports that meet health and physical needs of residents
c) Develop and maintain workforce
d) Fiscal stability
e) Sustain licensing

New Funding

Infrastructure:

Community Care Expansion Program funds the acquisition, construction and rehabilitation of adult and senior care facilities. Requires a match. Dept of Social Services – CCE (funding ends June 30, 2024)

Project Homekey: Local entities partner with the state to acquire and rehabilitate a variety of housing types, to include residential care facilities. homekey.hcd.ca.gov (funding ends June 20, 2026)

Home & Community-Based Alternatives (HCBA) **Waiver** & **Assisted Living Waivers** (ALW):

The HCBA Waiver provides long-term supports and services to eligible Medi-Cal beneficiaries in their home or community residence of choice.

The ALW provides eligible Medi-Cal beneficiaries the choice to reside in an assisted living setting as an alternative to long-term placement in a nursing facility.

The goal of both Waivers is to facilitate transition of institutionalized individuals to a less-restrictive, community-based setting, and prevent individuals who are at imminent risk of institutionalization from being admitted.

Home & Community-Based Alternatives Waiver & Assisted Living Waiver Integration, DHCS

End Notes:

1. ARFs that provide residential care to adults with mental illness survive at a larger scale (45+ beds), with "patches" provided by counties. Psynergy Programs, Inc. and Davis Guest Home offer examples of companies that operate RCFs with a financial model that works due to "patches" paid by counties (added to resident's SSI). Even with the additional revenue, this financial model requires a minimum of 45 residents. These are considered "Enhanced" or "Augmented Board & Cares" as they provide needed supports to the residents, including team leaders, activities, dietary staff, access to a psychiatrist and more. Psynergy additionally provides: Medication Support, Mental Health Services, Crisis Intervention, Case Management and Collateral (all Medi-Cal billable.)
2. CA Legislative Analyst's Office: http://www.lao.ca.gov/PolicyAreas/CJ/6_cj_inmatecost
3. The Price of Jails: Measuring the Taxpayer Cost of Local Incarceration (Page 26, Vera Institute of Justice.) 2014 amount reported in Alameda County was $155+/day. Adjusted for inflation, this equates to $194 per day in 2022.
4. 2021 CA Behavioral Health Planning Council Data Notebook, page 12.
5. 2018 CA Behavioral Health Planning Council ARF Issue Paper: www.dhcs.ca.gov/services/MH/Pages/CBHPC-Reports.aspx
6. Rates found on-line from 2022 Monterey County Contract with Psynergy Programs, Inc (page 28 and 30) and Amador County Contract with Davis Guest Home (page 14).

California Association of Local Behavioral Health Boards and Commissions

November 2020 www.facebook.com/CALBHBC www.calbhbc.org

ISSUE BRIEF: Children & Youth

CHILDREN & YOUTH — Schools as Centers of Wellness [1]

Integrated school-based mental health (MH) programs for children and youth have a profound and positive impact on individuals, families and communities.

Yet currently, **the vast majority of California's students do not receive the services and supports they need.** **75%** of CA principals report students' emotional and mental health were a moderate or severe problem. **2/3** of teachers report they are unequipped to address students' mental health needs. Up to one in five children—**20%**—have a diagnosable mental health condition. Approximately **1 in 3** students feel chronically sad and hopeless. **Suicide** is the second leading cause of death for youth. Unmet trauma and mental health needs are strongly associated with barriers to learning, and by extension, the school-to prison pipeline.

STATEWIDE SOLUTIONS

Funding

Scale—Ramp up funding to allow CA's mental health system to integrate at scale with CA's educational system.

Sustain

- Identify long-term funding solutions
- Communicate sustainable funding and braiding mechanisms of MHSA, Medi-Cal, LEA BOP SMAA, ERMHS, LCFF, private insurance, and First 5 funds.
- Technical assistance for CA's 59 MH agencies.

Performance Outcome Data [2]

Establish, collect & report. S*uggested* outcome data:

- School-based Wellness (Attendance, Grades, Classroom Behavior)
- Standardized Screening/Assessment
- Reporting by Self/Family
- Track culture/race/ethnicity/LGBTQ and age.
- Report trends for very small counties.

Technical Assistance

Communicate successful strategies and programs.

Workforce:

School psychologists, counselors, social workers and nurses are the foundation for school mental health. CA's Office of Statewide Health Planning (OSHPD) should work to identify and allocate funding to address school-based workforce needs. [3]

KEY LOCAL COMPONENTS

All Ages - Integrate mental health programs within schools (K-12) and early learning programs (0-5).

Barriers - Address barriers of parental consent, referrals, transportation, appointment wait times and privacy concerns.

Educators - Attend to educator well-being to reduce stress, burnout and attrition.

Families - Connect, communicate, involve and build trust among parents, schools and teachers.

Prevention & Early Intervention - Page 2.

Racial/Ethnic/Cultural - Programs and services that address racial, ethnic and cultural needs (including LGBTQ).

Trauma-Informed Care - Ensure trauma-informed practices, including training for: staff, families and youth.

Youth should be integral to planning and implementation, including peer programs.

Models & Strategies on Page 2

INTEGRATED MODELS

Early Childhood Models [4]

Early Childhood Mental Health Consultation
- Infants & Young Children
- Families
- Early Care Providers

First Steps to Success
- Kindergarten Students
- Teachers
- Families

Help Me Grow
- Birth to 5 years
- Families
- Health Care Providers

Triple P
- Mental Health
- Primary Care
- Schools
- Family Advocates

K-12 Leaders [5]

Fresno & Sacramento Counties are moving toward integrated school-based MH, including MH clinicians on **every** campus.

K-12 Models [6]

Project Cal-Well schools provide activities for **all students** that include positive behavioral interventions and support (PBIS), restorative justice, and social-emotional learning. Professional development training is provided to educators and community members so they can recognize and support students who show signs and symptoms of mental health needs.

Unconditional Education Model: A Multi-Tiered System (Seneca)
This model is a paradigm shift from traditional service delivery in which students must be referred to special education or mental health services, and those services are delivered by specialists in different settings. In the unconditional Education Model, integrated and coordinated services are available to **all students**, with the belief that each student has the potential to succeed if adults and professionals take the time to understand their past and current needs, and tailor individualized services in response.

Hathaway-Sycamores School Based Mental Health Model
School based mental health services are provided through full-time therapists and community wellness specialists that are embedded on school campuses. They work closely with educators. **Full provision of mental health services** include: individual, family and group therapy; medication support; rehabilitation services, co-occurring SUD services. Life skills, social skills, coping skills and anger management are provided to students who are at risk and need support to be successful in school.

PREVENTION & EARLY INTERVENTION: Strategies & Programs for Supporting Healthy Development [7]

Prenatal	Infancy	Early Childhood	Childhood	Early Adolescence	Adolescence	Young Adulthood
Foundation for mental health and school readiness						
Prenatal Care						
	Home Visitation Programs					
		Early Childhood Intervention/SEL				
				School Climate & Mental Health Literacy		
← Enhancing Family Strengths and Parenting Support →						
← Developmental/Behavioral Health Screening →						
Local planning and coordination						
Training, technical assistance, data & policy						

End Notes:

1. This issue brief summarizes information from "Every Young Heart and Mind: Schools as Centers of Wellness", November 2020 Report, Mental Health Services Oversight & Accountability Commission
2. CALBHB/C's Performance Outcome Data Issue Brief provides:
    a. CA law requiring state agencies to establish performance outcome data measures
    b. Role of CA's 59 local mental/behavioral health boards & commissions to review and comment on performance outcome data to the CA Behavioral Health Planning Council
    c. Links to "promising data" culled and compiled from 59 MHSA plans/updates along with Medi-Cal EQRO and SAMHSA PATH performance outcome data.
3. "Every Young Heart and Mind: Schools as Centers of Wellness", MHSOAC, Page 2
4. "Every Young Heart and Mind: Schools as Centers of Wellness", MHSOAC, Page 73
5. Schools and Mental Health Draft Report--Cover Memo on COVID-19 Response, MHSOAC, Page 3
6. "Every Young Heart and Mind: Schools as Centers of Wellness", MHSOAC, Page 74-75
7. "Every Young Heart and Mind: Schools as Centers of Wellness", MHSOAC, Page 20

California Association of Local Behavioral Health Boards and Commissions

July 2021 www.facebook.com/CALBHBC www.calbhbc.org/youth

ISSUE BRIEF: Transitional Age Youth

TRANSITIONAL AGE YOUTH (TAY) - Ages 16—25

The first onset of mental illness and/or addiction often occurs in the TAY age group. This is a time when biological, psychological and cognitive changes accompany major life transitions in areas of education, employment, housing and adult relationships. Guided by the TAY voice, it is important to assist and engage TAY through outreach, education and a robust continuum of behavioral health programs, addressing both mental health and substance use.

