MENDOCINO COUNTY
BEHAVIORAL HEALTH ADVISORY BOARD

Chairperson
Michelle Rich

Vice Chair
Flinda Behringer

Secretary
Jo Bradley

Treasurer
Richard Towle

BOS Supervisor
Mo Mulheren

REGULAR MEETING

AGENDA

June 22, 2022
10:00 AM – 12:00 PM

Zoom Meeting:
https://mendocinocounty.zoom.us/j/98557737710

Call in:
+1(669) 900-9128 or +1(346) 248-7799
Webinar ID: 985 5773 7710

1ST DISTRICT:	2ND DISTRICT:	3RD DISTRICT:	4TH DISTRICT:	5TH DISTRICT:
DENISE GORNY	MICHELLE RICH	VACANT	VACANT	FLINDA BEHRINGER
LOIS LOCKART	SERGIO FUENTES	JEFF SHIPP	VACANT	JO BRADLEY
RICHARD TOWLE	VACANT	VACANT	VACANT	MARTIN MARTINEZ

OUR MISSION: *"To be committed to consumers, their families, and the delivery of quality care with the goals of recovery, human dignity, and the opportunity for individuals to meet their full potential."*

	Agenda Item / Description	Action
1. 5 minutes	**Call to Order, Roll Call & Quorum Notice, Approve Agenda:** *Review and Possible Board Action.*	Board Action:
2. 2 minutes	**Approval of Minutes from the May 25, 2022 BHAB Regular Meeting:** *Review and Possible Board Action.*	Board Action:
3. 10 minutes (Maximum)	**Public Comments:** *Members of the public wishing to make comments to the BHAB will be recognized at this time. Any additional comments can be provided through email to bhboard@mendocinocounty.org.*	Board Action:
4. 5 minutes	A. **Resolution Authorizing Remote Behavioral Health Advisory Board Meetings:** *Discussion and Possible Board Action.*	Board Action:

5. **15 minutes**	**Board & Committee Reports:** *Discussion and Possible Board Action.* A. Chair – *Michelle Rich* o 2021 BHAB Annual Report B. Vice Chair – *Flinda Behringer* C. Secretary – *Jo Bradley* D. Treasurer – *Richard Towle* E. Advocacy & Legislation Committee – *Member Bradley, Chair Rich* F. Appreciation Committee – *Member Fuentes & Martinez* G. Contracts Committee – *Member Fuentes and Chair Rich* H. Membership Committee – *Member Behringer, Bradley, Gorny, Chair Rich* I. Public Comment Follow Up Committee – *Member Martinez and Shipp* J. Site Visit Committee - *Member Behringer, Fuentes, Martinez, & Towle*	Board Action:
6. **20 minutes**	**Mendocino County Report:** *Jenine Miller, BHRS Director* A. Director Report Questions B. Psychiatric Health Facility Update C. Staffing Update D. Flow Charts E. Trainings for Mental Health Workers	Board Action:
7. **15 minutes**	**RQMC Report:** *Camille Schraeder, Redwood Quality Management Company* A. Data Dashboard Questions B. Staffing Update	Board Action:
8. **15 Minutes**	**Mendocino County 2022 Data Notebook:** *Discussion and Possible Board Action.*	Board Action:
9. **20 minutes**	**COVID Reflection:** *Discussion and Possible Board Action.*	Board Action:
10. **10 Minutes**	**Member Comments:**	Board Action:
11. **2 minutes**	**Adjournment**	

AMERICANS WITH DISABLITIES ACT (ADA) COMPLIANCE

The Mendocino County Behavioral Health Advisory Board complies with ADA requirements and upon request will attempt to reasonably accommodate individuals with disabilities by making meeting material available in appropriate alternative formats (pursuant to Government Code Section 54953.2). Anyone requiring reasonable accommodations to participate in the meeting should contact the Mendocino County Behavioral Health Administrative Office by calling (707) 472-2355 at least five days prior to the meeting.

BHAB CONTACT INFORMATION:

PHONE: (707) 472-2355 | FAX: (707) 472-2788

EMAIL THE BOARD: bhboard@mendocinocounty.org | **WEBSITE:** www.mendocinocounty.org/bhab

MENDOCINO COUNTY BEHAVIORAL HEALTH ADVISORY BOARD

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BOS Supervisor
Mo Mulheren

REGULAR MEETING

MINUTES

May 25, 2022
10:00 AM – 12:30 PM

Location:
Behavioral Health Regional Training Center
8207 East Road, Redwood Valley

1ST DISTRICT:	2ND DISTRICT:	3RD DISTRICT:	4TH DISTRICT:	5TH DISTRICT:
DENISE GORNY LOIS LOCKART RICHARD TOWLE	MICHELLE RICH SERGIO FUENTES VACANT	MILLS MATHESON JEFF SHIPP LARANN HENDERSON	VACANT VACANT VACANT	FLINDA BEHRINGER JO BRADLEY MARTIN MARTINEZ

OUR MISSION: *"To be committed to consumers, their families, and the delivery of quality care with the goals of recovery, human dignity, and the opportunity for individuals to meet their full potential."*

	Agenda Item / Description	Action
1. 5 minutes	**Call to Order, Roll Call & Quorum Notice, Approve Agenda:** *Review and Possible Board Action.* ○ Meeting called to order by Chair Rich at 10:05 AM ○ Members present: Gorny, Lockart, Martinez, Shipp, Towle, Chair Rich, and Supervisor Mulheren.	Board Action: Motion made by Member Martinez, seconded by Member Gorny to approve the agenda as presented. Motion passes unanimously.
2. 2 minutes	**Approval of Minutes from the April 27, 2022 BHAB Regular Meeting:** *Review and Possible Board Action.* ○ Minutes approved as presented.	Board Action: Motion made by Member Towle, seconded by Member Gorny to approve the minutes as presented. Motion passes with one abstention (Shipp).

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3. 10 minutes (Maximum)	**Public Comments:** *Members of the public wishing to make comments to the BHAB will be recognized at this time. Any additional comments can be provided through email to bhboard@mendocinocounty.org.* ○ Jo Silva inquired about psychiatrists available locally and the lack of cognitive and spiritual therapy. Member Towle mentioned there is one psychiatric at Hillside Clinic. Dr. Timme is still providing psych services, as well as well as Dr. Segal. ○ Noah Schutz on behalf of New Life clinic: New Life clinic is a new clinic in Ukiah (located where the old probation office used to be). They are an opioid use disorder treatment facility and also offer MAT services. The clinic currently consists of about 10 staff members, and is open from 6:00 AM – 2:30 PM Monday – Friday. New Life clinic is able to serve clients from any county not just Mendocino County. The clinic offers methadone, and so this tends to bring in a lot of people. The clinic has 118 people in their census already. New Life clinic is trying to partner with as many community agencies as possible. Their medical team is from RCS. The clinic has a screening process as clients come in, they do take walk-ins, no appointment needed. Discharge planning is done in collaboration with the ER. New Life clinic currently does not have any youth services available as there are legal concerns with putting patients under 18 on medication for addiction.	Board Action: None.
4. 5 minutes	**A. Resolution Authorizing Remote Behavioral Health Advisory Board Meetings:** *Discussion and Possible Board Action.* ○ June meeting proposition for a remote meeting for logistical difficulties due to Measure B meeting.	Board Action: Motion made by Member Gorny, seconded by Member Towle to meet remotely in June. Motion carries with one disapproval (Lockart).
5. 25 minutes	**Board & Committee Reports:** *Discussion and Possible Board Action.* A. Chair – *Michelle Rich* ○ 2021 BHAB Annual Report ○ A copy of the draft annual report was presented to all board members. ○ Board agreed to finalize approval at next month's meeting. ○ BHRS staff will reserve a spot in the August 16, 2022 BOS meeting agenda to present the annual report. ○ Data Notebook is due in October; the board will begin working on it in the next couple of months. ○ 2022 BHAB Calendar ○ Calendar approved as presented. B. Vice Chair – *Flinda Behringer* ○ Absent. C. Secretary – *Jo Bradley* ○ Absent. D. Treasurer – *Richard Towle* ○ Treasurer Towle reminded the board to send any mileage	Board Action: Motion made by Member Shipp, seconded by Member Martinez to approve the calendar as presented. Motion passes unanimously.

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	expenses to BHRS staff as soon as possible as the end of the fiscal year is coming up. E. Advocacy & Legislation Committee – *Member Bradley, Chair Rich* o Nothing to report. F. Appreciation Committee – *Member Fuentes & Martinez* o Discussion about Manzanita transitioning their services to Tapestry. The County will be doing an RFP for the wellness centers. o The Appreciation Committee plans to have an appreciation day for Tapestry once transition is done. o The Appreciation Committee will prepare letters for Mills Matheson and Julia Eagles. G. Contracts Committee – *Member Fuentes, Matheson, Chair Rich* o Contracts committee reports that the RFP process for Healthy Living Community, results are pending. H. Membership Committee – *Member Behringer, Bradley, Gorny, Chair Rich* o Chair Rich reports that Member Henderson took a position with Consolidated Tribal Health, and this puts her in a conflict of interest as Consolidated Tribal Health receives funding from the county. o There are 2 vacancies in the third district, 3 in the fourth, and 1 in the second district. BHRS Director Miller shared that NAMI Mendocino has been putting the word out with peer population about BHAB vacancies for anyone interested in joining the board. o Membership committee will get together in the next month. I. Public Comment Follow Up Committee – *Member Martinez and Shipp* o Member Martinez attempted to follow up with peer from Manzanita who participated in a meeting a few meetings ago, but was not able to. J. Site Visit Committee - *Member Behringer, Fuentes, Martinez,& Towle* o Recommendation to do a site visit at Willow Terrace.	Motion made by Member Martinez, seconded by Member Shipp to approve the creation of a flyer with information to recruit board members, and to distribute the flyer at public events. Motion passed unanimously.
6. **20 minutes**	**Mendocino County Report:** *Jenine Miller, BHRS Director* A. Director Report Questions o Director's report handout included in the agenda packet. o BHRS has been busy working on contracts as contract season is one of the busiest times of the year. The ASO and provider contracts will be going to the Board of Supervisors on June 21st for approval. BHRS staff will provide a copy of the ASO/Provider contract to the contracts committee and a list of all contracts later this year. o BHRS Director Miller reports that conservatorships continue to impact the budget, and requests for conservatorship continue to rise. Realignment funds cover these costs. o BHRS has had multiple audits this year including: MHSA Program, MHSA FY 10/11 finance audit, EQRO, SABG, Drug Medi-Cal, Triennial, SUDT cost report audit. BHRS has received a lot of good feedback on all audits; Triennial results are pending. o BHRS SUDT provides services in Ukiah, Willits, and Fort Bragg, and is looking into expanding services to the South	Board Action: None.

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	Coast as well. B. Psychiatric Health Facility Update - The demolition of the building is starting later this year. BHRS Director Miller will provide a copy of plans for space to the board, once completed. C. Staffing Update - Continuous efforts to recruit and fill vacancies. D. Other: - SUDT is hosting a Fentanyl training on June 24th at the Ukiah Fairgrounds Carl Purdy Hall. The training is open to the general public. A copy of the flyer will be provided to the board. - BHRS will be doing 2 De-escalation trainings, one in Ukiah and another in Fort Bragg. More information will be provided once dates are confirmed. - Discussion on updating the BHRS program brochure and flow charts. BHRS staff will update the flow charts and present to the board at next month's meeting. - BHRS Director Miller reports BHRS has been working with NAMI Mendocino who has also been leading a Native Connections group which is intended to help connect the tribes to mental health services.	
7. **20 minutes**	**RQMC Report:** *Camille Schraeder, Redwood Quality Management Company* A. Data Dashboard Questions - Camille reports crisis has been over utilized this last quarter and that law enforcement contacts vary, some months are lower some higher. - Update on Manzanita: board working on a merger due to overarching legal and other issues. RQMC sent a letter to the BOS clarifying what the longstanding challenges have been. Manzanita staff and clients have been picked up by other agencies. - The most acute clients are addressed every morning at ACT meetings. Children's system of care is still concerning compared to previous years. B. Staffing Update - Increase in salary and benefits helped with the a few new hires recently including 4 clinicians. C. Willow Terrace: - The last death was very hard on providers and RCHDC staff. ECM contract allowed wellness coaches to be there every day. The clients are a part of Manzanita, MCAVHN, and RCS but right now it is primarily RCS and crisis. D. Other: - Camille reports RQMC has a couple of Corrective Action Plan's (CAPs) pending that were issued by the County. The CAPs are regarding timeliness and how to address workforce about moment of service request to first offered appointment. RQMC expects new hires will help with the timeliness.	Board Action: None.

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	- RQMC is changing their name to Anchor Health Management as of July 1, 2022.	
8. **20 Minutes**	**External Quality Review Organization (EQRO) Mental Health Plan FY 2021-22 Report Overview:** *Jenine Miller, BHRS Director* - Final Mendocino MHP report included in agenda packet. - Page 53 of the report includes EQRO's recommendations; BHRS is working on recommendations although some are already in effect. BHRS Director Miller commented that BHRS is always looking to increase bilingual staffing. RCS and the county are doing mentorship programs, trying to increase options for interns to bring in more long term staffing. - Outcome measurement data recommendation: outcome measures will be a non-clinical performance improvement project (PIP) next year. - Pages 31-32 have psychiatric hospitalizations data. Mendocino County is performing a lot higher than other California counties. Re-hospitalizations for Mendocino County are below state levels.	Board Action: None.
9. **20 minutes**	**COVID Reflection:** *Discussion and Possible Board Action.* - Tabled	Board Action: None.
10. **10 Minutes**	**Member Comments:** - No member comments.	Board Action: None.
11. **2 minutes**	**Adjournment:** 12:35	Motion made by member Towle, seconded by Member Shipp to adjourn the meeting.

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Behavioral Health Advisory Board

BHRS Director's Report

June 2022

1. Board of Supervisors:

- **Recently passed items or presentations:**

  i. Mental Health:

  - Approval of Agreement with A&A Health Services, LLC. to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
  - Approval of Agreement with Canyon Manor to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
  - Approval of Agreement with California Psychiatric Transitions, Inc., to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
  - Approval of Agreement with Casa Serenity, LLC. to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, for the Period of July 1, 2022 through June 30, 2023.
  - Approval of Agreement with Crestwood Behavioral Health, Inc. to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
  - Approval of Agreement with Davis Guest Home to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
  - Approval of Agreement with Mendocino Coast Hospitality Center to Provide Case Management and Supportive Supervisory Services to Residents with Severe Mental Illness in the Homeless and Transitional Housing Apartments in Fort Bragg, Effective July 1, 2022 Through June 30, 2023.
  - Approval of Agreement with Nadham Inc. DBA Creekside Convalescent Hospital-Behavioral Health Unit to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 Through June 30, 2023.
  - Approval of Agreement with NetSmart Technologies, Inc., to Provide the Annual Licensure, Maintenance, and Support for Behavioral Health and Recovery Services' Electronic Health Record System, MyAvatar, Effective July 1, 2022 through June 30, 2024.
  - Approval of Agreement (Retroactive Amendment to the Enhanced Care Management Provider Fee For Services Agreement No. MH-21-040) Between Partnership HealthPlan of California and Mendocino County Behavioral Health and Recovery Services, Effective on a New Start Date of January 1, 2022

(original start date of January 27, 2022) Through December 31, 2024

- Approval of Agreement with Vista Pacifica Center to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, for the Period of July 1, 2022 through June 30, 2023.
- Approval of Agreement with Willow Glen Care Center to Provide Residential Care to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2022 through June 30, 2023.
- Approval of Amendment to BOS Agreement 21-101, with Psynergy Programs, Inc. to Provide Residential Care Services to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2021 through June 30, 2022.
- Approval of Amendment to BOS Agreement 21-076, with Davis Guest Home to Provide Residential Care Services to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2021 through June 30, 2022.
- Approval of Amendment to BOS Agreement No. 21-089, with Telecare Corporation to provide skilled nursing services to Mendocino County Lanterman-Petris-Short Clients, Effective July 1, 2021 through June 30, 2022.
- Noticed Public Hearing - Discussion and Possible Action to Approve the Mendocino County Proposed Budget for Fiscal Year (FY) 2022-23, Including All Recommended Actions and Adjustments.

ii. Measure B: None.

iii. Substance Use Disorders Treatment: None.