TAY

STATISTICS

Access [1]

- 1 in 3 California youth lack reliable access to mental health resources
- 48% of TAY (13—24) "do not know where to go" for mental health needs
- 8 out of 10 young people surveyed are looking to learn coping skills to help them deal with the stresses of everyday life.

Cost [1]

- 36% of TAY (13-24) "can't afford the cost" of mental health resources

The Need

- 50% of all lifetime mental illnesses develop by age 14, and 75% of all mental health needs emerge before the age of 24. [3]
- 42% of young adults with mental illness went untreated (U.S. 2018) [2]
- Nearly 90% of TAY with substance use disorders went untreated (U.S. 2018) [2]
- Suicide is the second leading cause of death for youth. [4]

KEY COMPONENTS [5]

Culturally Relevant: Providers that represent and relate to ethnicity, race, religion, and culture, including LGBTQ

Early Intervention: It is very important to implement solutions that eliminate gaps and delays in access to care.

Employment Services: Integrated behavioral health / employment (vocational) services for TAY youth. Work is a major therapeutic tool. See calbhbc.org/employment

Membership to include youth voice and leadership on:

- Children & Youth Committees
- Mental/behavioral health boards and commissions

Outreach to inform youth about resources and how to access them, with information intentionally directed at TAY. Youth also want adults in their community to reach out to them about their mental health.

Peer Support groups and services. Youth do not always trust adults or feel adults can relate to their experiences.

Schools: Integrate behavioral health programs within schools to include:

- Mental health and substance use education in K-12
- Workforce to include: School psychologists, counselors, social workers and nurses.
- Mental Health First Aid training for staff.
- College-Based Mental Health—see page 2.

Trauma-Informed practices, including training for: staff, families and youth.

Youth-informed resources that engage youth.

See page 2 & CALBHB/C website for more information: Transitional Age Youth & Foster Youth

Programs

Allcove (Stanford Department of Psychiatry and Behavioral Services

Integrated Youth Mental Health Centers

- Stand-alone sites designed by & for youth
- Focus on mild to moderate
- Integrated Care Services (mental health, physical health, substance use, peer support, family support and supported education and employment.)
- Reduce stigma in mental health

Psychosis Early Intervention Treatment Program (PREP)

- Rigorous early diagnosis using the ____ and SCID
- Individual Cognitive Behavioral Therapy for Psychosis (CBTp)
- Psychoeducational Multi-Family Groups
- Algorithm-guided Medication Management
- Vocational & Educational Support (IPS)
- Peer Support / Family Support
- Support and Skills Groups
- Computer-based Cognitive Rehabilitation

Supportive Outreach & Access to Resources (SOAR)

- Psychiatric medication management
- Individualized clinical case management
- Weekly psychoeducation and support groups
- Weekly multi-family support groups (Napa)
- Bi-monthly family and multi-family support groups (Solano County Only)
- Peer advocate support
- Education and employment support

Integrated School-Based Behavioral Health [6]

Project Cal-Well
Unconditional Education Model (Seneca)
Hathaway-Sycamores School Based MH

Peer Support

TAY Peer Support (Humboldt County)
MHSA Update, pages 87, 88

Program includes of:

- Shared Supervising Mental Health Clinician
- Five full-time peer coaches are an integral part of the multidisciplinary team at TAY Division Programs: HCTAYC, Behavioral Health, Independent Living Skills, and the Drop-in Center
- Peer coaches operate from the lens of empowerment and recovery and integrate into the division through:
  1. Relationship Building and Mentoring
  2. Outreach and Engagement
  3. Linkage to Resources
  4. Activity Coordination.

Psychiatric Medication Video Mini-Series [7]

TAY are often prescribed psychiatric medication following a formal diagnosis by a healthcare provider. Yet, many young people are under-informed about the benefits, risks, and side-effects of the medications they're provided.

In short, young people often do not understand their rights in regard to psychiatric medications.

College Based Behavioral Health—Key Components [8]

- With leadership of students, mental health information and resources should be tailored to and embedded in different communities on campus to best meet their needs.
- Students demand and create formal peer support programs, even with push back from universities.
- To make support accessible, resources need to be available 24/7 in-person, via phone, and across campus, including in living spaces.
- Disability cultural centers create spaces where students with disabilities can connect with one another and celebrate disability culture and identity, as opposed to emphasizing disability as an impairment.

See CALBHB/C website for more information: Transitional Age Youth & Foster Youth

End Notes:

1. 2019 California Youth Mental Health Wellness Survey Results Dashboard, Mental Health Services Oversight & Accountability Commission and Lady Gaga Born This Way Foundation
2. Entering Adulthood: Getting Help for Mental and Substance Use Disorders, SAMHSA TAY Infographic
3. National Alliance on Mental Illness: Teens & Young Adults
4. National Institute for Mental Health: https://www.nimh.nih.gov/health/statistics/suicide
5. 2020 State of the Community Report, CA Youth Empowerment Network, page 22 (a project of Mental Health America, CA)
6. "Every Young Heart and Mind: Schools as Centers of Wellness", MHSOAC, Pages 74-75
7. Medication Options: Young People and mental Health (A PEERS Video Mini-Series)
8. Collegiate Mental Health Innovation Council 2018-19 Report Highlights

California Association of Local Behavioral Health Boards and Commissions

Rev. January 2024 www.calbhbc.org/jails--prisons.html

ISSUE BRIEF: Criminal Justice

CRIMINAL JUSTICE — Reviewing & advising to reduce incarceration and recidivism.

Social and financial costs are high when a person with serious mental illness (SMI) or Substance Use Disorder (SUD) is incarcerated if they otherwise could be in the community, have treatment, have access to medication, and still be accountable.

Statistically High Incarceration

80% of those incarcerated in CA jails and prisons have SUD (General population percentage in CA is 9.2%) (CCJBH PP Page 5)

36% of those incarcerated in CA jails and prisons have a mental illness. General population percentage in CA is 15.9%) (CCJBH PP Page 5)

Reducing Incarceration: Tools/Best Practices

1. SUD & SMI Prevention/Early Intervention
2. Triage Programs: MH /SUD services in:
   - Shelters
   - Hospitals & Clinics
   - Sobering Centers
   - Schools
   - Crisis Stabilization Services
   - Mobile Crisis Units
   - Peer Respite Services
3. Crisis Intervention & DeEscalation Trainings are required for law enforcement personnel.
4. Mental Health Court | Drug Court Young Adult Court | Homeless Court
5. Laura's Law/Assisted Outpatient Therapy
6. CARE Act (Community Assistance, Recovery & Emplowerment Act)
7. Pre-Release and Post-Release Support: Connection to treatment and social services, including Medi-Cal 90-day in-reach and Enhanced Care Management.

Advice/Resources for Reviewing Services & Facilities

Speakers: BH Director/Staff/Contractors, District Attorneys and Public Defenders' Offices, Jail Warden/staff, Probation Director/staff

Topics: Invite speakers to address:

- Behavioral Health services/programs
- "Warm Hand-Offs" - Access to MH/BH services and social supports (eg. vocational, housing) in preparation and upon release.
- "Sequential Intercept Model" (next page)

Patients Rights Advocates (PRAs):

Federal disability rights laws mandate equal access to programs, services and activities for all people with disabilities in custody. PRAs are authorized to review the mental health programs in jails. Invite PRAs to participate at monthly meetings.

Site Visits (access varies by jurisdiction).

Board Liaison

Ask one of your local board/commission members to attend the local Community Corrections Partnership (AB 109) Committees and Juvenile Justice (AB 1913) Coordinating Council meetings and report back to your local board/commission.

Grand Jury Annual Reports

One of the civil grand jury's duties is to look into the quality and management of the county's jails and prisons. Links to reports.

Removing Charges for Individuals with SMI Before or After Incarceration

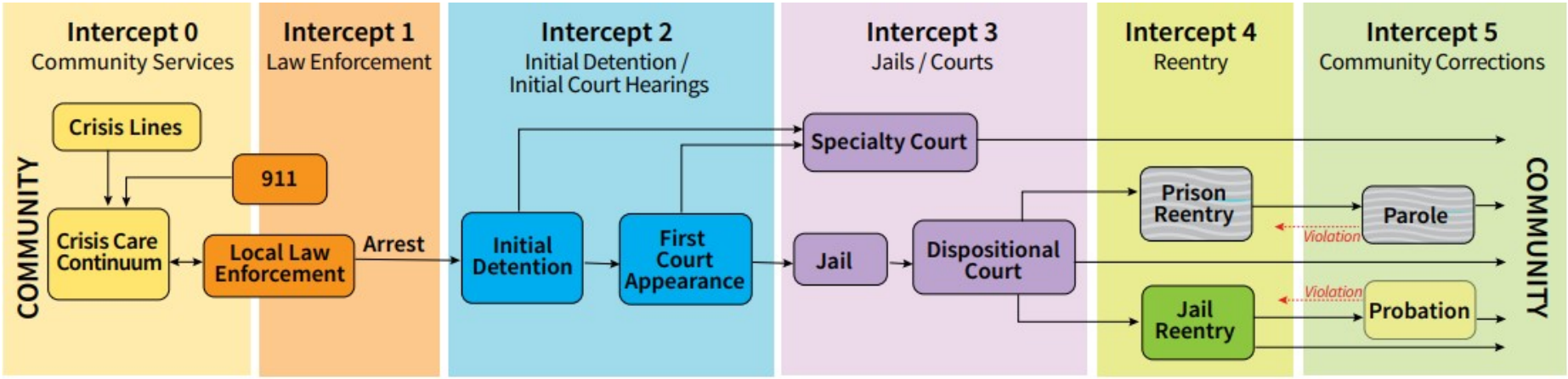
1. Charges dismissed PC 1001.35 - 36
2. Expungement PC 1203.4 - .4a

CALBHBC supports the work of California's 59 local mental/behavioral health boards commissions by providing resources, communication and statewide advocacy. www.calbhbc.org

The Sequential Intercept Model

The Sequential Intercept Model is a tool to help counties identify programs and resources and how best to coordinate them. This model was developed in the 1990s in response to the high prevalence of mental illness in people involved in the criminal justice system.[3]

For more information, see "Together We Can—Reducing Criminal Justice Involvement for People with Mental Illness", Mental Health Services Oversight & Accountability Commission (MHSOAC), 2017— Page 29: "Together We Can".



California Association of Local Behavioral Health Boards and Commissions

Rev. 3, June 2023 www.calbhbc.org/crisis-care-continuum

ISSUE BRIEF: Crisis Care Continuum

CRISIS CARE CONTINUUM — Ensuring timely access to effective services and supports.

Social and financial costs are high as unserved and underserved individuals with severe mental illness and/or substance use disorder repeatedly experience behavioral health crisis. Local communities must provide a comprehensive behavioral health crisis continuum for all ages, while also addressing foundational elements (see page 2) that reduce the need for crisis services.

RECOMMENDED CRISIS SERVICES & SUPPORTS — With 24/7 availability & Peer Providers Imbedded

1. **988 Call Center/Crisis Line:** Anyone (including people worried about a loved-one) can call 9-8-8 to receive guidance and support related to a suicidal, mental health and/or substance use related crisis." CA HHS [1]

2. **Crisis Intervention Team or Coordinator:**[2] Many individuals in crisis, their families and supports, must navigate multiple transitions in care during a very vulnerable time. It is difficult for individuals to move smoothly to higher or lower levels of service intensity as needs change. A dedicated team or coordinator aids in providing continuity of care through a crisis episode, and facilitates a smooth transition through different levels of service.

3. **Mobile Crisis Teams:** (conducted without law enforcement as much as possible)[6] increase access to timely and appropriate services, and decrease unnecessary emergency room visits or arrests. Teams can respond to individuals and families in their own homes, or even on the streets, can de-escalate behavioral health crisis and facilitate appropriate follow-ups. They can also respond to service settings such as emergency rooms, clinics, housing programs, criminal justice settings and schools. Examples:
   - SMART (San Mateo County)
   - Mobile Crisis Triage (Placer County)

4. **Crisis Stabilization Services** are short-term treatment units that provide immediate care to individuals experiencing a mental health or substance use disorder crisis. Examples:
   - MH Urgent Care Center (Sacramento)
   - BH Triage (School-Based) (Humboldt)

5. **Sobering Stations** provide a comfortable, safe environment for individuals intoxicated from either alcohol or drugs. Clinicians and peer staff engage clients in substance and/or mental health services, ensuring linkage and warm hand-offs to community-based services and follow-up. Examples:
   - Bakersfield Recovery Station
   - Mission Street Sobering Center

6. **Peer Respites** utilize peer providers (individuals with lived experience of mental illness and/or substance use) to engage people in services and supports. In rural settings, services are provided on an as-needed basis (e.g. utilizing a room within a behavioral health agency or renting a room from a contractor for overnight stays). Medical, nursing or clinical services are provided as needed. Examples:
   - Cedar Home (Trinity County)
   - Hacienda of Hope (L.A. County)

7. **Crisis Residential Treatment Programs:** Short-term, intensive, supportive services in a home-like environment. Examples:
   - Santa Clara County
   - Santa Barbara County

Foundational Elements—Averting Crisis: Page 2 **Funding/Grants:** Page 3

FOUNDATIONAL ELEMENTS — Averting Crisis

A continuum of care must address factors that prevent entry into crisis care.

The following are key components within a behavioral health continuum of care, along with a listing of CALBHB/C issue briefs, addressing specific issues and populations.

1. **Engagement Tools** including peer staff whenever possible.
   - Comprehensive Outreach
   - Shared Decision Making
   - Psychiatric Advance Directives [3]
   - Assisted Outpatient Therapy (AOT)/Laura's Law *see below*
   - Court-Ordered Care & Conservatorship [4] (As a last resort.)
2. **Comprehensive Community Services** that are accessible, integrated, recovery-focused, trauma-informed, culturally relevant, have significant use of peer staff, & address:
   - Housing (including Board & Cares)
   - Mental Health
     - Prevention/Early Intervention
     - Psycho-Social Services
     - Peer Support
     - Medication Management
     - Crisis Care
     - Hospitalization (As a last resort.)
   - Physical / Behavioral Health Integration
   - Public Guardians & Conservators
     - Appropriately trained
     - Manageable caseloads
   - Substance Use / Behavioral Health Integrated Services
   - Vocational / Behavioral Health Integrated Services
3. **Inter-Agency Collaboration** between crisis care programs, emergency services, hospitals, jails, law enforcement, prisons, schools and behavioral health departments (public & private) that include:
   - Information Sharing
   - Discharge/Aftercare Plans
   - Warm hand-offs

ISSUE BRIEFS

Board & Cares (ARFs/RCFEs)

Children & Youth
- Integrated School-Based Services
- Transitional Age Youth

Criminal Justice

Disaster Prep/Recovery

Employment

LGBTQ+

Older Adults

Performance Outcome Data

Suicide Prevention

Full Listing of Issues (30+):

www.calbhbc.org/newsissues

Assisted Outpatient Treatment (AOT)[4]/Laura's Law[4]

Designed to help individuals with mental illness who have a condition known as "anosognosia" (a lack of awareness of their mental illness), specific criteria are required for consideration of AOT, related to a demonstrated history of repeat crises. AOT services are court-ordered, and include AOT status hearings. While medication is not forced, medication outreach is ordered when an individual agrees to medication as part of treatment (it is self-administered.)

www.calbhbc.org/lauras-law

Cost Savings

In addition to addressing social costs, crisis continuum programs reduce financial costs associated with emergency services, incarceration, hospitalization and homelessness. Crisis Care Services, in Phoenix, AZ were estimated to reduce inpatient spending by $260 million in 2016, preventing $37 million in emergency room costs.