- **Future BOS items or presentations:**

i. Mental Health: To be determined.

ii. Substance Use Disorders Treatment: To be determined.

iii. Measure B: To be determined.

2. Staffing Updates:

a. New Hires:
   i. Mental Health: 1
   ii. Substance Use Disorders Treatment: 0
b. Promotions:
   i. Mental Health: 1
   ii. Substance Use Disorders Treatment: 0
c. Transfers
   i. Behavioral Health: 0
d. Departures:
   i. Mental Health: 1
   ii. Substance Use Disorders Treatment: 1

3. Audits/Site Reviews:

a. Completed/Report of Findings:

i. Partnership SUDT site review Completed
ii. BHRS Triennial Audit Completed (results pending)
iii. FY 2021-22 Regional Model DMC-ODS Review Completed (results pending)
iv. Substance Abuse Block Grant Audit Completed (results pending)

b. Upcoming/Scheduled: To be determined.

c. Site Reviews:
   i. Redwood Community Services FB – Completed
   ii. Mendocino County Youth Project – Completed
   iii. TLC Child and Family Services – Pending

4. Grievances/Appeals:

a. MHP Grievances: 0
b. SUDT Grievances: 0
c. MHSA Issue Resolutions: 0
d. Second Opinions: 0
e. Change of Provider Requests: 1
f. Provider Appeals: 0
g. Consumer Appeals: 0

5. Meetings of Interest:

a. Cultural Responsiveness for Behavioral Health working with Native American Communities: June 30, 2022 2:00 - 4:30 PM via Zoom.
Registration link: https://www.surveymonkey.com/r/Q8BV5XX

b. Diversity Equity and Inclusion Training June 27, 2022 1:00 - 3:30 PM via Zoom.
Registration link: https://www.surveymonkey.com/r/CHN7WJP

c. MHSA Forum/ QIC Joint Meeting tentatively scheduled for August 30, 2022: 12:00 – 2:00 PM at The Center, 200 Main Street Point Arena 95468 and also via Zoom.

6. Grant Opportunities:

a. N/A

7. Significant Projects/Brief Status:

a. **Assisted Outpatient Treatment (AOT): AB 1421/Laura's Law May 2022**
Melinda Driggers, AOT Coordinator, is accepting and triaging referrals:

   i. Referrals to Date: 125 (duplicated)
   ii. Total that did not meet AOT criteria: 102
      - Total Referrals FY 21/22: 18
      - Client Connected with Provider/Services: 2
      - Unable to locate/connect with client: 2
   iii. Currently in Investigation/Screening/Referral: 1
   iv. Settlement Agreement/Full AOT FY 21/22: 4
   v. Other (Pending Assessments to file Petition): 1 (hearing scheduled)

8. Educational Opportunities:

a. Fentanyl Awareness Summit hosted by Behavioral Health & Recovery Services SUDT: Friday, June 24, 2022 9:00 AM – 4:30 PM at the Ukiah Fairgrounds Carl Purdy Hall. Registration link: https://forms.gle/9AqHkmTVU7ccdb1h8

b. Diversity Equity and Inclusion Training: June 27, 2022 1:00 - 3:30 PM via Zoom. Registration link: https://www.surveymonkey.com/r/CHN7WJP

c. Cultural Responsiveness for Behavioral Health working with Native American Communities: June 30, 2022 2:00 - 4:30 PM via Zoom. Registration link: https://www.surveymonkey.com/r/Q8BV5XX

d. MHSA Forum/ QIC Joint Meeting tentatively scheduled for August 30, 2022: 12:00 – 2:00 PM at The Center, 200 Main Street Point Arena 95468 and also via Zoom.

9. Mental Health Services Act (MHSA):

a. MHSA Forum/ QIC Joint Meeting tentatively scheduled for August 30, 2022: 12:00 – 2:00 PM at The Center, 200 Main Street Point Arena 95468 and also via Zoom.

10. Lanterman Petris Short Conservatorships (LPS):

a. Number of individuals on LPS Conservatorships: 58

11. Substance Use Disorders Treatment Services:

a. Number of Substance Use Disorders Treatment Clients Served in **April 2022**:
   - i. Total number of clients served: 76
   - ii. Total number of services provided: 352
   - iii. Fort Bragg: 10 clients served for a total of 31 services provided
   - iv. Ukiah: 49 clients served for a total of 255 services provided
   - v. Willits: 17 clients served for a total of 66 services provided

b. Number of Substance Use Disorder Clients Completion Status
   - i. Completed Treatment/Recovery: 8
   - ii. Left Before Completion: 8
   - iii. Referred: 4
   - iv. Total: 16
   - v. Average Length of Service: 144 hours

12. New Contracts:

- None.

13. Capital Facilities Projects:

a. Crisis Residential Treatment Facility "Orchard Project":
    i. Project opened doors and has been receiving clients. Documents submitted for Grant disbursement.
b. Willow Terrace Project:
    i. Vacancies filled through Coordinated Entry process as they come available.
    ii. Some turnover in tenancy.
c. Orr Creek Commons Phase 2:
    i. Facility in final construction phase. Providers are screening applications for criteria. Anticipated to open July 2022.

YOU'RE INVITED

Fentanyl Awareness Day

BHRS SUDT & Safe Rx Mendocino are working together to keep our community informed & safe from Fentanyl overdose.

Friday, June 24, 2022 9am to 4:30 pm

Fentanyl, a dangerous opioid implicated in fatal overdoses, is here in Mendocino County. It is mixed into other drugs, like street Xanax or party drugs without users' knowledge. It can be fatal in tiny amounts.

Ukiah Fairgrounds Carl Purdy Hall

Join us for a free in-person discussion with local experts, including Dr. Shannon Robinson of HMA, to learn how to keep yourself and our community safe.

Pre-registration required for **free lunch**. Please use this link to pre-register:
https://forms.gle/7cNaNdpNekmi9pbd6

QUESTIONS, PLEASE CONTACT JILL ALES-707-472-2618

1120 S. Dora Street
Ukiah, CA 95490

Buffey Bourassa
707-456-3803
bourassab@mendocinocounty.org

behavioral health & recovery services
Mendocino County

Diversity, Equity, and Inclusion Training

Brought to you by
Behavioral Health & Recovery Services
MHSA

Presenter:
Gayle Zepeda
Redwood Valley/Little River Band of Pomo Indians
Diversity Equity and Inclusion Discussion

Training Topics:

- Defining and differentiating between the terms diversity, equity and inclusion with discussion of how they apply in behavioral health
- Developing common language and understanding around privilege and implicit bias
- Describing strategies to address these topics in an agency/ organizational structure to reduce disparity and inequity
- Presenting impacts of topics on work and service delivery

June 27th, 2022
1:00 pm—3:30 pm

Location: Via Zoom

Register via the following link

https://www.surveymonkey.com/r/CHN7WJP

behavioral health & recovery services
Mendocino County

Cultural Responsiveness and Tribal Communities

Brought to you by Mendocino County Behavioral Health & Recovery Services
MHSA

Presenter:

Gayle Zepeda

Redwood Valley/Little River Band of Pomo Indians

Cultural Responsiveness to Behavioral Health Clients

Training Topics:

- Brief history of local Native American culture; tribal leadership, education about local cultural practices form a personal perspective
- Discussion of perspectives from the Native American community in accessing local services including historical trauma and local experiences of discrimination and institutional distrust
- Techniques and strategies for clinicians to improve trust, address and overcome barriers and increase access and equity in services
- Discussion of how the concepts of Diversity, Equity, and Inclusion pertain to services with clients from the Native American community

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June 30th, 2022

2:00 PM am to 4:30 PM

Location: Via Zoom

Pre-registration is required

Registration Link:

https://www.surveymonkey.com/r/Q8BV5XX

QI Work Plan - 8.1

Report - Appeals, Grievances, Change of Provider - April 2022

Provider Appeal (45 days)

Receipt Date	Provider Name	Reason	Results	Date Completed	Date Letter sent to Provider
Total	0				

Client Appeal (45 days)

Receipt Date	Provider Name	Reason	Results	Date Completed	Date Letter sent to Client
Total	0				

Issue Resolutions (60 Days)

Receipt Date	Provider Name	Reason	Results	Date Completed	Date Letter sent to Provider
Total	0				

SUDT Grievance (60 Days)

Receipt Date	Provider Name	Reason	Results	Date Completed	Date Letter sent to Provider
Total	0				

Client Grievance (60 Days)

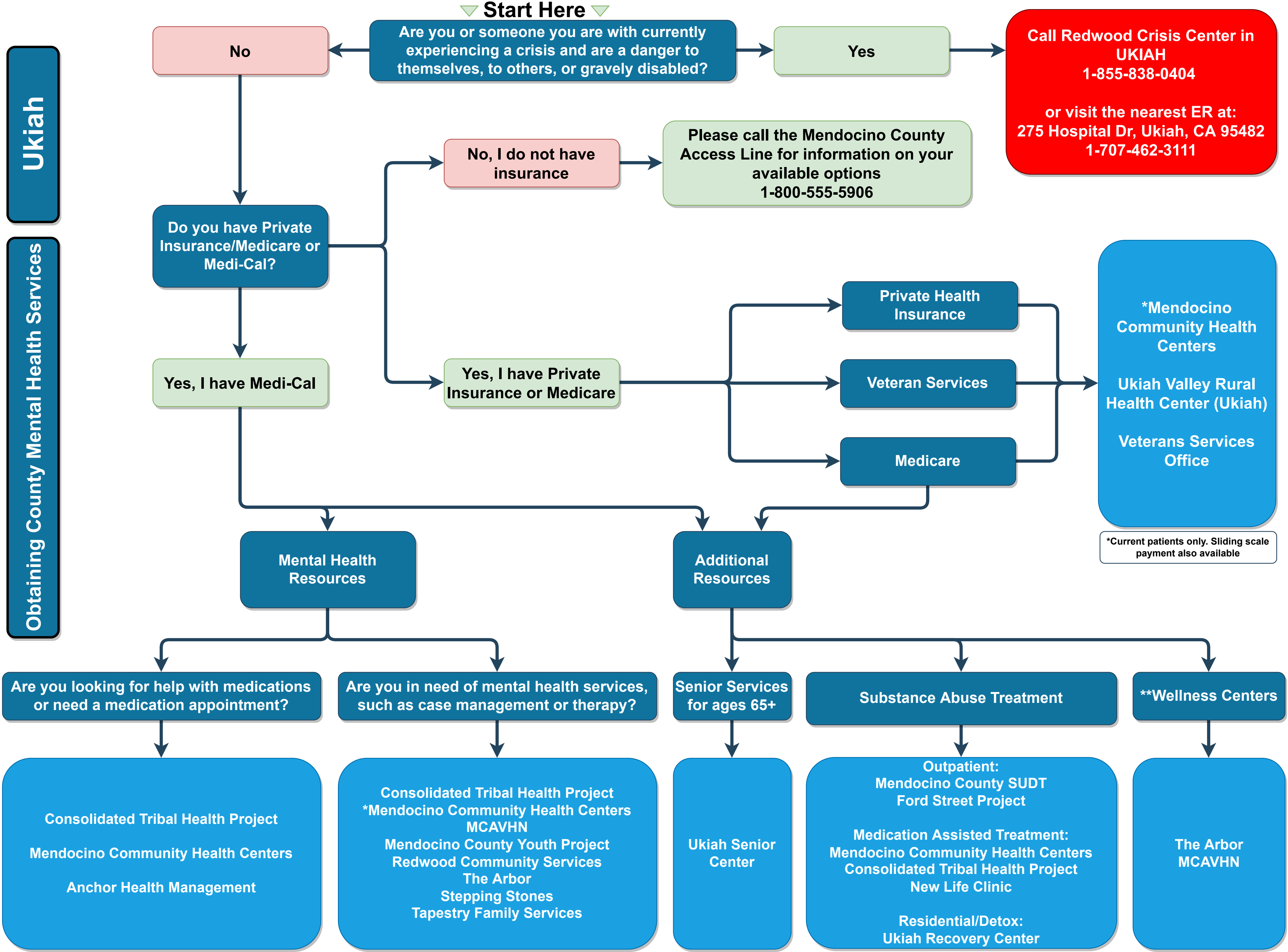
Receipt Date	Provider	Reason	Results	Date Completed	Date Letter sent to Client
Total	0				

Client Request for Change of Provider (10 Business Days)

Receipt Date	Provider	Reason	Results	Date Completed	Date Letter sent to Client
4/20/2022	Manzanita	Beneficiary request to change provider from Manzanita to MCAVHN due to contact issues with Manzanita.	Request processed, beneficiary referred to MCAVHN.	5/4/2022	5/5/2022
Total	1				

0 Provider Appeals
0 Client Appeals
0 Issue Resolutions
0 SUDT Grievances
0 Grievances
1 Requests for Change of Provider (Completed)

Report Completed by: Lili Chavoya, Program Specialist I, BHRS Quality Asssurance



**A Wellness Center is where healthcare professionals, nutritionists and/or life-coaches provide a variety of treatments and services to encourage and educate people on the health of their minds and bodies.