California counties have recognized improved performance even in very small counties (e.g. Sierra County, Glenn County).

FUNDING

FEES & MEDI-CAL

Below are links to recommended best practices for funding crisis services. Note: Medi-Cal (federally known as Medicaid) requires matching funds. Common sources of matching funds: Mental Health Services Act (MHSA) and Realignment Funding (1991 and 2011 (AB 109).

Crisis Call Center: Cell-Phone & Land-Line Fee+

Substance Abuse and Mental Health Services Administration (SAMHSA) Toolkit Page 38+

Crisis Care Coordination:

CalAIM Enhanced Care Management Policy Guide, Page 48, CA Department of Health Care Services (DHCS), September 2021

Crisis Stabilization Services & Crisis Residential:

- SAMHSA Toolkit , page 40
- Medi-Cal Provider Billing Manual, DHCS
- Children—Medi-Cal EPSDT (Early Periodic Screening Diagnostic Treatment) services are for Medi-Cal beneficiaries under age 21. EPSDT services include mental health and substance use treatment, including assistance with scheduling appointments and arranging transportation for Medi-Cal covered appointments.

Mobile Crisis:

The federal match (Medicaid) is 85% starting April 1, 2022 for up to three years. DHCS

Substance Abuse and Mental Health Services Administration (SAMHSA) Toolkit, page 39+

Respite Services:

Medi-Cal Community Supports (Previously called "In Lieu of Services") Policy Guide, Page 28+, DHCS, September 2021

Sobering Centers:

Medi-Cal Community Supports (Previously "In Lieu of Services") Policy Guide, P. 488

PRIVATE INSURANCE

States, counties and local jurisdictions should establish rates that can be applied to all payers (public and private). Establishing reasonable reimbursement rates for crisis services reduces the demand on communities to cover health care expenses that should be covered by insurers. This supports the existence of critical safety net services that are timely and accessible to all.[7]

LOCAL FUNDS

It is in the interest of cities, counties, schools, law enforcement and private hospitals to collaborate and partner with funding due to the shared value that a robust crisis care continuum can provide.

Funds administered by local Behavioral Health Agencies include: Mental Health Services Act (MHSA) funding (from the Community Services and Supports (CSS) component), and Realignment Funding.

GRANTS

Infrastructure

Behavioral Health Continuum Infrastructure Grants to construct, acquire, and rehabilitate real estate assets, or invest in mobile crisis infrastructure, including crisis intervention, crisis stabilization, crisis residential and peer respite. Community Care Expansion: Operating Subsidy Payments & Capital Project funding for licensed adult and senior care facilities.

Workforce

HCAi—Loan Repayment, Scholarship or Grant Program, Health Care Access and Information (HCAi) (formerly OSHPD).

See CALBHB/C Newsletter for current grant listings.

End Notes:

1. Statewide 988 Roll-Out: https://www.chhs.ca.gov/blog/2022/07/18/statewide-988-roll-out/
2. Roadmap to the Ideal Crisis System: , page 79. The National Council for Behavioral Health, 2021
3. **Psychiatric Advance Directives (PADs)** are legal documents, drafted when a person is well enough to consider preferences for future mental health treatment. PADs allow appointment of a health proxy to interpret preferences in a crisis, and the PAD is used when a person becomes unable to make decisions during a mental health crisis. More at: www.calbhbc.org/pad
4. **Court-Ordered Care Related Programs & Legislation:**
   A. Community Assistance, Recovery & Empowerment (CARE) Court focuses on people with schizophrenia spectrum or other psychotic disorders who meet specific criteria – before they get arrested and committed to a State Hospital or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. It connects a person in crisis with a court-ordered Care Plan for up to 12 months, with the possibility to extend for an additional 12 months. The CARE Plan includes community-based services and supports that are culturally and linguistically competent, including: short-term stabilization medications, wellness and recovery supports, and connection to social services, including housing. CARE process participants will be prioritized for the Behavioral Health Bridge Housing program, which provides $1.5 billion in funding for housing and housing support services. www.chhs.ca.gov/care-court

   B. **Assisted Outpatient Treatment (AOT):** Designed to help individuals with mental illness who have a condition known as "anosognosia" (a lack of awareness of their mental illness), specific criteria are required for consideration of AOT, related to a demonstrated history of repeat crises. AOT services are court-ordered, and include AOT status hearings. While medication is not forced, medication outreach is ordered when an individual agrees to medication as part of treatment (it is self-administered.)

   CA's Department of Health Care Services 2019-20 Report highlighted:
   - **Homelessness** was reduced by 32 percent.
   - **Hospitalizations were reduced by a 40 percent change** during AOT, as compared to prior to the program.
   - **Law enforcement contacts were reduced by a 42 percent** change during AOT, as compared to prior to the program.

   C. Laura's Law: [Important Note: Research evidence has shown very little correlation between mental illness and any violent behavior.[5]] Signed into law in 2002, Laura's Law was adopted by the California Legislature after a man with mental illness fatally shot Laura Wilcox, a 19-year-old volunteer at a Nevada County mental health clinic. The legislation allows each county in the state to decide whether to adopt the provision. To qualify for Laura's Law, an individual must have a serious mental illness that resulted in a psychiatric hospitalization or incarceration twice in the previous three years or resulted in violent behavior within the past 48 months. 2020 legislation, AB 1976 requires counties to participate in Laura's Law, including implementation of AOT, unless they opt out. www.calbhbc.org/lauras-law

   D. Lanterman Petris Short (LPS) Act Issue Brief summarizes the LPS conservatorship process.
5. "While an estimated 18.3 percent of Americans suffer from some form of mental illness, only about 4 percent of community violence is attributable to psychopathology per se (Swanson, 1994)." 2016 "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice", SAMHSA, 2019, page 18. Also see Law Enforcement
6. CalAIM Enhanced Care Management Policy Guide, Page 48, CA Department of Health Care Services, September 2021
7. "National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit", Page 38, Substance Abuse and Mental Health Services Administration (SAMHSA), 2020

California Association of Local Behavioral Health Boards and Commissions

July 2019 r.1 www.facebook.com/CALBHBC www.calbhbc.org

ISSUE BRIEF

DISASTER — Integrating Mental/Behavioral Health into local disaster planning.

Preparing for, responding to, and recovering from disasters and traumatic events **is essential** to the behavioral health (mental health and substance use) of individuals and communities. Mental health interventions can help facilitate recovery and prevent long-term mental illness (such as depression, anxiety and Post-Traumatic Stress Disorder).

Prepare for Disaster

Questions to ask to assess your local level of Disaster Response Preparedness:

1. How is Mental/Behavioral Health integrated, staffed, funded and supported in your County?
2. Does your county have a Disaster MH/BH Subject Matter Expert?
3. Current, written, integrated disaster plan? Example of a Mental Health Disaster plan www.calbhbc.org/disaster-recoveryreadiness.html
4. Disaster Department Operations Center?
5. Staff identified for National Incident Management System (NIMS) Roles? Trained?
6. What are the Disaster BH Intervention Standards for those who are least impacted to most impacted?
7. What is your BH Department's Disaster Mission?
8. What is the working relationship between the American Red Cross and Disaster Mental Health Services in your County?
9. What are the BH plans for County staff disaster mental health? (Employee Health and Well Being Unit Leader selected and trained?)
10. Do you have back-up for every mental health position? (Staff may be evacuees.)

Children's Disaster Mental Health

Research shows that children are at particular risk for disaster-related mental illness. It is critical to provide best practice and evidence-based care immediately following disaster. The National Children's Disaster Mental Health Concept of Operations (NCDMH CONOPS) outlines a triage-enhanced children's disaster mental health incident response strategy for "seamless" preparedness, response and recovery operations. More info: CONOPS Handout and www.calbhbc.org/disaster-recoveryreadiness.html

Psychiatric Advance Directives (PAD)

PADs are legal documents, drafted when a person is well enough to consider preferences for future mental health treatment. PADs allow appointment of a health proxy to interpret preferences in a crisis, and the PAD is used when a person becomes unable to make decisions during a mental health crisis. PAD forms, information & Mental Health America's video links at: www.calbhbc.org/disaster-recoveryreadiness.html

CALBHBC: A STATEWIDE ORGANIZATION SUPPORTING THE WORK OF CA's 59 LOCAL MENTAL & BEHAVIORAL HEALTH BOARDS AND COMMISSIONS.