Mendocino County Youth Project
776 South State Street #107
Ukiah, CA 95482
1-707-456-9600

Redwood Community Services
631 S. Orchard Avenue
Ukiah, CA 95482
1-707-467-2010

The Arbor Youth Resource Center
810 North State Street
Ukiah, CA 95482
1-707-462-7267

Stepping Stones
140 Gibson Street
Ukiah, CA 95482
1-707-468-5536

Tapestry Family Services
290 East Gobbi Street
Ukiah, CA 95482
1-707-463-3300

Ukiah Senior Center
497 Leslie Street
Ukiah, CA 95482
1-707-462-4343

Ukiah Valley Rural Health Center
260 Hospital Drive
Ukiah, CA 95482
1-707-463-8000

Veteran Services Office
405 Observatory Avenue
Ukiah, CA 95482
1-707-463-4226

Ukiah Recovery Center
139 Ford Street
Ukiah, CA 95482
1-707-462-6290

Anchor Health Management
350 East Gobbi Street
Ukiah, CA 95482
1-707-472-0350

Mendocino County
Substance Use Disorders Treatment
1120 South Dora Street
Ukiah, CA 95482
1-707-472-2637

Consolidated Tribal Health Project
6991 North State Street
Redwood Valley, CA 95470
1-707-485-5115

MCAVHN
148 Clara Avenue
Ukiah, CA 95482
1-707-462-1932

New Life Clinic
280 East Standley Street
Ukiah, CA 95482
1-707-466-0001

Mendocino Community Health Centers:

Little Lake Health Center
45 Hazel Street
Willits, CA 95490
1-707-456-9600

Dora Street Health Center
1165 S. Dora Street
Ukiah, CA 95482
1-707-468-1015

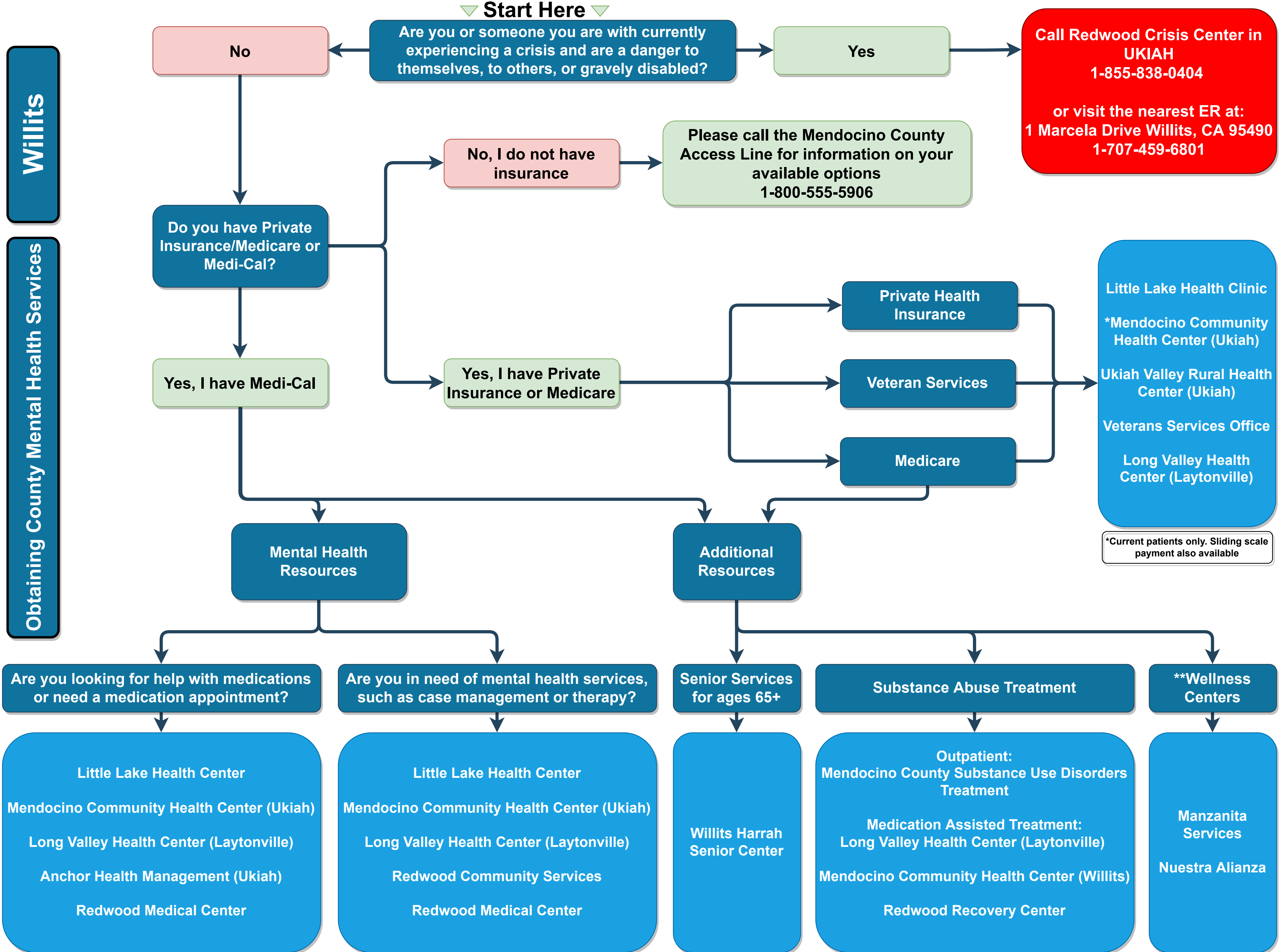
Hillside Health Center
333 Laws Avenue
Ukiah, CA 95482
1-707-468-1010

Obtaining Mental Health Services in Mendocino County

Ukiah

Mental Health Crisis Line:
1-855-838-0404

Mental Health Access Line:
1-800-555-5906



**A Wellness Center is where healthcare professionals, nutritionists and/or life-coaches provide a variety of treatments and services to encourage and educate people on the health of their minds and bodies.

Mendocino County
Substance Use Disorders Treatment
472 E. Valley Street
Willits, CA 95490
1-707-456-3850

Nuestra Alianza de Willits
291 School Street #1
Willits, CA 95490
1-707-456-9418

Willits Harrah Senior Center
1501 Baechtel Road
Willits, CA 95490
1-707-459-6826

Long Valley Health Center
50 Branscomb Road
Laytonville, CA 95454
1-707-984-6131

Mendocino Community Health Centers:
Little Lake Health Center
45 Hazel Street
Willits, CA 95490
1-707-456-9600

Dora Street Health Center
1165 S. Dora Street
Ukiah, CA 95482
1-707-468-1015

Hillside Health Center
333 Laws Avenue
Ukiah, CA 95482
1-707-468-1010

Mendocino County
Veterans Services
189 North Main Street
Willits, CA 95490
1-707-456-3792

Redwood Medical Center
1 Marcela Drive, Suite C
Willits, CA 95490
1-833-249-3556

Redwood Community Services
631 S. Orchard Avenue
Ukiah, CA 95482
1-707-467-2010

Anchor Health Management
350 E. Gobbi Street
Ukiah, CA 95482
1-707-472-0350

Redwood Medical Clinic
3 Marcela Drive, Suite C
Willits, CA 95490
1-707-459-6801

Community Resources:
National Alliance on Mental Illness (NAMI)
P.O. Box 1945
Ukiah, CA 95482
1-707-391-6867

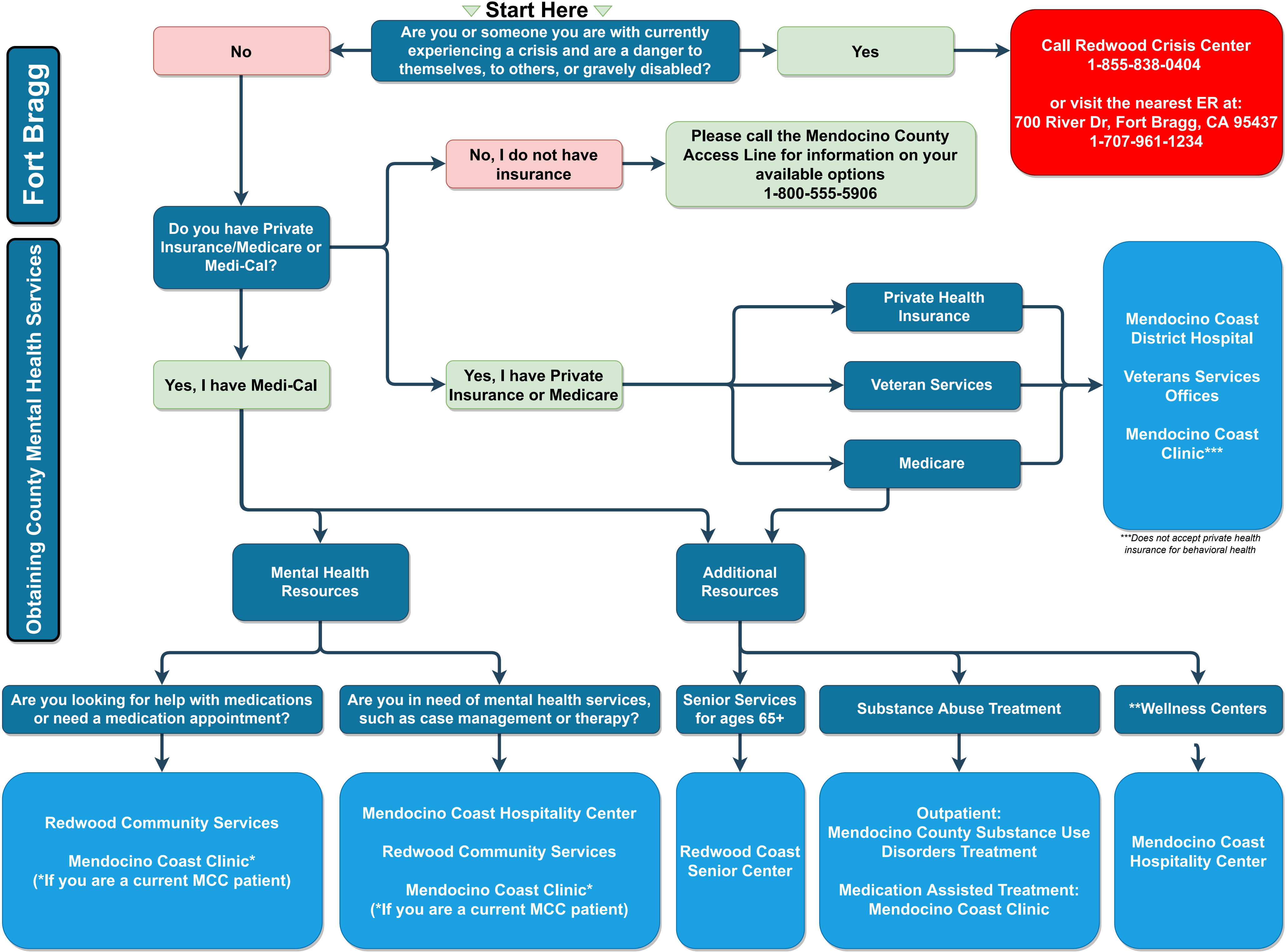
Redwood Coast Regional Center
270 Chestnut Street
Fort Bragg, CA 95437
1-707-964-6387

Obtaining Mental Health Services in Mendocino County

Willits

Mental Health Crisis Line:
1-855-838-0404

Mental Health Access Line:
1-800-555-5906



**A Wellness Center is where healthcare professionals, nutritionists and/or life-coaches provide a variety of treatments and services to encourage and educate people on the health of their minds and bodies.

Mendocino Coast Clinic
205 South Street
Fort Bragg, CA 95437
1-707-964-1251

Mendocino Coast District Hospital
700 River Drive
Fort Bragg, CA 95437
1-707-961-1234

Redwood Community Services
143 West Spruce Street
Fort Bragg, CA 95437
1-707-964-4770

Mendocino Coast Hospitality Center
101 North Franklin Street
Fort Bragg, CA 95437
1-707-961-0172

Mendocino Community Health Centers:

Little Lake Health Center
45 Hazel Street
Willits, CA 95490
1-707-456-9600

Dora Street Health Center
1165 S. Dora Street
Ukiah, CA 95482
1-707-468-1015

Hillside Health Center
333 Laws Avenue
Ukiah, CA 95482
1-707-468-1010

Redwood Coast Senior Center
490 North Harold Street
Fort Bragg, CA 95437
1-707-964-0443

Mendocino County SUDT
790 South Franklin Street
Fort Bragg, CA 95437
1-707-961-2665

Mendocino County Veterans Services
360 North Harrison Street
Fort Bragg, CA 95437
1-707-964-5823

Community Resources:

National Alliance on Mental Illness (NAMI)
P.O. Box 1945
Ukiah, CA 95482
1-707-391-6867

Parents and Friends Inc.
306 East Redwood Avenue
Fort Bragg, CA 95437
1-707-964-4940

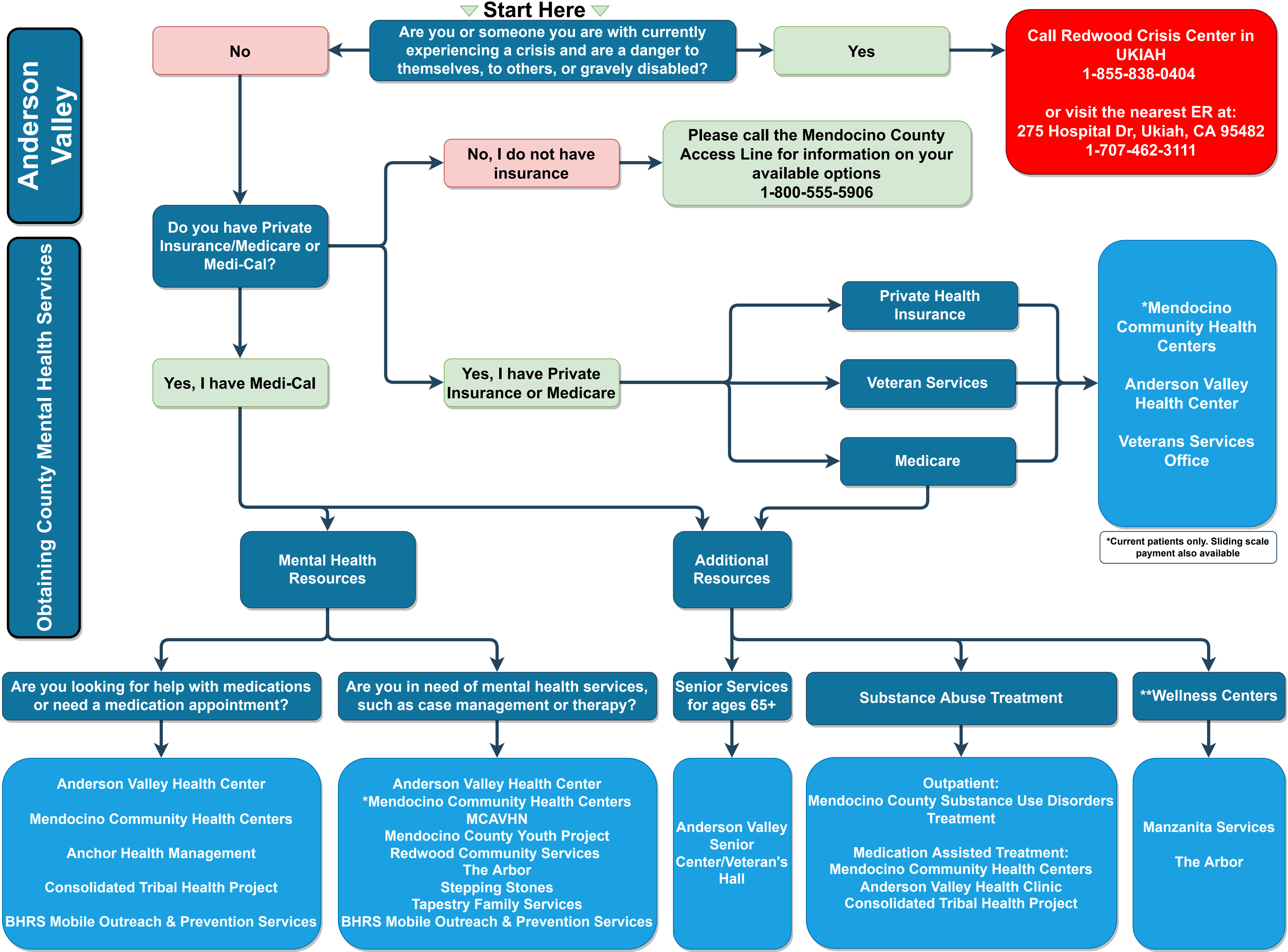
Redwood Coast Regional Center
270 Chestnut Street
Fort Bragg, CA 95437
1-707-964-6387

Obtaining Mental Health Services in Mendocino County

Fort Bragg

Mental Health Crisis Line:
1-855-838-0404

Mental Health Access Line:
1-800-555-5906



**A Wellness Center is where healthcare professionals, nutritionists and/or life-coaches provide a variety of treatments and services to encourage and educate people on the health of their minds and bodies.