California Association of Local Behavioral Health Boards and Commissions

Rev. October 2021 www.facebook.com/CALBHBC www.calbhbc.org/employment

ISSUE BRIEF: Employment

EMPLOYMENT — Successful practices for adults with mental illness.

Work helps us feel well. Employment is a major therapeutic tool, improving quality of life and reducing symptoms in those with mild to moderate to severe mental illness. The following items are important for board/commission members to understand and consider as they advise locally and as they join with CALBHB/C for statewide advocacy.

Individual Placement & Support (IPS) is a successful, evidence-based employment practice.

What is IPS?

IPS is a model of supported employment for people with serious mental illness (for example, schizophrenia spectrum disorder, bipolar, depression.) IPS is based on eight principles:

1. Competitive Employment
2. Systematic Job Development
3. Rapid Job Search
4. Integrated Services
5. Benefits Planning
6. Zero Exclusion
7. Time-Unlimited Support
8. Worker Preferences

IPS Data

- In CA, only 10% of people in the public mental health system work.
- IPS helps 50% or more of people get jobs. People are 2.5 times more likely to get a job with IPS vs. traditional rehab programs.
- People in IPS work longer stints, earn more, and are more likely to become steady workers than people in traditional programs.

See: www.calbhbc.org/employment.html

Vocational/Mental Health Services Program Examples

Behavioral health staff in a small county (Calaveras), medium county (Solano) & large county (Alameda) presentations in a **recorded webinar:** www.calbhbc.org/vr

Solano County's 2020/2021 Mental Health Services Act (MHSA) Annual Update reports that of 142 consumers who received employment services, 105 consumers secured employment. Of the 105 consumers, 78% (82) secured jobs that are considered "competitive employment" positions, and of those 55 consumers maintained their employment for 90 days or more for a **job retention rate of 67%.**

Peer Provider Certification

Due to SB 803, CA will implement a process for certification for peer support specialists (who have lived experience with the process of recovery from mental illness, substance use disorder, or both). This bill requires DHCS, by July 1, 2022, to establish requirements for counties. www.calbhbc.org/peer-supports.html

California Association of Local Behavioral Health Boards and Commissions

Rev. 1 November 2021 www.facebook.com/CALBHBC www.calbhbc.org

ISSUE BRIEF: LPS Act Reform

LANTERMAN PETRIS SHORT (LPS) Act — Reforming the LPS to improve CA's Mental Health

With thousands dying[1] and decompensating in California's streets and institutions, the relentless cycle between homelessness, hospitalization and the criminal justice system for unserved and underserved individuals with severe mental illness must stop. It is in the interest of the state of California, local communities and the individuals and families they serve to: **(1)** Reform the LPS Act; **(2)** Ensure the availability of requisite resources to reduce and minimize involuntary treatment.

RECOMMENDATIONS

1. **Requisite Resources**: Provide meaningful access to behavioral health treatment appropriate for each person's specific needs. Improving the quality and quantity of services will significantly reduce the revolving doors of incarceration, re-hospitalization and homelessness. See next column for listing of Requisite Resources.

2. **Consistent administration** of the LPS Act, to include identification of individuals who meet the criteria of **"gravely disabled".** Being "gravely disabled" means that someone is no longer able to provide for their own food, clothing, or shelter because of mental illness. (WIC § 5008(h)). Someone who cannot or will not try to find food or shelter as a direct result of a mental illness likely falls under the criteria of "gravely disabled."

3. **Physical Health**: Allow LPS Conservators to manage physical health conditions (as is currently allowable in the probate[2] setting based on the person's incapacity to give informed consent.)

REQUISITE RESOURCES

1. **Engagement Tools** w/Peer Providers Embedded
   - Comprehensive Outreach
   - Shared Decision Making
   - Psychiatric Advance Directives [3]
   - Assisted Outpatient Therapy (AOT) [4] / Laura's Law [5]
   - Conservatorship (As a last resort.)
2. **Comprehensive Community Services** that are accessible, integrated, recovery-focused, trauma-informed and culturally competent, addressing:
   - Peer Providers Embedded
   - Housing (including Board & Cares [5])
   - Mental Health
     - Prevention/Early Intervention
     - Psycho-Social Services
     - Medication Management
     - Crisis Care Continuum (See Issue Brief)
     - Hospitalization (As a last resort.)
   - Physical Health/Behavioral Health Integration
   - Public Guardians & Conservators
     - Appropriately trained
     - Manageable caseloads
   - Substance Use
   - Vocational / Behavioral Health Integration
3. **Inter-Agency Collaboration** between hospitals, jails, prisons and behavioral health departments (county and commercial) that include:
   - Information Sharing
   - Discharge/Aftercare Plans
   - Warm hand-offs

SAMHSA Policy Guidelines—Page 2 LPS Process Outline—Page 4

POLICY GUIDELINES For INVOLUNTARY COMMITMENT

from SAMHSA's 2019 "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice"[7]

1. Effective Treatment	Civil commitment, whether inpatient or outpatient, should be reserved for those reliably diagnosed with a serious mental illness for which there is available treatment that is likely to be effective. Commitment's purpose must be treatment, and need for treatment is an essential requirement for commitment.
2. Inability to Engage Voluntarily	If the person is willing and able to engage with services voluntarily, he or she should not be committed. In deciding whether to order commitment, courts should consider the preferences of the person and the degree to which the person understands the nature of his or her mental illness and the likely effect of treatment.
3. Risk of Harm for Person or Others	A person should not be subject to inpatient commitment unless, without a hospital level of care, the person will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to the person or others. Unless the serious mental illness for which treatment is needed places the person at risk for harm, inpatient commitment should not be used. Risk for harm, however, should not require risk of violent behavior. If an individual is at risk for injury, illness, death, or other major loss solely due to mental illness symptoms such as an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical
4. Outpatient Commitment is Preferable	If a less restrictive alternative to inpatient commitment is available, including outpatient commitment, inpatient commitment should not be ordered. If, with the help of family, friends, or others who are available and willing to help, a person is capable of remaining in the community without presenting risks associated with need for treatment, he or she should not be subject to inpatient commitment.
5. Outpatient Commitment Requirements	A person should not be subject to outpatient commitment unless (i) he or she meets the standard for inpatient commitment, but may be served in a less restrictive setting, or (ii) without the treatment proposed, and other supports the court might order, it is reasonably predictable that the person will experience further disability or deterioration to a degree that, in the foreseeable future, the person will meet the inpatient commitment standard. Because commitment under this second prong (i.e., on grounds of further disability or deterioration) addresses risks of harm that are less immediate, respect for personal autonomy may require an additional finding of impairment in the person's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if commitment is or is not ordered. Full legal incompetency,
6. Due Process	Legal proceedings should accord due process protection, including prompt notice of rights, assignment of counsel, and an opportunity to challenge commitment before a judge or other judicial authority without unreasonable delay.
7. Minimize Trauma	Commitment practices should respect the privacy and dignity of the individual. Every effort should be made to minimize trauma. If law enforcement agencies are responsible for transporting individuals proposed for or under order of commitment, they should assign plain-clothes officers in unmarked cars, whenever possible. Shackles and other restraints should be used only if necessary, never as a matter of routine.

POLICY GUIDELINES For INVOLUNTARY COMMITMENT *Continued*

from SAMHSA's "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice"[8]

8. No Incarceration	Unless already incarcerated for a criminal offense, or facing criminal charges, no candidate for commitment should be detained in a jail or other correctional facility pending commitment, and no person who has been committed should be placed in a correctional facility for treatment services.
9. Prevention Upon Release	Jail and prison authorities, when planning for the release (re-entry) of an inmate with a serious mental illness, should consider whether to initiate commitment proceedings (inpatient or outpatient), depending on the inmate's needs and the likelihood that the inmate will cooperate with treatment once released. Such authorities likewise should be attentive to the needs of inmates while incarcerated and, when faced with an inmate whose needs cannot be met in the institution, should take whatever steps are provided by law for the inmate's transfer or commitment to a more therapeutic setting.
10. Prompt Termination of Commitment	Civil commitment should never be used solely for preventive detention or community control. Treatment staff should have the authority to terminate commitment without the court's authorization and should terminate commitment as soon as the individual progresses to the point where he or she no longer meets commitment criteria. No court should insist that a hospital or other treatment provider retain an individual in services at a level of care that the hospital or provider believes is unnecessary. Before terminating an individual's commitment, treatment staff should arrange appropriate services and supports for the individual in the community.

MANDATORY CIVIL PROCESS TO INITIATE LPS CONSERVATORSHIP
(from CA WIC and San Francisco LPS Report 2019) [8]

Patients can contest holds at any time and be placed at lower levels of care at any time, if appropriate.

Psychiatric Emergency Services (PE) or other acute setting initiates or receives patients on **5150 Hold (72 Hours)**	• 5150 hold: for patients deemed to be gravely disabled and a danger to themselves and/or others • If patient stabilizes within 72 hours, patient is discharged. • If 5150 hold expires & treating psychiatrist determines patient is still gravely disabled, can initiate 5250 hold for up to an additional 14 days. Patients who appear to need a 5250 hold are scheduled for admission to the acute inpatient unit. • If patient stabilizes, patient is discharged.
Acute inpatient initiates **5250 Hold (Additional 14 days)**	• If 5250 hold expires and patient has not stabilized, can initiate 5270 hold for up to 30 days • Can refer patients to Public Conservator for temporary conservatorship at this stage or at any point during or after the initial 5150 hold • If patient stabilizes, patient is discharged.
Acute inpatient initiates **5270** Hold (Additional 30 days) If psychiatrist determines patient is still gravely disabled, refers patient to the Public Conservator to determine if a temporary conservatorship is appropriate (**5352.1 status**)	• If 5270 has expired or close to expiration and patient has not stabilized, can refer to Public Conservator for temporary conservatorship determination • Public Conservator investigates whether patient meets gravely disability criteria • If patient stabilizes or does not meet grave disability criteria, patient is discharged.
(**5352.1**) Public Conservator investigation finds grave disability. District Attorney petitions the Superior Court to grant temporary conservatorship (Additional 30 days)	• If Superior Court agrees, Court grants temporary conservatorship of 30 days, and can extend up to six months. The patient can be placed in the clinically appropriate level of care pending the permanent conservatorship hearing. • If Superior Court denies petition for temporary conservatorship, patient is discharged.
5008(h)(1)(a) hearing for one year conservatorship establishes permanent conservatorship	• If Superior Court denies petition for permanent conservatorship, patient is discharged. • If Superior Court approves petition, the patient is placed in the clinically appropriate level of care • Public Defender represents patients at hearings for permanent conservatorship and City Attorney represents Public Conservator & DPH • Annual psychiatric evaluation to determine readiness for discharge

End Notes:

1. https://insp.ngo/there-are-literally-thousands-of-people-dying-homeless-on-the-streets-of-america/
2. **Probate Conservatorships**: LPS conservatorships differ from probate conservatorships. California's Probate Code (Division 4, Part 3, Section 1800) authorizes the local Superior Court to appoint a conservator for adults who are unable to provide for their basic needs of food, clothing, and shelter, and/or manage their personal finances due to dementia or physical disabilities.
3. **Psychiatric Advance Directives (PADs)** are legal documents, drafted when a person is well enough to consider preferences for future mental health treatment. PADs allow appointment of a health proxy to interpret preferences in a crisis, and the PAD is used when a person becomes unable to make decisions during a mental health crisis.
4. **Assisted Outpatient Treatment (AOT):** From CA's Department of Health Care Services 2018-19 Report highlighted:
    - **Hospitalizations were reduced by a 33 percent change** during AOT, as compared to prior to the program. All counties reported a decrease in the number of days hospitalized, frequency of psychiatric hospitalizations, and/or crisis interventions per individual.
    - **Law enforcement contacts were reduced by a 43 percent** change during AOT, as compared to prior to the program. Five counties reported all participants avoided law enforcement contact while receiving services. Four of the six counties that reported incarcerations of participants during AOT, noted reductions in the number of days incarcerated per individual.
4. **Laura's Law:** [Important Note: Research evidence has shown very little correlation between mental illness and any violent behavior.[7]] Signed into law in 2002, Laura's Law was adopted by the state Legislature after a man with mental illness fatally shot Laura Wilcox, a 19-year-old volunteer at a Nevada County mental health clinic. The legislation allows each county in the state to decide whether to adopt the provision. To qualify for Laura's Law, an individual must have a serious mental illness that resulted in a psychiatric hospitalization or incarceration twice in the previous three years or resulted in violent behavior within the past 48 months. While outpatient treatment can be ordered, medication cannot. Laura's Law is designed specifically to help individuals with mental illness who suffer from a condition known as "anosognosia," a lack of awareness of their mental illness. 2020 legislation, AB 1976 requires counties to participate in Laura's Law unless they opt out.
5. See CALBHB/C's Issue Brief: Adult Residential Facilities (ARFs)
6. "While an estimated 18.3 percent of Americans suffer from some form of mental illness, only about 4 percent of community violence is attributable to psychopathology per se (Swanson, 1994)." Substance Abuse and Mental Health Services Administration [SAMHSA], 2016 "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice", SAMHSA, 2019, page 18.
7. SAMHSA "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice": Practical Tools to Assist Policy Makers in Evaluating, Reforming and Implementing Involuntary Civil Commitment: Policy Guidelines for Involuntary Commitment", page 32
8. City & County of San Francisco Policy Analysis Report Re: Review of LPS Conservatorship in San Francisco, Page A-6

California Association of Local Behavioral Health Boards and Commissions

August 2021 www.calbhbc.org/lgbtq

ISSUE BRIEF: LGBTQ+

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER or QUESTIONING (LGBTQ+)

Trauma from discrimination, oppression, bullying and family rejection can lead to high levels of mental illness, and substance use for individuals, young and old, who identify as LGBTQ+.

It is important for members of advisory boards and commissions to understand the need, and the key components for successful programs and services.

Terms & Acronyms: calbhbc.org/lgbtqtermsacronyms

THE STATISTICS

Adults

- 59% of LGBTQ adults & 60% of transgender adults experience mental illness (compared with 20.6% of adults) [1]
- LGBTQ adults are 2X as likely to use federally prohibited drugs [4]
- 61% of transgender adults of color experience mental illness. [5]
- 50% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25. [4]

Children & Youth

- 41.6% LGB report 4 or more Adverse Childhood Experiences (ACEs), compared to 25.3% for heterosexual individuals [2]
- Over 50% of LGBTQ+ youth report feelings of chronic sadness [2]
- 35% of LGBTQ youth, 45% of transgender youth and 40% of questioning youth have seriously considered attempting suicide, compared to 13% of non-LGBTQ youth. [3]
- Over 50% of transgender youth report contemplating suicide compared to about 15% of non-transgender youth [2]
- LGBT youth are 2X as likely to experiment with drugs and alcohol. [4]
- BIPOC (Black, Indigenous, People of Color) LGBTQ youth report feeling: Depressed (79%); Hopeless or worthless (73%); Nervous or anxious (82%) [3]

◦ Family support and acceptance is associated with less depression, less substance abuse and less suicidal behavior in LGBT youth. [10]

KEY COMPONENTS [6]

All Ages:

Data Collection, Reporting & Analysis

◦ Forms that provide options for multiple gender identities and sexual orientation

◦ Performance outcome data to include LGBTQ+ alongside race and ethnicity

Policies & Procedures

◦ To prevent the use of stigmatizing or invalidating language

◦ To prevent bullying/harassment

◦ Inclusivity/Anti-Discrimination Statements visible on materials, in offices and facilities

Providers that represent and relate to age, ethnicity, race, religion, and culture, including LGBTQ+

Training for Providers, Families, Schools

◦ Sexual orientation, gender identity and expression

◦ Intersectionality: How race, gender, sexuality, age, ethnicity, health and many other characteristics are inseparable and experienced simultaneously [7]

Suicide Prevention

Programs that provide accessible resources to LGBTQ+ identified individuals

Children & Youth:

Alliances: Support networks that include both LGBTQ+ and non-LGBTQ+ allies.