Anderson Valley Health Center
13500 Airport Rd
Boonville, CA 95415
1-707-895-3477

Anchor Health Management
350 East Gobbi Street
Ukiah, CA 95482
1-707-472-0350

Mendocino County
Substance Use Disorders Treatment
1120 South Dora Street
Ukiah, CA 95482
1-707-472-2637

Consolidated Tribal Health Project
6991 North State Street
Redwood Valley, CA 95470
1-707-485-5115

MCAVHN
148 Clara Avenue
Ukiah, CA 95482
1-707-462-1932

Mendocino Community Health Centers:

Dora Street Health Center
1165 S. Dora Street
Ukiah, CA 95482
1-707-468-1015

Hillside Health Center
333 Laws Avenue
Ukiah, CA 95482
1-707-468-1010

Mendocino County Youth Project
776 South State Street #107
Ukiah, CA 95482
1-707-456-3792

Redwood Community Services
631 S. Orchard Avenue
Ukiah, CA 95482
1-707-467-2010

The Arbor Youth Resource Center
810 North State Street
Ukiah, CA 95482
1-707-462-7267

Stepping Stones
140 Gibson Street
Ukiah, CA 95482
1-707-468-5536

Tapestry Family Services
290 East Gobbi Street
Ukiah, CA 95482
1-707-463-3300

Ukiah Valley Rural Health Center
260 Hospital Drive
Ukiah, CA 95482
1-707-463-8000

Veteran Services Office
405 Observatory Avenue
Ukiah, CA 95482
1-707-463-4226

Anderson Valley Senior Center/Veteran's Hall
14400 CA-128
Boonville, CA 95415
1-707-895-3609

Obtaining Mental Health Services in Mendocino County

Anderson Valley

Mental Health Crisis Line:
1-855-838-0404

Mental Health Access Line:
1-800-555-5906

Mendocino County Behavoiral Health and Recovery Services
Behavioral Health Advisory Board General Ledger
FY 21/22
6/15/2022

ORG	OBJ	ACCOUNT DESCRIPTION	YR/PER/JNL	EFF DATE	AMOUNT	INVOICE #	CHECK #	VENDOR NAME	COMMENT
MHB	862080	FOOD							
		FOOD Total			**$0.00**				
MHB	862150	MEMBERSHIPS	2022/06/000766	12/30/2021	$600.00	MCMH12/16/21BHB DUES	4350806	CALBHB/C	FY21/22CALBHB/C MEMBERSHIP
		MEMBERSHIPS TOTAL			**$600.00**				
MHB	862170	OFFICE EXPENSE							
		OFFICE EXPENSE Total			**$0.00**				
MHB	862190	PUBL & LEGAL NOTICES	2022/08/000332	02/10/2022	119.35	AVA ADVERTISEMENT	4352793	ANDERSON BRUCE	ONLINE RECRUITMENT FY21/22
		PUBL & LEGAL NOTICES Total			**$119.35**				
MHB	862210	RNTS & LEASES BLD GRD							
		RNTS & LEASES BLD GRD Total			**$0.00**				
MHB	862250	TRNSPRTATION & TRAVEL	2022/06/000584	12/16/2021	84.56	110421	4350689	TOWLE RICHARD	LOCAL 7/01-10/18/21 FY21/
		TRNSPRTATION & TRAVEL Total			**$84.56**				
		TRAVEL & TRSP OUT OF COUNTY Total			**$0.00**				
		Grand Total			**$803.91**				

Summary of Budget for FY 21/22

OBJ	ACCOUNT DESCRIPTION		Budget Amount	YTD Exp	Remaining Budget
862080	Food		1,000.00	0.00	1,000.00
862150	Memberships		600.00	600.00	0.00
862170	Office Expense		500.00	0.00	500.00
862190	Publ & Legal Notices			119.35	-119.35
862210	Rents & Leases Bld		30.00	0.00	30.00
862250	In County Travel		3,000.00	84.56	2,915.44
862253	Out of County Travel		2,000.00	0.00	2,000.00
		Total Budget	$7,130.00	$803.91	$6,326.09

Behavioral Health Recovery Services
Mental Health FY 2021-2022
Budget Summary
Year to Date as of **June 15, 2022**

			EXPENDITURES						REVENUE					
	Program	**FY 21-22 Approved Budget**	**Salaries & Benefits**	**Services & Supplies**	**Other Charges**	**Fixed Assets**	**Operating Transfers**	**Total Expenditures**	**2011 Realign**	**1991 Realign**	**Medi-Cal FFP**	**Other**	**Total Revenue**	**Total Net Cost**
1	Mental Health (Overhead)	**(4,024,268)**	50,070	584,160	14,076,314		(51,696)	**14,658,848**	4,581,666	2,764,730	5,547,981	1,444,033	**14,338,410**	**320,438**
2	Administration	**737,846**	968,186	311,110			(38,484)	**1,240,812**				142,646	**142,646**	**1,098,166**
3	Mental Health Block Grant ARPA	**0**						**0**					**0**	**0**
4	CalWorks	**38,371**	110,702	6,009				**116,711**				50,058	**50,058**	**66,653**
5	Mobile Outreach Program	**(41,083)**	288,857	27,566			(4,451)	**311,972**				141,651	**141,651**	**170,321**
6	Adult Services	**240,338**	155,839	30,989			(76,063)	**110,764**				11,726	**11,726**	**99,038**
7	Path Grant	**0**		13,422				**13,422**	8,218			0	**8,218**	**5,204**
8	SAMHSA Grant	**0**		118,294				**118,294**	33,996				**33,996**	**84,298**
9	Mental Health Board	**7,130**		804				**804**					**0**	**804**
10	CCMU -BCHIP	**0**						**0**					**0**	**0**
11	Business Services	**805,465**	615,624	65,326				**680,951**				21,278	**21,278**	**659,673**
12	CCMU-CRRSAA Grant	**0**						**0**					**0**	**0**
13	Mental Health Block Grant CRRSAA	**0**						**0**					**0**	**0**
14	MH Grant (Other)	**0**						**0**					**0**	**0**
15	MAT Grant	**0**						**0**					**0**	**0**
16	AB109	**1,027**	16,669	26,334				**43,003**	28,372				**28,372**	**14,631**
17	Conservatorship	**1,896,328**	222,419	117,063	2,306,871		(25,283)	**2,621,070**				57,598	**57,598**	**2,563,472**
18	MH CAL-AIM							**0**				357,434	**357,434**	**(357,434)**
19	QA/QI	**506,229**	313,275	86,836			(4,808)	**395,304**				35,441	**35,441**	**359,863**
a	**Total YTD Expenditures & Revenue**		2,741,641	1,387,914	16,383,184	0	(200,784)	**20,311,955**	4,652,252	2,764,730	5,547,981	2,261,865	**15,226,829**	**5,085,127**
b	**FY 2021-2022 Adjusted Budget**	**167,383**	3,771,297	1,667,615	18,769,395	0	(158,340)	**24,049,967**	6,525,253	3,579,855	10,604,948	3,172,528	**23,882,584**	**167,383**
c	**Variance**		1,029,656	279,701	2,386,211	0	42,444	**3,738,012**	1,873,001	815,125	5,056,967	910,663	**8,655,755**	**(4,917,744)**

Report generated by Electronic Health Records

Behavorial Health Recovery Services

Mental Health Services Act (MHSA) FY 2021-2022 Budget Summary

Year to Date as of **June 15, 2022**

Program	FY 21-22 Approved Budget	Salaries & Benefits	Services & Supplies	Other Charges	Fixed Assets	Operating Transfers	Total Expenditures	Revenue Prop 63	Other-Revenue	Total Net Cost
Community Services & Support	17,946	368,706	420,526	1,160,833		(12,136)	**1,937,928**		**4,007,167**	**(2,069,239)**
Prevention & Early Intervention	(52,755)	191,796	296,601	843		(24)	**489,217**		**1,037,668**	**(548,452)**
Innovation	567,704		76,106				**76,106**		**258,693**	**(182,587)**
Workforce Education & Training	-		(150)				**(150)**			**(150)**
Capital Facilities & Tech Needs							-			-
Total YTD Expenditures & Revenue		560,502	793,082	1,161,676	-	(12,160)	**2,503,100**	**-**	**5,303,528**	**(2,800,428)**
FY 2021-2022 Approved Budget	532,895	689,526	4,415,118	1,532,776	0	(4,131)	**6,633,289**	**(6,100,395)**	**-**	**532,894**
Variance		129,024	3,622,036	371,100	-	8,029	**4,130,189**	**(6,100,395)**	**(5,303,528)**	**3,333,322**

Prudent Reserve Balance **1,894,618**

WIC Section 5847 (a)(7) - Establishment & mantenance of a prudent reserve to ensure the county continues to be able to serve during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

Report generated by Electronic Health Records

Behavioral Health Recovery Services
SUDT FY 2021-2022 Budget Summary
Year to Date as of **June 15, 2022**

			EXPENDITURES						REVENUE					
	Program	**FY 21-22 Approved Budget**	**Salaries & Benefits**	**Services and Supplies**	**Other Charges**	**Fixed Assets**	**Operating Transfers**	**Total Expenditures**	**SAPT Block Grant and FDMC**	**2011 Realign**	**Medi-Cal FFP**	**Other**	**Total Revenue**	**Total Net Cost**
1	SUDT Overhead	**(2,297,294)**	24,021	1,731			(24,021)	**1,731**	1,020,538	354,260	64,712	22,891	**1,462,400**	**(1,460,669)**
2	County Wide Services	**1,415,273**	0	306,128				**306,128**			153,864	(117,973)	**35,891**	**270,237**
3	Elevate Youth	-						**0**					**0**	**0**
4	Drug Court Services	-	100,803	12,515				**113,318**		87,264		21,692	**108,956**	**4,362**
5	Ukiah Adult Treatment Services	**8,445**	412,023	122,856			(119,181)	**415,698**		20,722		204,036	**224,758**	**190,940**
6	Women In Need of Drug Free Opportunties	**(1)**	93,565	29,990			(55,162)	**68,393**		65,711			**65,711**	**2,682**
7	Family Drug Court	-	193,633	24,815			(208,853)	**9,595**				3,733	**3,733**	**5,862**
8	Friday Night Live	-	0	1,442				**1,442**				(5,500)	**(5,500)**	**6,942**
9	Willits Adult Services	-	59,806	27,221			(53,778)	**33,249**				(5,866)	**(5,866)**	**39,115**
10	Fort Bragg Adult Services	**206,022**	180,326	38,476			(48,609)	**170,192**				335	**335**	**169,857**
11	DDMIP	-						**0**						**0**
11	Administration	**824,861**	406,591	284,731			(2,774)	**688,548**				109,522	**109,522**	**579,026**
12	Adolescent Services	**(68,937)**	34,472	41,967				**76,439**				5,795	**5,795**	**70,644**
13	SABG ARPA	-						**0**					**0**	**0**
14	COSSAAP	-						**0**					**0**	**0**
15	SABG CRRSAA	-						**0**					**0**	**0**
16	DDMATX	-						**0**					**0**	**0**
14	Prevention Services	**0**	109,219	6,807			(5,755)	**110,271**				11,661	**11,661**	**98,610**
a	**Total YTD Expenditures & Reve**	**88,370**	1,614,457	898,677	0	0	(518,132)	**1,995,002**	1,020,538	173,697	153,864	250,326	**2,017,397**	**(22,394)**
b	**FY 2021-2022 Budget**	**88,370**	2,284,613	2,409,905	0	0	(1,037,852)	**3,656,666**	1,675,741	736,860	440,130	715,565	**3,568,296**	**88,370**
c	**Variance**	**0**	670,156	1,511,228	0	0	(519,720)	**1,661,664**	655,203	563,163	286,266	465,239	**1,550,899**	**110,764**

Report generated by Electronic Health Records

MENDOCINO COUNTY: DATA NOTEBOOK 2022

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, resilience, and wellness of Californians living with severe mental illness.

For information, you may contact the following email address or telephone number:

DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413 Sacramento, CA 95899-7413

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2022 Data Notebook survey, as well as **supplemental data** for your county, state, and country. I t is meant as a **reference document only**.

Some of the survey items appear differently on the live survey due to the difference in formatting. For a more accurate preview of the online survey, please reference the **Data Notebook 2022 SurveyMonkey Preview PDF**, which you received along with this document. We recommend reviewing both documents while preparing your survey responses.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2022 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/PSQQ2HF

Please note, if you are working from a PDF, scanned image or photocopy, you will need to retype the above address into your browser bar.

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CBHPC 2022 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

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

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

What's New This Year?

The topic selected this year by the Planning Council is a focus on the "Impact of the Covid-19 public health emergency on:

(1) The behavioral health of vulnerable populations in California, and

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

(2) The ability of county behavioral health departments to provide mental health and substance use disorder (SUD) treatment services in 2020 and 2021."

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

Example of Statewide Data for Specialty Mental Health and Access Rates

Tables 1-A and 1-B on the next two pages shows typical data and demographics for California recipients of Specialty Mental Health Services (SMHS) for fiscal year (FY) 2019-2020. These are the most recent data available at the time this document was prepared. These data overlap with the beginning of the Covid-19 pandemic in March-June of 2020. SMHS are intended for adults with serious mental illness (SMI) and for children with serious emotional disorders (SED). The category of 'certified eligibles' means those persons (also called beneficiaries) who are eligible and approved to receive Medi-Cal benefits for health care.

Subsequent data for FY 2020-2021 typically would be released by DHCS in August or September of 2022.Those readers who are interested at that time may seek to extract more current data using the DHCS internet tool for 'AB 470' Dashboards[4].

Examples of County Data are shown in Tables 2-A and 2-B on the subsequent pages, with information arranged in the same format as the statewide data.

.

[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.

[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

[4] Performance Dashboard AB 470 Report Application, published by California Department of Health Care Services (DHCS) at: https://data.chhs.ca.gov/dataset/adult-ab470-datasets/resource/c1908f78-3716-4b91-8afa-0dc9c3c2058a.

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[5] Fiscal Year 2019-20.

	Specialty Mental Health Services		
	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	7,777	801,586	1.00%
Children 3-5	19,206	841,770	2.30%
Children 6-11	79,256	1,706,727	4.60%
Children 12-17	118,686	1,717,523	6.90%
Youth 18-20	31,460	724,208	4.30%
Alaskan Native or American Indian	1,200	18,572	6.50%
Asian or Pacific Islander	7,109	373,754	1.90%
Black	26,745	390,574	6.80%
Hispanic	153,661	3,369,129	4.60%
Other	10,689	365,314	2.90%
Unknown	13,657	497,605	2.70%
White	43,324	776,866	5.60%
Female	122,205	2,837,274	4.30%
Male	134,180	2,954,540	4.50%
Totals and Average Rates	256,385	5,791,814	4.43%

Notes: The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this is taken as the "Access Rate."

[5] In contrast, non-specialty Mental Health Services (i.e., Managed Care (MC), Fee-for-Service (FFS), etc), services generally designed for people with mild-to-moderate mental health needs.

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2019-20.[6]

	Specialty MH Services		
	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	96,242	2,639,420	3.60%
Adults 33-44	84,145	2,052,352	4.10%
Adults 45-56	78,314	1,633,359	4.80%
Adults 57-68	64,195	1,410,393	4.60%
Adults 69+	12,957	1,024,999	1.30%
Alaskan Native or American Indian	2,270	37,482	6.10%
Asian or Pacific Islander	19,583	1,035,431	1.90%
Black	51,180	676,335	7.60%
Hispanic	96,024	3,779,762	2.50%
Other	29,540	734,979	4.00%
Unknown	31,204	611,186	5.10%
White	106,052	1,885,348	5.60%
Female	172,484	4,916,908	3.50%
Male	163,369	3,843,614	4.30%
Totals and Access Rates	335,853	8,760,522	3.83%

Notes: The data for Adults and Older Adults were calculated similarly to the data for Children and Youth in Figure 1-A. For example, out of all Adult 3,760,522 Medi-Cal beneficiaries, a total of 335,853 individuals, i.e. 3.83 % received Specialty Mental Health Services (SMHS).

[6] For comparison, the population of the state of California was **39,538,223** on April 1, 2020, according to the U.S. Census Bureau. https://www.census.gov/quickfacts/CA. Of those residents,22.34% of Californians were adults (age 21 and above) receiving Med-Cal benefits. Also, 14.7 % of Californians were children or youth ≤ 20 who received Medi-Cal benefits. These numbers show that 37.01 % of all Californians of all age groups received Medi-Cal in FY 2019-20.

Table 2-A. Mendocino County Children and Youth: Access Rates for Specialty Mental Health Services (SMHS),[7] Fiscal Year 2019-20.

Specialty Mental Health Services

	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	^	2,427	^
Children 3-5	^	2,622	^
Children 6-11	349	5,100	6.80%
Children 12-17	484	4,859	10.00%
Youth 18-20	129	2,029	6.40%
Alaskan Native or American Indian	80	879	9.10%
Asian or Pacific Islander	^	164	^
Black	18	108	16.70%
Hispanic	317	6,928	4.60%
Other	^	182	^
Unknown	68	2,375	2.90%
White	526	6,401	8.20%
Female	506	8,359	6.10%
Male	510	8,678	5.90%
Totals and Average Rate(s)	1,016	17,037	5.96%

^ = Data suppressed due to small numbers

[7] In contrast, non-specialty Mental Health Services (i.e., Medi-Cal Managed Care (MC), Fee-for-Service (FFS), etc), services generally designed for people with mild-to-moderate mental health needs.

Table 2-B. Mendocino County Adults and Older Adults: Access Rates for Specialty Mental Health Services[8], Fiscal Year 2019-20.[9]

Specialty Mental Health Services

	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	386	7,750	5.00%
Adults 33-44	373	7,652	4.90%
Adults 45-56	336	5,263	6.40%
Adults 57-68	256	4,884	5.20%
Adults 69+	47	2,529	1.90%
Alaskan Native or American Indian	65	1,449	4.50%
Asian or Pacific Islander	16	633	2.50%
Black	21	294	7.10%
Hispanic	146	7,115	2.10%
Other	23	415	5.50%
Unknown	122	1,994	6.10%
White	1,005	16,178	6.20%
Female	709	14,769	4.80%
Male	689	13,309	5.20%
Totals and Rates (Averages)	1,398	28,078	4.98%

^ = Data suppressed due to small numbers

[8] Data for Table 1-A and 1-B and Table 2-A and 2-B were all calculated using Performance Dashboard AB 470 Report Application, published by California Department of Health Care Services (DHCS) at www.dhcs.ca.gov and more specifically at: https://data.chhs.ca.gov/dataset/adult-ab470-datasets/resource/c1908f78-3716-4b91-8afa-0dc9c3c2058a.

[9] For comparison, the population of Mendocino County was 90,806 on July 1, 2021, according to www.dof.ca.gov and the U.S. Census Bureau. https://www.census.gov/quickfacts/CA..

CBHPC 2022 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[10]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2021-2022 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[11] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[12] available to serve individuals with SMI, and how many of these individuals (for whom the county

[10] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'

[11] Link to ARF data at California Department of Social Services. [Note 02-12-2022 by editor: link not working]. https://secure.dss.ca.gov/CareFacilitySearch/Search/AdultResidentialAndDaycare.

[12] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

has financial responsibility) are served in facilities such as ARFs or IMDs. ‘Bed day’ is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

The following is a text summary of the survey questions for Part I of the 2022 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.

Questions:

1) **Please identify your County / Local Board or Commission.**

2) **For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year?** (*Text response*)

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?** (*Text response*)

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are <u>not</u> living in an ARF?** (*Text response*)

5) **Does your county have any ‘Institutions for Mental Disease’ (IMD)?**
    a. No
    b. Yes. If Yes, how many IMDs? *(Text response*)

6) **For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?**
    In-county: (*Text response*) Out-of-county: (*Text response*)

7) **What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?** (*Text response*)

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[13] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.

Preliminary data for January, 2021 had been posted in early February 2022, but those only contained data for the individuals in shelters or other temporary housing. There was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. The count for 2022 took place in many communities during the last week in February. The federal analysis and publication of that data will not be available for at least six to twelve months. Therefore, we are presenting the previous year's data for January 2020 in Table 3 as a baseline reference for comparison to the most recent year's data for 2021 and/or 2022, whenever that data becomes available.

[13] Link to data for yearly Point-in-Time Count:
https://www.hudexchange.info/programs/coccoc-homeless-populations-and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=CA&filter_CoC=&program+Coc&group=PopSub

Table 3: State of California Estimates of Homeless Individuals PIT[14] Count (January 2020)

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Homeless Individuals (not in families)	28,246	107,525	135,771	5.4%
People in families with children	19,591	6,186	25,777	14.6%
Unaccompanied homeless youth[15]	2,662	9,510	12,172	1.5%
Veterans	3,405	7,996	11,401	3.8%
Chronically homeless individuals	8,046	40,776	48,812	24.3%
Total (2020) Homeless Persons in CA	47,888	113,660	161,548	6.8%
Total (2020) Homeless Persons, USA	354,386	226,080	580,455	2.2%

[14] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those who were in homeless shelters and various types of transitional or emergency housing.

[15]Data definition: Persons in Households with only Children <18 includes unaccompanied child or youth, parenting youth<18 who have one or more children, or may include sibling groups<18 years of age.

Questions, continued:

8) **During the most recent fiscal year (2021-2022), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?** (Mark all that apply.)
    a. Emergency Shelter add option for providing support and services in housing
    b. Temporary Housing
    c. Transitional Housing
    d. Housing/Motel Vouchers
    e. Supportive Housing
    f. Safe Parking Lots
    g. Rapid Re-Housing
    h. Adult Residential Care Patch/Subsidy
    i. Other (*Please specify)*

<u>Child Welfare Services: Foster Children in Certain Types of Congregate Care</u>

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

<u>Examples of the foster care CDSS data for Q4, 2020, in CA</u>:

- Total foster youth and children: 53,180
- Total placed in an STRTP: 2,444 (or 4.6% of foster youth)
- Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)
- Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)

Questions (continued):

9) Do you think your county is doing enough to serve the foster children and youth in group care?

a. Yes
b. No. If No, what is your recommendation? Please list or describe briefly. (*Text response*)

10) Has your county received any children needing "group home" level of care from another county?

a. No
b. Yes. If Yes, how many? (*Text response*)

11) Has your county placed any children needing "group home" level of care into another county?

a. No
b. Yes. If Yes, how many? (*Text response*)

CBHPC 2022 Data Notebook – Part II:

Impact of the Covid-19 Public Health Emergency on Behavioral Health Needs and Provision of Services in California

Context and Background

The Planning Council selected this year's special topic for the Data Notebook to focus on questions regarding the impact of the Covid-19 public health emergency on the behavioral health system during 2020 through 2021. Our goal for the choice of this topic is to evaluate effects of the pandemic on (1) the behavioral health of vulnerable populations in California, and (2) the impact on county behavioral health departments' ability to provide mental health and substance use disorder (SUD) treatment services in 2020 and 2021.

The major themes are as follows:

(1) The major effects on behavioral health in the vulnerable populations of adults, children and youth served by California's public mental health system. We will present some national data that describes some of the major effects.

(2) The effects of the Covid-19 pandemic on the ability of county behavioral health departments to provide mental health and substance use treatment services.

(3) The lessons learned and successes achieved during a time when everyone was challenged to be flexible and to devise new ways to support mental health while implementing Covid-19 public health protocols.

This 2022 Data Notebook includes questions about effects of the pandemic on BH needs and services for children and youth, adults, and finally, some questions about potential county staffing challenges. To provide background and context for this part, we will discuss some of the limited public health data available thus far. The national data show that reports of serious behavioral health challenges were already trending upward in the two years prior to 2020. Further, the numbers of children, youth, and adults who need BH services appear to have increased further during both 2020 and 2021. Newer reports from California agencies that address similar issues have evaluated data collected in 2020 and 2021. Reports containing analyses of the most recent data are expected sometime in the second half of 2022.

In the strictest sense, we may not be able to establish that any of the changes in 2020-2021 were due to effects of the pandemic itself. Nonetheless, the continuing trends in 2020 and 2021 are cause for concern and attention, regardless of the difficulty of distinguishing cause from correlation and mere chance. Note that in our questions and discussion we often use the shorthand of speaking about the effects of Covid-19 on

clients' mental health or on a county system's ability to respond to the larger challenges of the pandemic. We are not speaking in the biologic sense of what this virus does to a person's body, but rather the totality of the pandemic experience as we face this ongoing public health emergency.

We may find from the data we plan to collect through this Data Notebook that the pandemic had significant effects on system capacity to provide quantity, quality, or timeliness in the provision of many types of services, especially during the transition to online and telehealth services. Efforts to maintain Covid-19 protocols, (including social distancing), and limited access to technology may have increased barriers to access and impaired service delivery to our most vulnerable populations and to historically disadvantaged communities.

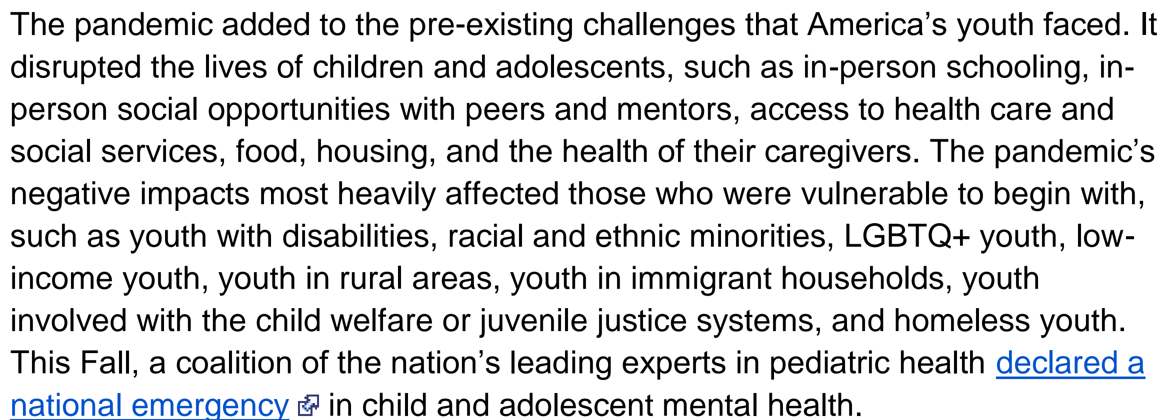
What were the Behavioral Health Impacts of the Covid-19 Pandemic on Children and Youth?

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Most recently, this urgency led the U.S. Surgeon General to issue a special health advisory:[16]

> "Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade." said **Surgeon General Vivek Murthy**. "The COVID-19 pandemic further altered their experiences at home, school, and in the community, and the effect on their mental health has been devastating. The future wellbeing of our country depends on how we support and invest in the next generation. Especially in this moment, as we work to protect the health of Americans in the face of a new variant, we also need to focus on how we can emerge stronger on the other side. This advisory shows us how we can all work together to step up for our children during this dual crisis."
>
> Before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the U.S. having a mental, emotional, developmental, or behavioral disorder. Additionally, from 2009 to 2019, the share of high school students who reported persistent feelings of sadness or hopelessness increased by 40%, to more than 1 in 3 students. Suicidal behaviors among high school

[16]"Protecting Youth Mental Health: The Surgeon General's Advisory", by Dr. Vivek Murthy, M.D., U.S. Public Health Service, pages 1-53. December 7, 2021. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

students also increased during the decade preceding COVID, with 19% seriously considering attempting suicide, a 36% increase from 2009 to 2019, and about 16% having made a suicide plan in the prior year, a 44% increase from 2009 to 2019. Between 2007 and 2018, suicide rates among youth ages 10-24 in the U.S. increased by 57%, - PDF and early estimates show more than 6,600 suicide deaths - PDF among this age group in 2020.



The pandemic added to the pre-existing challenges that America's youth faced. It disrupted the lives of children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic's negative impacts most heavily affected those who were vulnerable to begin with, such as youth with disabilities, racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

The Surgeon General's Advisory on Protecting Youth Mental Health outlines a series of recommendations to improve youth mental health across eleven sectors, including young people and their families, educators and schools, and media and technology companies.

Challenges, Resilience, and Possible Lessons Learned while Addressing Behavioral Health Impacts during the Covid-19 Pandemic

Many agencies of the state have held discussions regarding the challenges and lessons learned from our collective experiences of continuing to provide services or a variety of administrative supports for those involved in provision of direct services. These discussions or assessments are an ongoing process at multiple levels.

In the 2020 Data Notebook, the Planning Council asked questions about the use of telehealth for mental health therapy to adults during early stages of the pandemic[17]. Some service providers and clients encountered problems of access, such as technology issues, lack of home internet, or lack of adequate bandwidth, especially in rural areas. Other issues included the challenges of learning to work with the virtual therapy platform for both providers and clients. Some individuals had disabilities with impaired hearing and/or impaired vision (hard to see keys to type), which led to

[17] 2020 Data Notebook, and 2021 Overview Report on this project: California Behavioral Health Planning Council, with the California Association of Local Mental Health Boards Commissions: www.calmhbc.com.

difficulties in access or to being completely unable to access telehealth. Also, there were language challenges for some individuals.

However, as we saw in the analyses of the responses collected from the 2020 Data Notebook, for clients who were able to overcome any technology barriers to access, they reported a fair degree of success in being able to improve their handling of mental health issues. Some clients were also able to get tele-health appointments for medication evaluation and prescriptions. Tele-health is an example of a rapid system-wide adaptation enabled by rapid policy changes for Medicaid/Medi-Cal at the federal and state levels, and rapid adaptation by local government and care providers.

The Planning Council advocates for a behavioral health system that can meet the needs of vulnerable populations and historically disadvantaged groups. Systemic, economic, or other societal factors that can reduce access to behavioral health services likely overlap with those factors that reduce access to medical care and preventative public health measures.

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African-American, and Native-American people.[18] Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. And due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"[19] symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including better adapting our outreach and messaging.

Next we turn to the discussion questions for Part II regarding the provision of behavioral health services in your community during the Covid-19 pandemic. Two questions ask for optional comments about either services for Children and Youth, or those for Adults. These 'open comment' questions could address unique county successes, continuing challenges, or lessons learned to aid future resilience, or any other comments about behavioral health services in your county.

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[18] "Tracking COVID-19 in California: Cases, Hospitalizations, and Deaths; Vaccination Rates; Cases and deaths by County; Cases and deaths by ethnicity, gender, and age." https://covid19.ca.gov/state-dashboard/

[19] 'Long Covid' is a variable syndrome of symptoms that persist for sustained periods or even months after the patient has recovered from the acute phase of infection with Covid-19.

<u>Part II: Data Notebook Questions</u>.

Please respond by means of the Survey Monkey link provided with this Data Notebook.

12). Please identify the points of stress on your county's system for <u>children and youth</u> behavioral health services during the pandemic *(multiple checkboxes; mark all that apply)*

a. Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.

b. Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.

c. Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.

d. Increased Emergency Department admissions of youth for episodes of self-harm and/or suicide attempts.

e. Increased Emergency Department visits related to misuse of alcohol and drugs among youth.

f. Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).

g. Decreased access/utilization of mental health services for youth.

h. Other (Please specify).

i. None of the above.