Youth & Families: Advocacy and therapeutic-style support for families and youth

PROGRAMS [9]

OUTREACH

Breaking Down Barriers (San Diego) is an outreach campaign that engages five distinct, underserved communities, including Latino, African-American, Native American, African immigrants/refugees, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) individuals, to increase access to mental health services.

PREVENTION & EARLY INTERVENTION

Community Partnership - LGBTQ Counseling (Monterey) provides outreach, engagement and mental health counseling (individual, family and group) for LGBTQ individuals and their significant others. This program also provides specialized trainings to staff, community providers and therapists.

Engagement (Amador) A monthly, activity-based group was created to engage isolated members of the LGBTQ community in a unique way. Each month the group is held in a different location within Amador County. A case manager (or Personal Services Coordinator) organizes the activity and arranges transportation, if necessary, for behavioral health participants.

Older & Out Therapy Groups (Alameda)
Free, drop-in therapy groups for LGBTQIA+ adults over 60, now all online. Groups are facilitated by a licensed therapist, clinician, and trained peer specialist. Topics include: coping with loss, wisdom that comes with aging, going back in the closet to survive, ageism, dating, invisibility in the LGBTQIA+ community, family acceptance challenges, loneliness, resilience, and more.

PREVENTION & EARLY INTERVENTION *Continued*

Community Counseling & Supportive Services (CCSS) (Orange) is a short-term counseling program for Orange County residents of all age groups, who have or are at risk of developing a mild to moderate behavioral health condition. The program specializes in providing services to diverse communities including Lesbian, Gay, Bisexual, Transgender, Intersex, and/or Questioning (LGBTIQ+), deaf and hard of hearing and underserved ethnic communities. CCSS provides:

- Screening & Assessment
- Individual Counseling
- Groups (Support & Educational)
- Case Management
- Referral and Linkage
- Community Outreach

RESPITE

Danelle's Place Respite Program (Sacramento)
Danelle's Place Respite Program, administered by Gender Health Center (GHC), provides mental health respite care, via a drop in center, to unserved and underserved adults ages 18 and over, who identify as lesbian, gay, bisexual, transgender, queer, questioning and/or allied. There is an emphasis on serving transgender individuals who are experiencing overwhelming stress.

Lambda Lounge Respite Program (Sacramento)
Lambda Lounge Adult Mental Health Respite Program provides drop-in mental health respite care designed to prevent an acute mental health crisis from occurring, as well as suicide prevention support services to unserved and underserved adults ages twenty-four (24) and older who identify as LGBTQ.

WORKFORCE EDUCATION & TRAINING (WET)

FACES introduces high school students to career paths in healthcare, public health, mental and behavioral health while supporting them with academic and behavioral health services that address their needs.

Also see: http://transparency.mhsoac.ca.gov/searchpage—Select "Additional Target Populations" and "LGBTQ"

YOUTH & TRANSITIONAL AGE YOUTH (TAY) PROGRAMS [9]

Our Safe Place (San Diego) provides a full range of mental health treatment services for LGBTQ youth. Multiple drop-in centers across San Diego County will provide supportive services to any youth who identifies as Lesbian, Gay, Bisexual, Transgender, and Questioning. The drop-in centers will have support groups for youth, family members and/or caregivers, youth partners, and alumni mentorship programs.

Reducing Time Spent in Foster Care: The Youth Acceptance Project (YAP)[8] (Alameda) is designed to keep LGBTQ youth safe in their family homes (family reunification/family preservation) and to advocate for safe and equitable permanency of LGBTQ youth when family reunification is not possible. This involves working with parents and caregivers of children either in care or at risk of entering in order to increase acceptance of LGBTQ children among their support systems. The YAP intervention reduces the time that children spend in foster care and reunites children with their families.

Yellow Submarine TAY Drop-In Centers (Los Angeles) Assist youth who are LGBTQ identified or questioning, foster youth, and/or experiencing homelessness between the ages of 16-25. TAY centers are an LA County Department of Mental Health (DMH) funded contract in partnership with CA's Department of Rehab (DOR) in order to provide services for mental health as well as career preparation.

LGBT Support (Calaveras)

With a contract from BHS, a local therapist provides bi-weekly community support group facilitation, in order to improve wellbeing, increase confidence/self-esteem, increase support network, and gain coping skills. The support group meets in local High Schools twice a month.

On-Line Programs & Resources

Gender Spectrum hosts free online groups for preteens, teens, parents, caregivers, and other family members and adults. These groups provide the opportunity to connect with others, share experiences, and feel the comfort of a supportive community. Various groups Include: Pre-Teens and Teens (13-19); Black Trans, Non-Binary & Gender Expansive Teen Group (13-19); People of Color Trans, Non-Binary & Gender Expansive Teen Group (13-18); Pre-Teens (10-12); Parent Support Group; Topic-based Discussion Groups for Parents and Other Adult Family Members and Facilitators Support Group (for anyone who runs a group serving youth and/or families)

Family Acceptance Project is a research, intervention, education and policy initiative to prevent health and mental health risks for LGBTQ children and Youth.

The Trevor Project provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer & questioning (LGBTQ) young people under 25.

Detrimental Impact of "Conversion Therapy"

"Change" Efforts Double and Triple Rates of Depression, Suicide Attempts, Decrease Self-Esteem, Social Support, Education & Income in Young Adulthood

November 2018, Family Acceptance Project

The American Medical Association, American Psychiatric Association & American Psychological Association all strongly oppose "Conversion Therapy". "Conversion Therapy" is illegal in California (SB-1172).

End Notes:

1. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
2. A Child is a Child—Snapshot: California Children's Health: LGBTQ+ Youth Health & Wellbeing, The Children's Partnership, June 2020
3. The State of Mental Health in the LGBTQ Community, Human Rights Campaign Foundation, 2021
4. Sexual Orientation and Estimates of Adult Substance Use and Mental Health, Substance Use and Mental Health Services Administration (SAMHSA), 2015
5. The State of Mental Health in LGBTQ Communities of Color, Human Rights Campaign Foundation, 2021
6. First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California, The California LGBTQ Reducing Mental Health Disparities Population Report
7. SOGIE Handbook, Sexual Orientation, Gender Identity, and Expression, Affirming Approach and Expansive Practices, Kiku Johnson, Once Circle Foundation, 2019, Page 18
8. Family Builders: Best Practice for Serving LGBTQ Youth in Foster Care, Council on Accreditation
9. Mental Health Services Oversight & Accountability Commission (MHSOAC) Program Search Tool
10. LGBTQ Youth and Family Acceptance, Pediatric Clinics North America, 2016

More information is at: www.calbhbc.org/lgbtq

CA Association of Local Behavioral Health Boards & Commissions supports the work of California's 59 local mental and behavioral health boards & commissions.

California Association of Local Behavioral Health Boards and Commissions

September 2019 www.facebook.com/CALBHBC www.calbhbc.org

ISSUE BRIEF: Older Adults

OLDER ADULTS — Increasing mental/behavioral health access and engagement.

A dramatic increase in CA's older adult population has begun, with a projected 80.8% increase from 2010—2030.* The state and local communities must scale and roll-out evidence-based mental/behavioral health offerings to address the needs of older adults.

Following the statistics are recommendations for local and state action.

The Statistics*

- **Mental illness** impacts one in four older adults.
- **Suicide rate** for males 85+ is more than 4 X higher than national rate.
- **Depression:** Nationally 15-20 percent of older adults have experienced depression.
- **Anxiety Disorders:** Approximately 11 percent of older adults have anxiety disorders.
- **Alcohol & Drugs:** 16% of older adults are estimated to be alcoholic or at risk. 25% of senior emergency room visits in 2012 involved narcotic and nonnarcotic pain relievers.
- **50%** of depression care is provided in the primary care setting.
- **50%** of patients with mental illness only have contact with their primary care physician.
- **66%** of people who commit suicide had contact with a primary care physician in month prior to death.