13). Of the previously identified stressors, which are the top three concerns for your county for <u>children and youth</u> services? *(Matrix of dropdown menus to select answers, 1, 2, 3, in descending order of significance)*

a. Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.

b. Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.

c. Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.

d. Increased Emergency Department admissions for episodes of self-harm and suicide attempts among youth.

e. Increased Emergency Department visits related to misuse of alcohol and drugs among youth.

f. Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).

g. Decreased access/utilization of mental health services for youth.

h. None of the above

i. Other (Please specify).

14). Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, mental health services for children and youth in your county during the Covid-19 pandemic? *(written response)*

15). Please identify the points of stress on your county's system for all adult behavioral health services during the pandemic *(multiple checkboxes; mark all that apply).*

a. Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.

b. Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.

c. Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.

d. Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.

e. Increased Emergency Department visits related to misuse of alcohol and drugs among adults.

f. Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).

g. Decreased access/utilization of mental health services for adults.

h. None of the above

i. Other (Please specify)

16). Of the previously identified stressors, which are the top three concerns for your county for behavioral health needs of all adults during the pandemic? Please select your county's top three points of impact in descending order *(matrix of dropdown menus to select answers; i.e., 1, 2, 3)*

a. Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.

b. Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.

c. Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.

d. Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.

e. Increased Emergency Department visits related to misuse of alcohol and drugs among adults.

f. Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).

g. Decreased access/utilization of mental health services for adults.

h. None of the above

i. Other (Please specify)

17). Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for all adults in your county during the Covid-19 pandemic? *(written response)*

18). Since 2020, has your county increased the use of telehealth for all adult behavioral health therapy and supportive services?

- Yes
- No

19). Since 2020, has your county increased the use of telehealth for psychiatric medication management for all adults?

- Yes
- No

20). Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders?

- **Yes.**
- **No.**
- **Not Applicable**: if your board does not oversee SUD along with Mental Health.

21). Many or most MAT programs rely on in-person visits by necessity in order to get certified to provide these services. [Some of these medications include buprenorphine, methadone, suboxone, emergency use Narcan]. **As part of SUD treatment services, are you able to coordinate routine drug testing with clinics near the client?**

- **Yes**. If so, how has this been useful in promoting successful outcomes? *(Text answer).*

- **No.** If not, do you have alternatives to help clients succeed? *(Text answer*)

- **Not Applicable**: if your board does not oversee SUD along with Mental Health.

22). Have any of the following factors impacted your county's ability to provide crisis intervention services? *(Check all that apply)*

a. Increase in funding for crisis services

b. Decrease in funding for crisis services

c. Issues with staffing and/or scheduling

d. Difficulty providing services via telehealth

e. Difficulty implementing Covid safety protocols

f. Other (please specify)

g. None of the above

23). Did your county experience negative impacts on staffing as a result of the pandemic? Please select your county's <u>top points of impact, all in descending order</u> of importance *(matrix of dropdown menus to select answers; i.e., 1, 2, 3, 4, etc.; or enter zero if no significant impact or not applicable)*

a. Staff quit (part of mass resignation/ social trend, etc.)

b. Staff re-directed or re-assigned to support the Covid-19 Teams

c. Staff out to quarantine for self

d. Staff out to care/quarantine due to family member's contracting of Covid-19

e. Staff out due to disagreement to comply with safety protocols

f. Staff out due to decision to not get vaccinated for Covid-19

g. Staff out due to burnout

h. Staff out due to inability to manage telework environment

i. Staff unable to obtain daycare or childcare

j. Other, please specify.

k. None of the above.

24). Has your county used any of the following methods to meet staffing needs during the pandemic? *(Multiple checkboxes; please mark all that apply)*

a. Utilizing telework practices

b. Allowing flexible work hours

c. Bringing back retired staff

d. Facilitating access to childcare or daycare for workers

e. Hiring new staff

f. Increased use of various types of peer support staff and/or volunteers

g. Other (please specify)

h. None of the above.

25). Consider how the pandemic may have affected your county's ability to reach and serve the behavioral health needs of clients from diverse backgrounds. **Has the pandemic adversely affected your county's ability to reach and serve clients and families from the following racial/ethnic communities?** *(Check all that apply.*)

a. Asian American / Pacific Islander

b. Black / African American

c. Latino/ Hispanic

d. Middle Eastern & North African

e. Native American/Alaska Native

f. Two or more races

g. Other, please specify.

h. None of the above.

26). Based on your experience in your county, has the pandemic adversely impacted your county's ability to reach and serve behavioral health clients and families from the following communities and backgrounds? *(Check all that apply.)*

a. Children & Youth

b. Foster Youth

c. Immigrants & Refugees

d. LGBTQ+

e. Homeless individuals

f. Persons with disabilities

g. Seniors (65+)

h. Veterans

i. Other, please specify.

j. None of the above.

27). Which of the following pandemic-related challenges have presented significant barriers to accessing behavioral health services in your county? (*Please check all that apply.)*

a. Difficulty with or inability to utilize telehealth services

b. Concerns over Covid-19 safety for in-person services

c, Inadequate staffing to provide services for all clients

d. Lack of transportation to and from services

e. Client or family member illness due to Covid-19

f. Client disability impairs or prevents access

g. Mistrust of medical and/or government services

h. Language barriers (including ASL for hard-of-hearing)

i. Other (please specify).

APPENDIX I.

NSDUH Data Shows Evidence of Covid-19 Impacts on Mental Health and Substance Use Disorder Treatment Needs and Services during 2020.

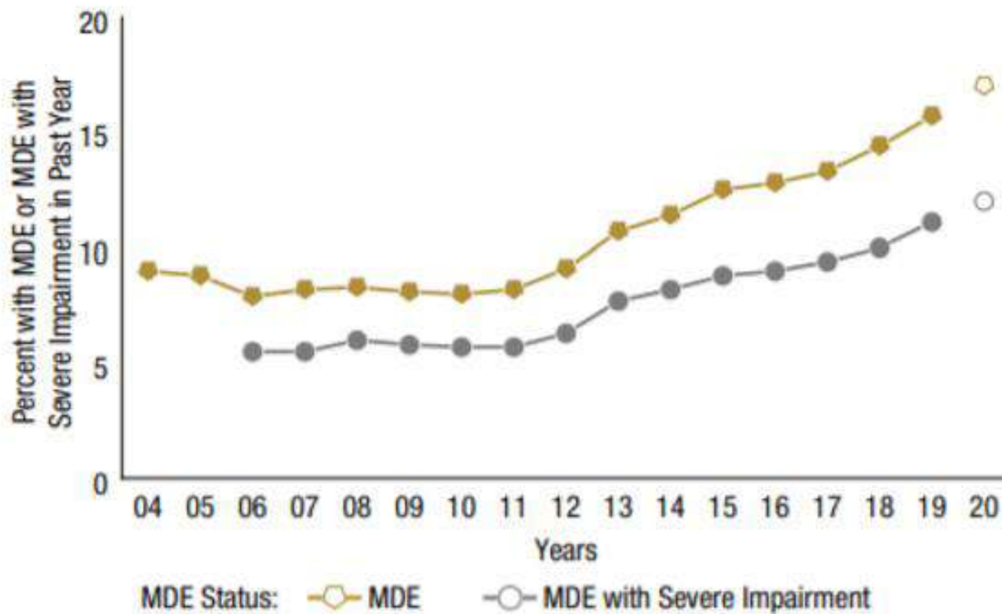
Some of the Behavioral Health problems in youth include, but are not limited to, the issues highlighted by the following series of data and figures taken from the National Survey of Drug Use and Health, (NSDUH Survey)[20] published in October, 2021, regarding data collected in 2020, which overlaps the first year of the pandemic. **Their methods of data collection changed in 2020 due to the public health restrictions and safety protocols**. Their methods changed from telephone surveys to include online survey methods in early 2020. **As a consequence, the data shown for 2020 are not connected by a solid line to that for prior years**. Also, the study authors did not perform certain tests of statistical significance between 2020 and prior years because the tests might not be valid due to the changes in methods.

Note that we are able to present these national data because they are based on live surveys. Of interest, the state level NSDUH data for California is expected to be released in the first half of 2022. Most other behavioral health data for our state and counties rely on paid claims data derived from billing records that have built-in reporting delays of 18-24 months. Thus, they would not show impacts of the pandemic which began in early 2020 or in 2021.

The next figure shows the progressive upward trends in the occurrence of major depressive episodes in children and youth aged 12-17. The numbers of persons experiencing major depressive episodes with severe impairment have steadily increased, in recent years. Here, as in all the figures that follow, we are interested in the data for calendar year 2020, as the initial pandemic health emergency declaration in the U.S. was put in place during March,2020.

[20] https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health, published October 2021 on data collected in 2020.

Figure 1. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year; Among Youths Aged 12-17; 2004 – 2020 (NSDUH).

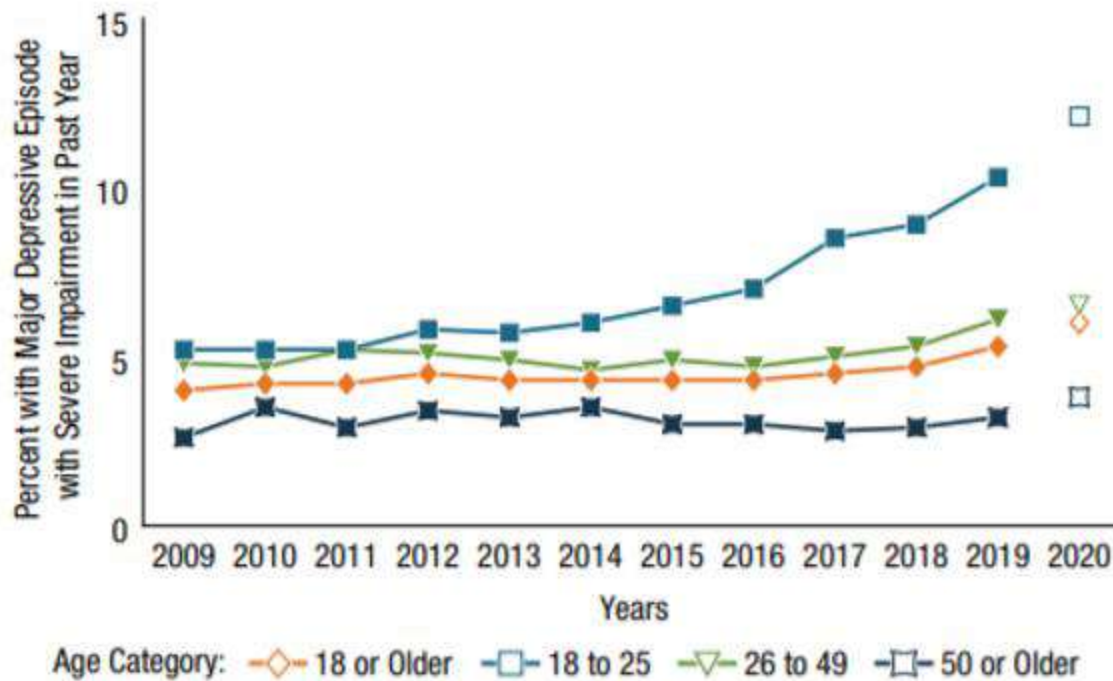


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The following series of data and figures show some of the impacts to adults and older adults. These data represent excerpts from the 2021 NSDUH Survey[21] on survey data collected in 2020. Nonetheless, the data are illustrative of trends during this challenging period of time. As an example of concerning trends, we note that October, 2021 marked the highest 12-month loss of American lives to drug overdoses, in excess of 100,000 total. Numbers of adults experiencing major depression also increased.

[21] Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf

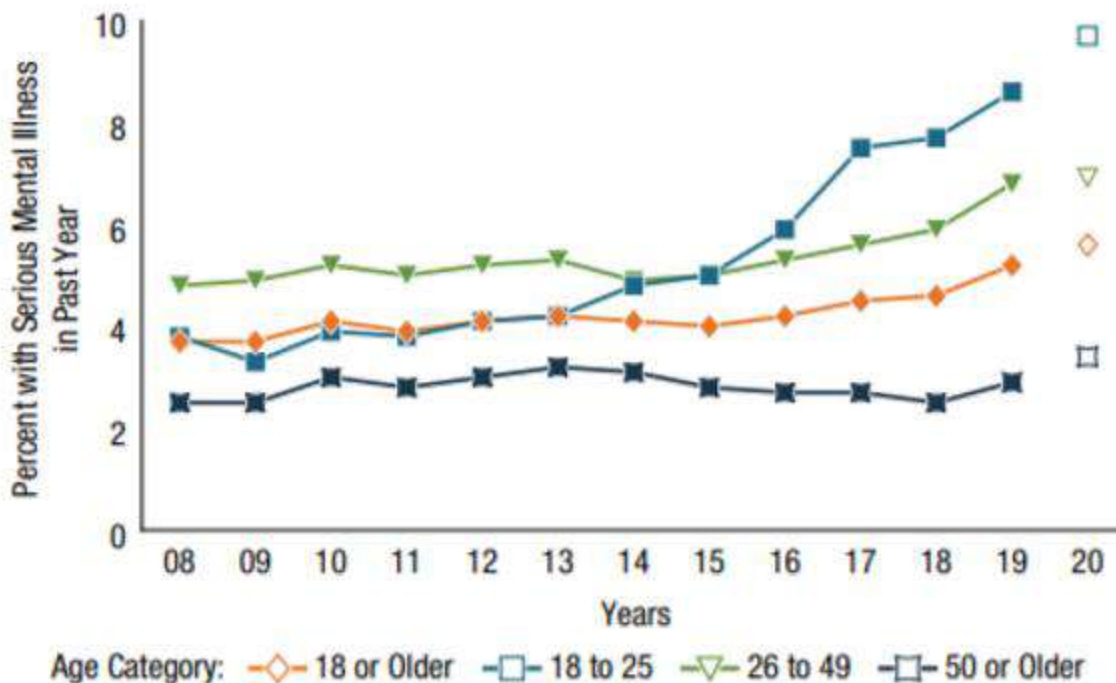
<u>Figure 2</u>. Major Depressive Episode with Severe Impairment In the Past Year: Among Adults Aged 18 or Older; 2009 – 2020 (NSDUH).



Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The data in the figure above indicate marked increases in the prevalence of major depressive disorder in young adults aged 18 to 25 during 2020 compared to 2019. For the same time period, there were only moderate increases in the prevalence of major depression in the other adult age groups, including depression in all adults age 18 and older.

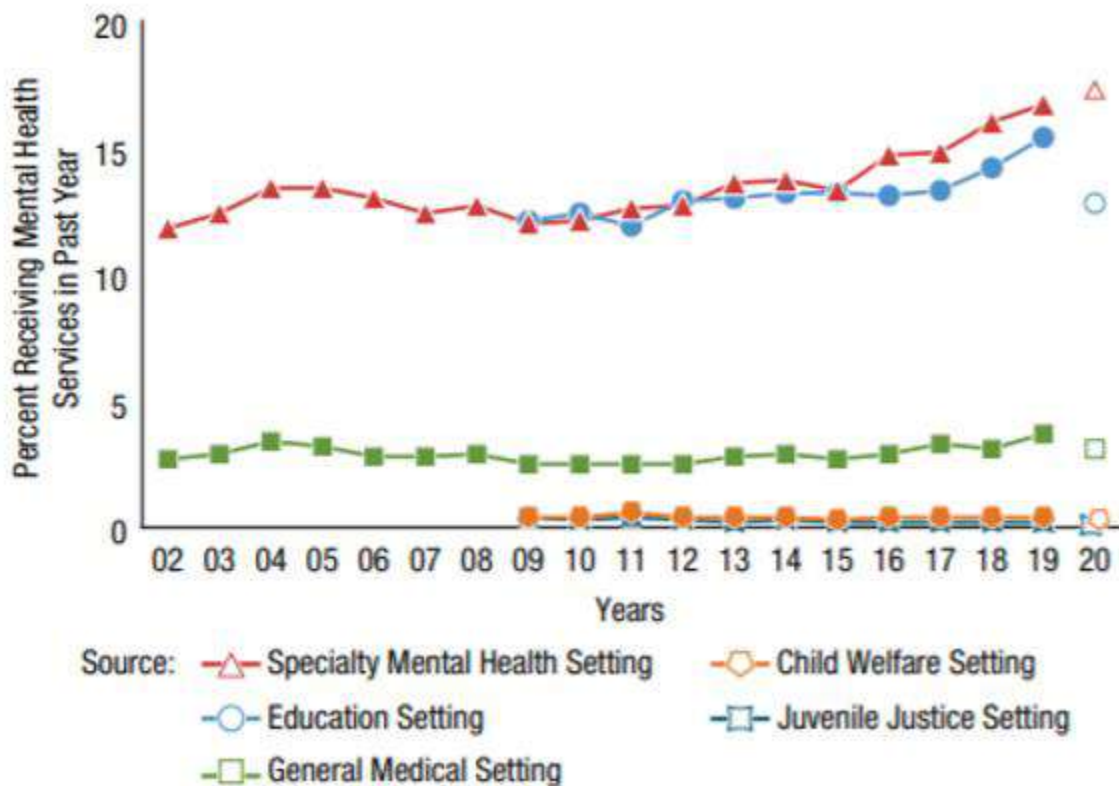
Figure 3. Serious Mental Illness in the Past Year; Among Adults Aged 18 or Older; 2008-2020 (NSDUH).



The data in the figure above show the highest incidence of serious mental illness in adults aged 18 to 25, and second highest in adults aged 26 to 49. Similarly, the greatest year over year increases from 2019 to 2020 occurred in those people aged 18 to 25, and similarly the second largest increase was in adults aged 26 to 49.

Where and how were services provided? The next figure addresses the trends in how youth aged 12 – 17 received BH services, in terms of the place where the person is most likely to have received services. For those who wish more detail, we refer the reader to extensive tables contained in the 2021 NSDUH Survey.

Figure 4. **Sources of Mental Health Services in the Past Year: Among Youths Aged 12 – 17; 2002 – 2020 (NSDUH).**



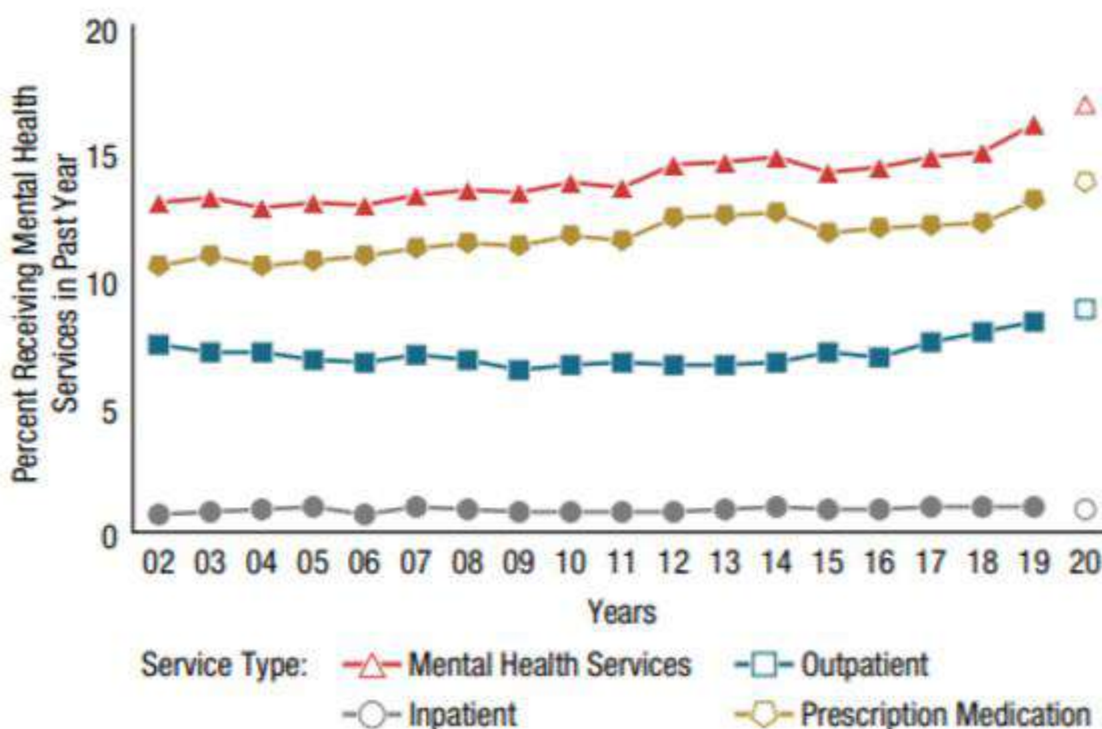
Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The figure above shows that sources of MH treatment for youth changed in 2020 when compared with prior years, with a substantial decrease in numbers who received MH services received at school (blue line), and a moderate decrease in numbers who received MH services in a general medical setting (green line). There was a slight increase in services received in a specialty mental health setting (red line). Each year, only about 0.1 to 0.4 % of youths received services in a child welfare setting (orange line) or in a juvenile justice setting (light blue line, overlapped and obscured by the orange line).

These data, overall, suggest that the prolonged shutdowns of medical offices, clinics, and the transition to online classes for education may have reduced the total number of youth who accessed MH services during the pandemic. This is particularly evident in the decrease in youth receiving mental health services in school and educational settings (as shown by the 2020 data points above).

In the next figure (below), note that the most common form of service was the combination of medication and either outpatient or inpatient services, and the second most common was medication alone, third was outpatient treatment services, and the least common form of service was inpatient hospitalization.

Figure 5. Type of Mental Health Services Received in the Past Year by Adults Aged 18 and Over, 2020. (NSDUH).

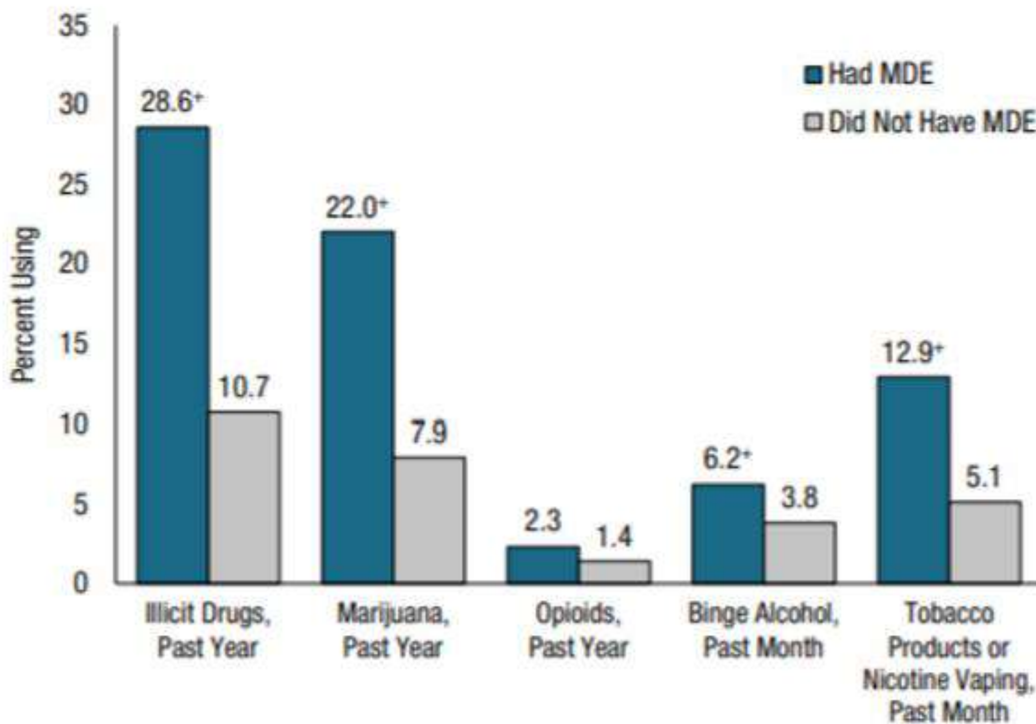


Note: Mental Health Services include any combination of inpatient or outpatient services or receipt of prescription medication.

Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The data above show that in 2020, compared to 2019, there were slight increases in the provision of the top three forms of service provision, but not in hospitalizations. The NSDUH Survey asked additional questions to collect information about telehealth, and found that in 2020, at least 11.0 % of adults (or 26.3 million people) received telehealth services (data not shown).

<u>Figure 6</u>. Substance Use among Youths Aged 12-17, by Past Year Major Depressive Episode (MDE) Status, 2020. (NSDUH).



+ Difference between this estimate and the estimate for youths without MDE is statistically significant at the .05 level.

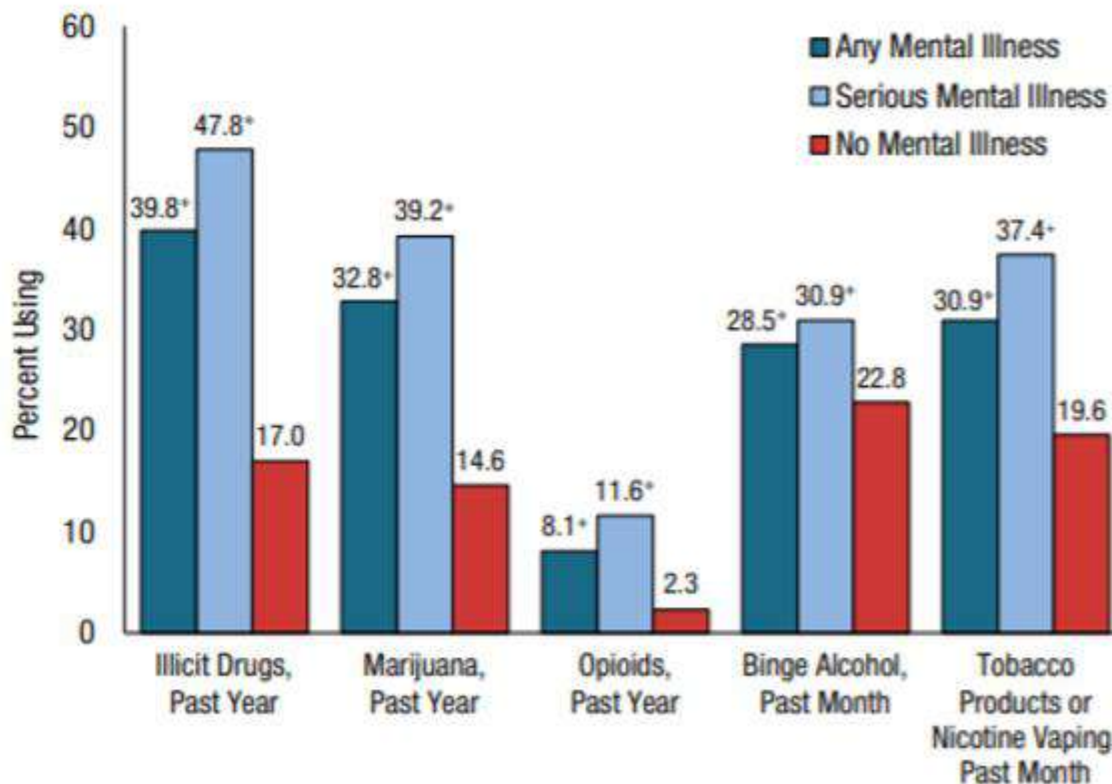
Note: Youth respondents with unknown MDE data were excluded.

In the figure above, the data for 2020 from the NSDUH Survey show that those youth who experienced a major depressive episode in the past year were more at risk for all forms of harmful substance use in the prior month. These substances and drugs included marijuana, tobacco, nicotine vaping, opiates and binge-drinking of alcohol.

Serious hazards for accidental fatal overdoses are presented by illicit drugs and opioids, due in part to the prevalence of unknown (to the user) ingredients such as fentanyl, methamphetamine, or others. Use of nicotine vaping products or tobacco is associated with risks for poor outcomes for individuals who also have asthma, or who develop pneumonia from influenza or severe Covid-19 illness (www.cdc.gov).

Next, we consider the prevalence in adults of substance use disorders co-occurring with mental illness.

Figure 7. Substance Use: Among Adults Aged 18 and Older; by Mental Illness, 2020 (NSDUH).

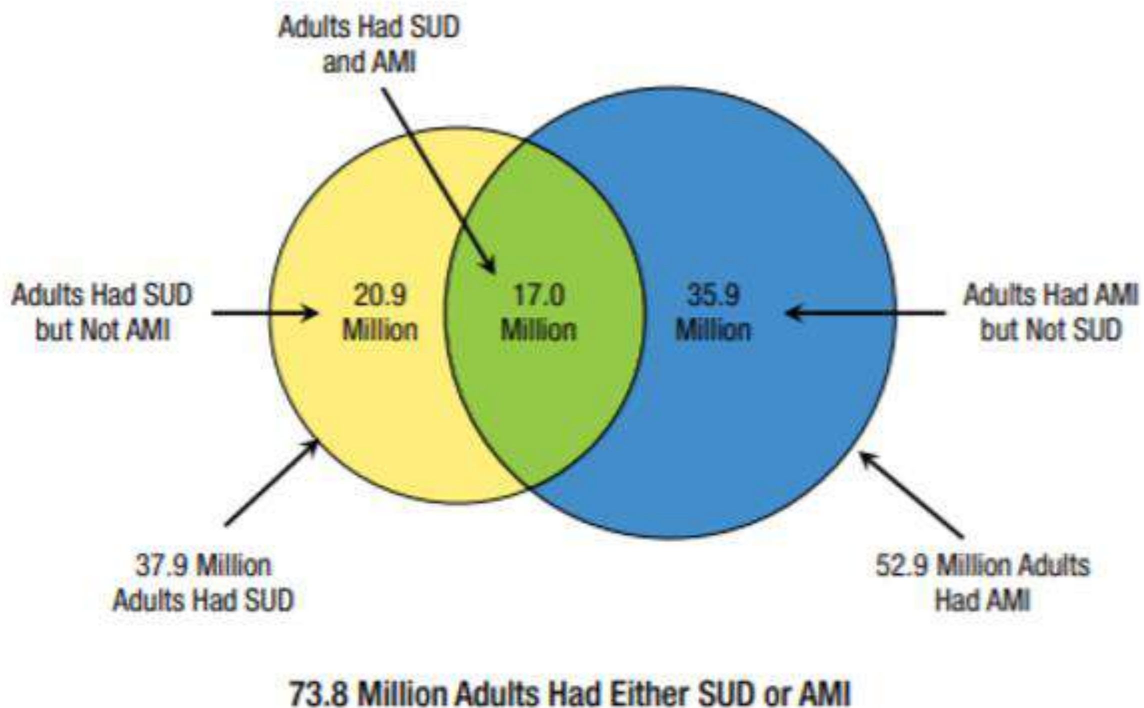


These data show the greatest incidence of substance use for those with serious mental illness, and second greatest incidence of substance use in those with 'any' mental illness. Those with serious mental illness showed at least twice the incidence of substance use for all substances except binge alcohol, compared to those adults with no mental illness. Those with no mental illness showed nearly two-thirds as much alcohol abuse as those with serious mental illness.

The incidence of alcohol binge drinking in those without a diagnosed mental illness seems fairly high. Researchers from various academic and medical backgrounds are still debating whether this amount of alcohol use and/or abuse represents a temporary increase due to the stress and isolation of the pandemic, expecting that these levels of alcohol use will subside to pre-pandemic levels, or whether the elevated levels of alcohol use and/or abuse will persist as part of the 'new normal.'