*Sources: CA DOF, SAMHSA & UCLA Center for Health Policy Research

More at: www.calbhbc.org/seniors

Statewide Solutions

MH Data should include age-specific:
- Performance Outcome Data
- Service Penetration Rates for seniors

Residential Care Facilities for the Elderly (RCFE) "Board & Care" Shortage—Issue Paper

Workforce issues to address:
- Workforce Shortage—Fund MHSA WET 5-Year Plan calbhbc.org/workforce
- Training statewide to include MH/BH, Geriatric & Peer Specialist Certification
- Medi-Care Access: 43% of psychiatrists do not take Medi-Care.

Local Solutions

Evidence-Based Practices
Examples: PEARLS & IDEAS programs

Outreach: Increase outreach and engagement.

Planning should include input from older adults, such as the Area Agency on Aging (AAA): https://4csl.org/aging-network-directory/)

Workforce/Training
- **Fund MHSA WET** programs.
- **Geriatric Training—**6-month programs for Mental Health providers. Example: SDSU
- MH First Aid Training for professionals and volunteers who work with Older Adults (such as Meals on Wheels, Community Centers, Residential and Hospice Care.)
- **Peer Specialists** offer experience-based support. Examples: Pool of Consumer Champtions; Alliance on Aging Peer Counseling
- **Training** in older adult suicide screening and differential diagnosis of SMI and dementia.

CALBHBC supports the work of CAs 59 local mental/behavioral health boards and commissions by providing resources, communication and statewide advocacy.

California Association of Local Behavioral Health Boards and Commissions
August 2020 www.calbhbc.org/performance

ISSUE BRIEF: Performance Outcome Data

PERFORMANCE OUTCOME DATA

It is in the best interest of the state and local communities to know the impact of Mental Health Services Act ("MHSA", Proposition 63) offerings.

Need to Standardize

Each of CA's 59 mental/behavioral health agencies collect and report on different MHSA performance outcome data, with some providing meaningful data, and some providing very little performance outcome data.

Suggested Data Points[1] [2]

Children & Youth
- School-based Wellness (Attendance, Grades, Classroom Behavior)
- Standardized Screening /Assessment
- Reporting by Self/Family

Criminal Justice Involvement
- Incarceration/Diversion (# of Days, # of Arrests, Referral/Placement)

Employment
- Competitive
- Sustained

Hospitalizations
- # of Hospitalizations
- Days Hospitalized
- Emergency-Room Visits
- Crisis Psychiatric Visits

Housing/Homelessness
- Permanent Housing
- Days of Homelessness

1. Data should include outcomes specific to culture/race/ethnicity and age.
2. Very small counties may need to report trends instead of numbers.

California Law WIC 5848(c)) specifies that MHSA plans shall include reports on the achievement of performance outcomes, to be established jointly by:

Department of Health Care Services
and
Mental Health Services Oversight & Accountability Commission

in collaboration with

County Behavioral Health Directors Association of CA

and with the review and approval of the

CA Behavioral Health Planning Council

CBHPC is tasked with reviewing and approving the performance outcome measures, and reviewing the performance of mental health and substance use disorder programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources (WIC 5772)

On the local level, it is the duty of:

California's 59
Local Mental/Behavioral Health Boards & Commissions

to review and comment on performance outcome data to the CA Behavioral Health Planning Council. (WIC 5604.2(7))

CALBHB/C supports the work of California's 59 local mental/behavioral health boards and commissions. www.calbhbc.org

PROMISING DATA

The following counties report the most MHSA-related performance outcome data by topic.

Children & Youth
Nevada County

Criminal Justice
Los Angeles County
Merced County
Sacramento County
San Diego County
San Mateo County
Sonoma County

Employment
Alameda County
Los Angeles County
Solano County

Hospitalization
Los Angeles County
Merced County
Riverside County
Sacramento County
Sonoma County

Housing/Homelessness
Los Angeles County
Merced County
Placer County
Sonoma County

ALL COUNTIES

Links to performance outcome data for all counties/juridictions (Medi-Cal, SAMHSA and MHSA).

Alameda
Alpine
Amador
City of Berkeley
Butte
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Fresno
Glenn
Humboldt
Imperial
Inyo
Kern
Kings
Lake
Lassen
Los Angeles
Madera
Marin
Mariposa
Mendocino
Merced
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Riverside
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Santa Cruz
Shasta
Sierra
Siskiyou
Solano
Sonoma
Stanislaus
Sutter-Yuba
Tehama
Tri-City
Trinity
Tulare
Tuolumne
Ventura
Yolo

California Association of Local Behavioral Health Boards and Commissions

April 2020 www.calbhbc.org/suicide

ISSUE BRIEF: Suicide Prevention

SUICIDE PREVENTION [1]

Integrated suicide prevention practices are recommended within education, healthcare, justice and other local systems. **Key Components** and **Promising Practices** are summarized.

KEY COMPONENTS

Access to health, mental health & SUD Care:

- Insurance Coverage
- Integrated Care
- Mental health workforce adequate to provide access for all
- Primary Care Doctors able to screen for suicide risk, depression and SUD, and treat within integrated care systems

Connection to community and family support through culturally-competent training, programs and partnerships

Lethal Means Restriction:

- Railways & Bridges—Deterrent Systems
- Prescription Policies for certain medications
- Carbon Monoxide Emission Controls on autos
- Weapons
  - ⇒ Firearm safety mechanisms such as gun locks and safes.
  - ⇒ Suicide Awareness Training of firearm professionals

Responsible Media Reporting to:

- Prevent suicide clusters
- Share prevention and recovery information

Vulnerable Groups

(According to Statewide Statistics)

People in Middle and Older Age, Veterans and LGBTQ

- Age 35-64: *High rates in 2017*
- Age 65+ *Historically High Rate*
- Veterans *appr. 14% of U.S. Suicides 2016*
- LGBTQ Adults & Youth

People Admitted to and Discharged from Hospital Settings

- Emergency Departments—Individuals seen for self-injury are 30 times more likely to die by suicide than other patients.
- Psychiatric Hospitalization—Suicide risk increases during the first week of admission to a psychiatric hospital and during the first week after discharge.

CALBHB/C supports the work of California's 59 local mental/behavioral health boards and commissions by providing resources, communication and statewide advocacy.

PROMISING PRACTICES

Tools

Crisis Intervention Tools:

- Universal Screening for Suicide Risk with secondary assessment by a physician
- Resources at discharge to include:
  - Safety Plan
  - Follow-up Calls
  - Follow-up Care

Risk Assessment and Management Tools:

- Columbia-Suicide Severity Rating Scale
- Patient Health Questionnaire (PHQ9)
- Crisis Response Planning
- Safety Plan

Treatment Tools:

- Dialectical Behavioral Therapy
- Cognitive Behavioral Therapy for Suicide Prevention
- Collaborative Assessment and Management of Suicidality.
- Attempted Suicide Short Intervention Program (ASSIP)
- Pharmacological Interventions

Postvention Tools directed toward suicide loss survivors, including family, friends, professionals and community at large to address:

- Grief and distress (e.g. face-to-face bereavement support groups)
- Negative effects of exposure to suicide
- Prevent additional suicide by people at risk

Programs

CALM: Counseling on Access to Lethal Means—On-line Training

Gatekeeper Training for teachers, families, coaches, military, supervisors, clergy, emergency responders, urgent care and others to identify at-risk individuals and respond effectively, including connection to services

- Adults
  - ⇒ Question, Persuade, Refer
  - ⇒ Living Works
- Children & Youth
  - ⇒ More Than Sad
  - ⇒ Signs Matter Early Detection
  - ⇒ LGBT Youth

Overdose Response: Harm reduction interventions such as Medication Assisted Treatment for opioid overdose.

Resilience & Skills Training to promote critical thinking, conflict resolution, stress management and coping. (e.g. Good Behavior Game, American Indian Life Skills Development curriculum)

Crisis Lines — How to Connect

National Suicide Prevention Life Line
1-800-273-TALK (8255) or On-Line Chat

MY3 Mobile App: my3app.org

Veterans Crisis Line:
1-800-273-8255 and Press 1
Text: 838255
Chat: veteranscrisisline.net

1 Issue brief is based on: "Striving for Zero - CA's Strategic Plan for Suicide Prevention 2020-2025" by the Mental Health Services Oversight & Accountability Commission. www.calbhbc.org/suicide