Events are still unfolding during the repeated waves and surges of Covid-19 infections, and therefore the data are incomplete at present (April, 2022).

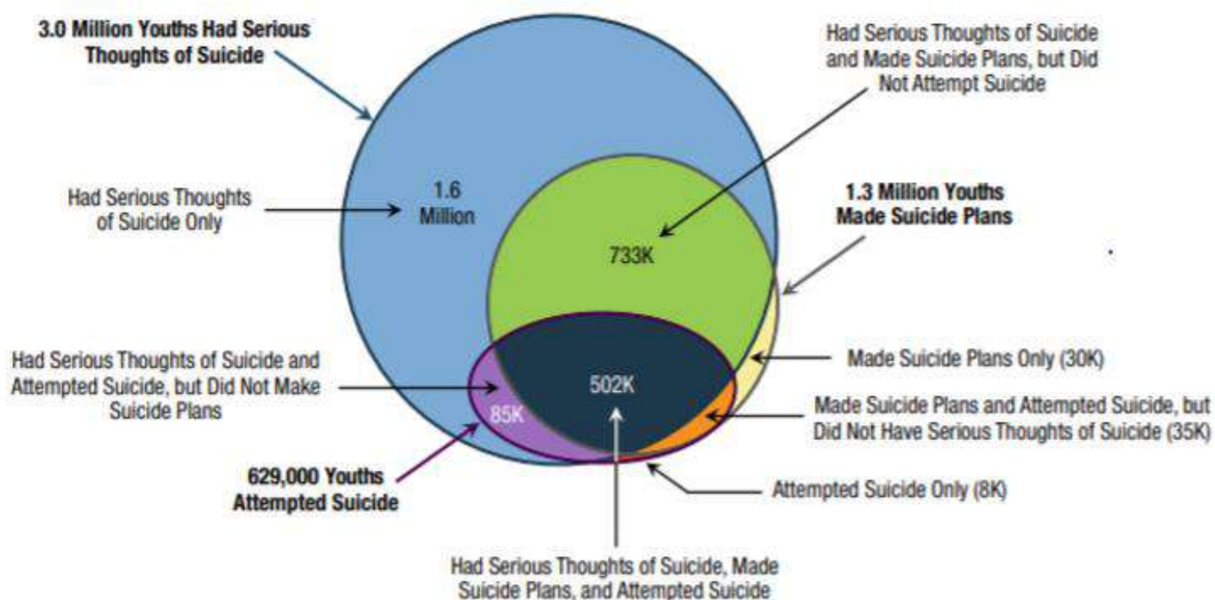
Figure 8. Past Year Substance Use Disorder (SUD) and Any Mental Illness (AMI): Among Adults Aged 18 or Older, 2020 (NSDUH).



The figure (shown above) illustrates the incidence of co-occurring disorders of substance use and mental illness. 'Any mental illness' (AMI) includes serious mental illness as well as mild-to-moderate mental illness. Of those with any mental illness, we see that 47.4 %, or nearly half, had a co-occurring substance use disorder.

The next figure shows the approximate numbers of youths aged 12 - 17 who expressed serious thoughts of suicide, made plans, or attempted suicide in the last year. The graph is a little bit complex, but the overall messages are extremely important.

Figure 9. Youths Aged 12-17 with Serious Thoughts of Suicide, Suicide Plans, or Attempted Suicide in the Past Year; 2020 (NSDUH).



What we can conclude from this figure is that issues of suicidal thoughts, plans, and attempts comprise a significant risk among youth aged 12 to 17.

Data in California for 2015 showed that there were 36.5 hospitalizations for self-inflicted injuries per 100,000 persons in the age group 5 - 20[22]. In the year 2019, there were 525 deaths by suicide in CA for persons age 5-20. Clearly, strategies are needed to reduce negative outcomes, including publicizing links to help-lines and reducing barriers to the access of mental health services.[23]

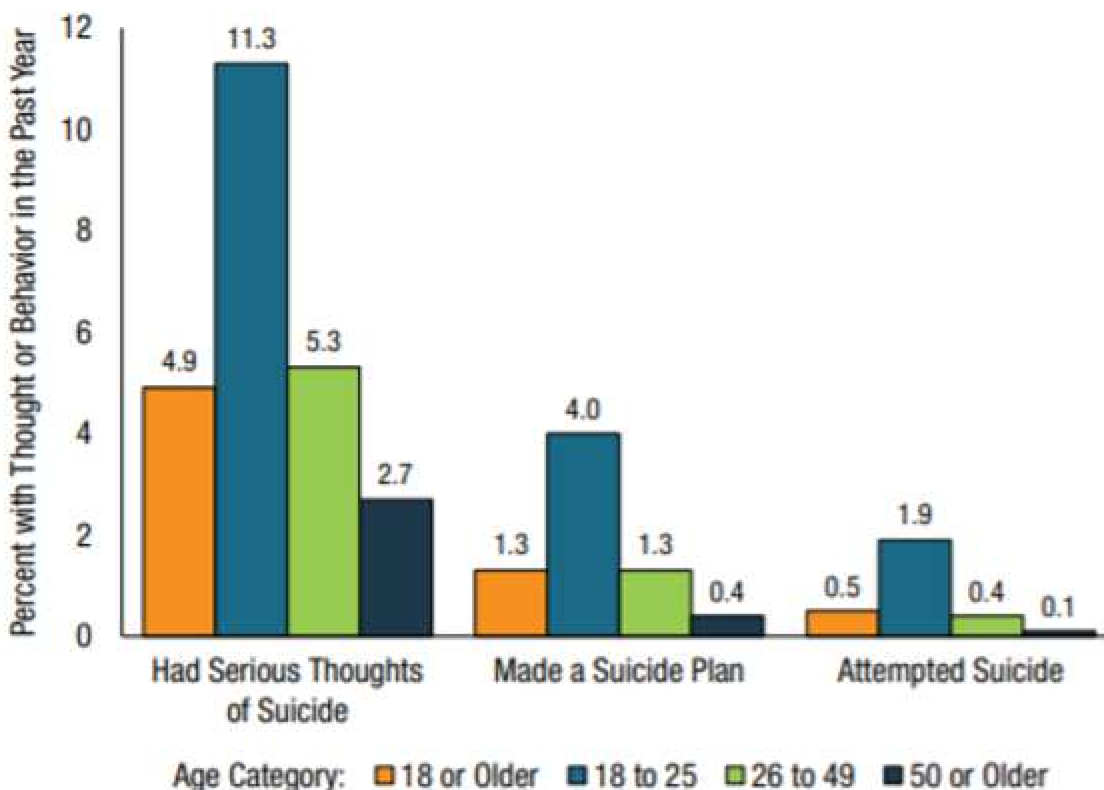
Privacy and confidentiality are key issues for adolescents, but the barriers to their access to services may involve the legal requirement for parental consent, and perhaps for parental health insurance. The most important issues are to keep the child safe and to provide timely access to competent, effective help.

Next we turn our attention to data about those adults that had thoughts of suicide, made a plan, or attempted suicide in the preceding year.

[22] www.kidsdata.org, accessed 2/3/2022.

[23] Please refer to the US Surgeon General's report and recommendations for suicide prevention, referenced later in this report in the section addressing BH in adults. The Report was release in early 2020 and addresses needs and programs for both youth and adults.

Figure 10. Had Serious Thoughts of Suicide, Made a Suicide Plan, or Attempted Suicide in the Past Year: Among Adults Aged 18 or Older, 2020. (NSDUH).



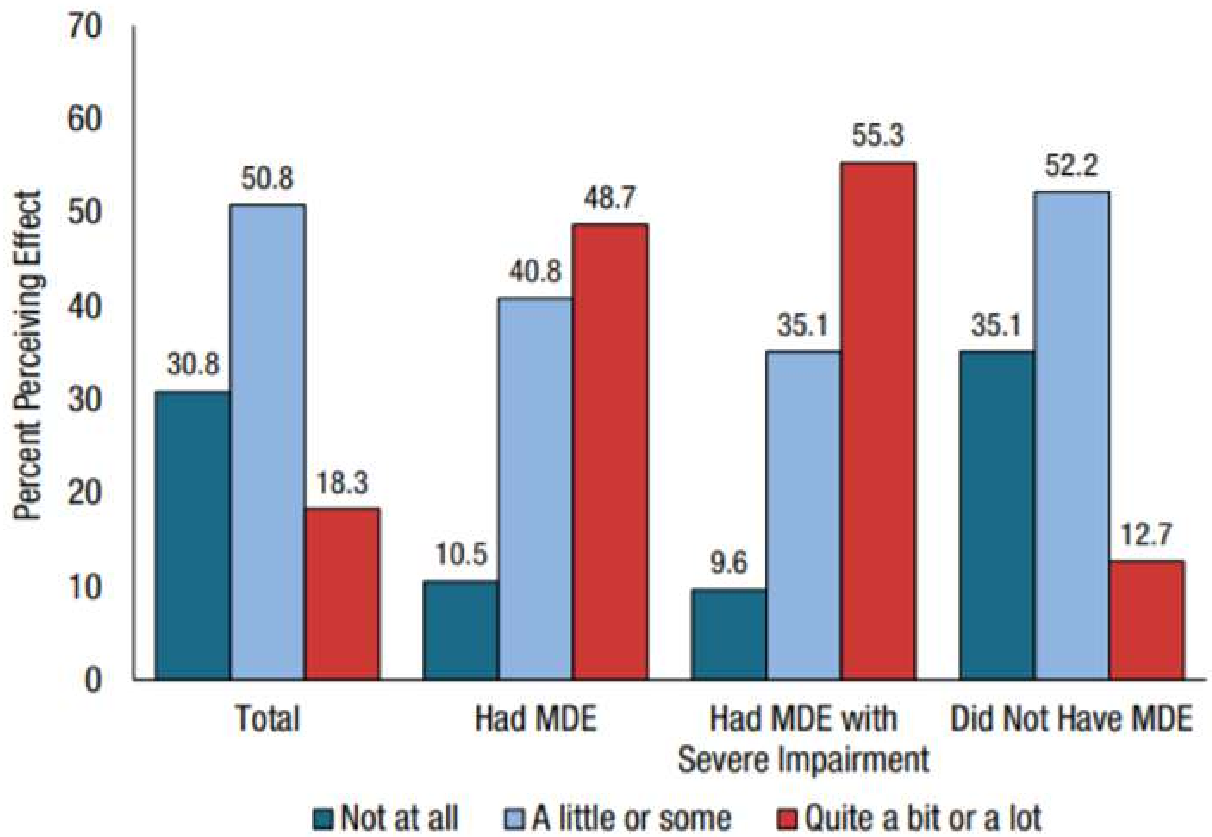
The data above show that in any given year, suicidal thoughts, or plans are perhaps more common than people might think, especially in those age 18 to 25. These data reinforce the need to have strategies[24] and programs[25] in place to help people in crisis and to publicize helplines and other resources for those of all age groups. The strategy document states:

> "We know that the coronavirus disease-2019 (COVID-19) pandemic is taking a tremendous toll on Americans' emotional and economic well-being. While no one is immune from the stress and anxiety resulting from this crisis, these effects are magnified in households that already faced systemic disparities before the pandemic began. During these times, we must focus on strengthening individuals and communities to cope with adversity, and supporting those who may be facing multiple challenges. We also need to ensure that those at risk for suicide are provided with effective care that will support their recovery." [7]

[24] The National Alliance for Suicide Prevention, "National Strategy for Suicide Prevention."

[25] U.S. Surgeon General's Call to Action: To Implement the National Strategy for Suicide Prevention, Dr. J. M. Adams, U.S. Public Health Service, pages 1-92, January 19, 2021. www.hhs.gov/sites/default/files/sprc-call-to-action.pdf

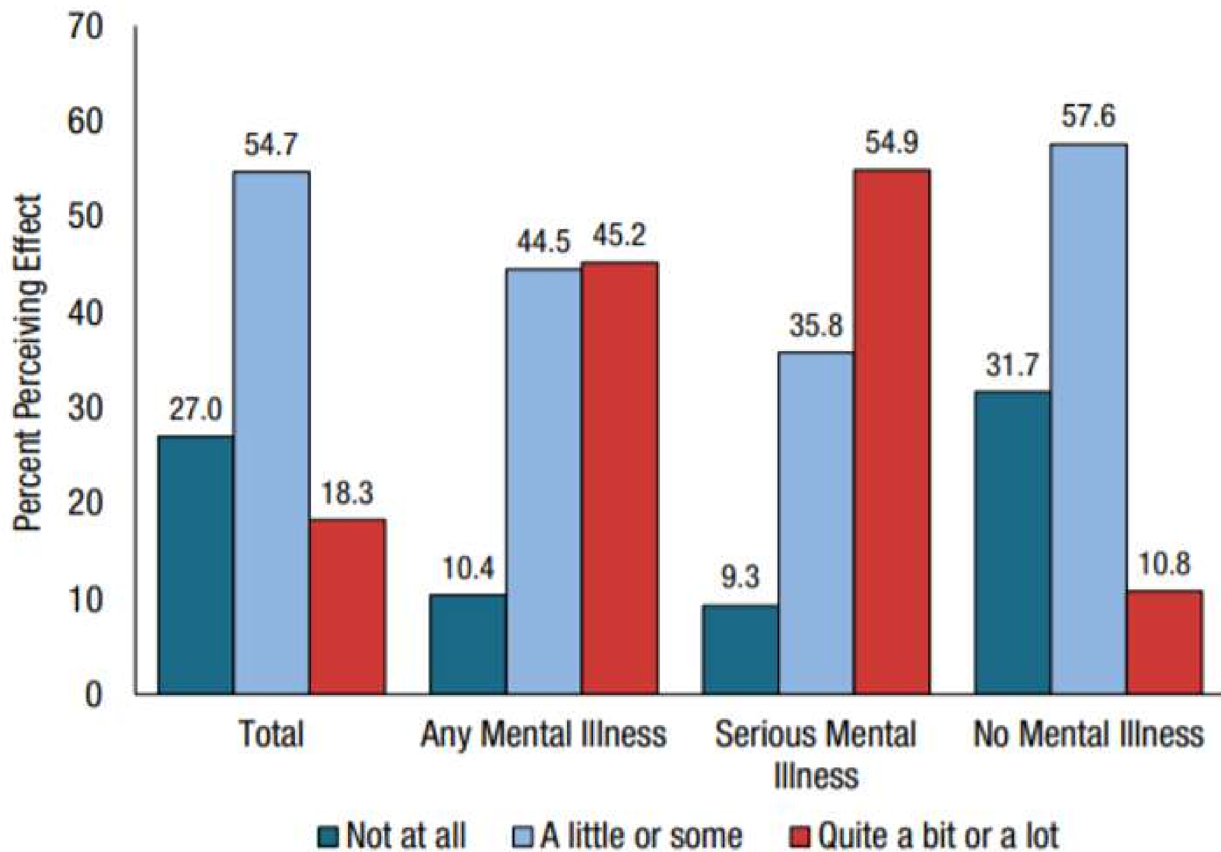
<u>Figure 11</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) States, Quarter 4, 2020 (NSDUH).



Note: The percentages do not add to 100 percent due to rounding.

Based on the 2021 NSDUH Survey data shown above, we conclude that those youth who had a major depressive episode during the prior year were most likely to perceive that the pandemic had a negative impact on their mental health and wellbeing.

<u>Figure 12</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Adults Aged 18 and Older; by Past Year Mental Illness Status, Quarter 4, 2020 (NSDUH)

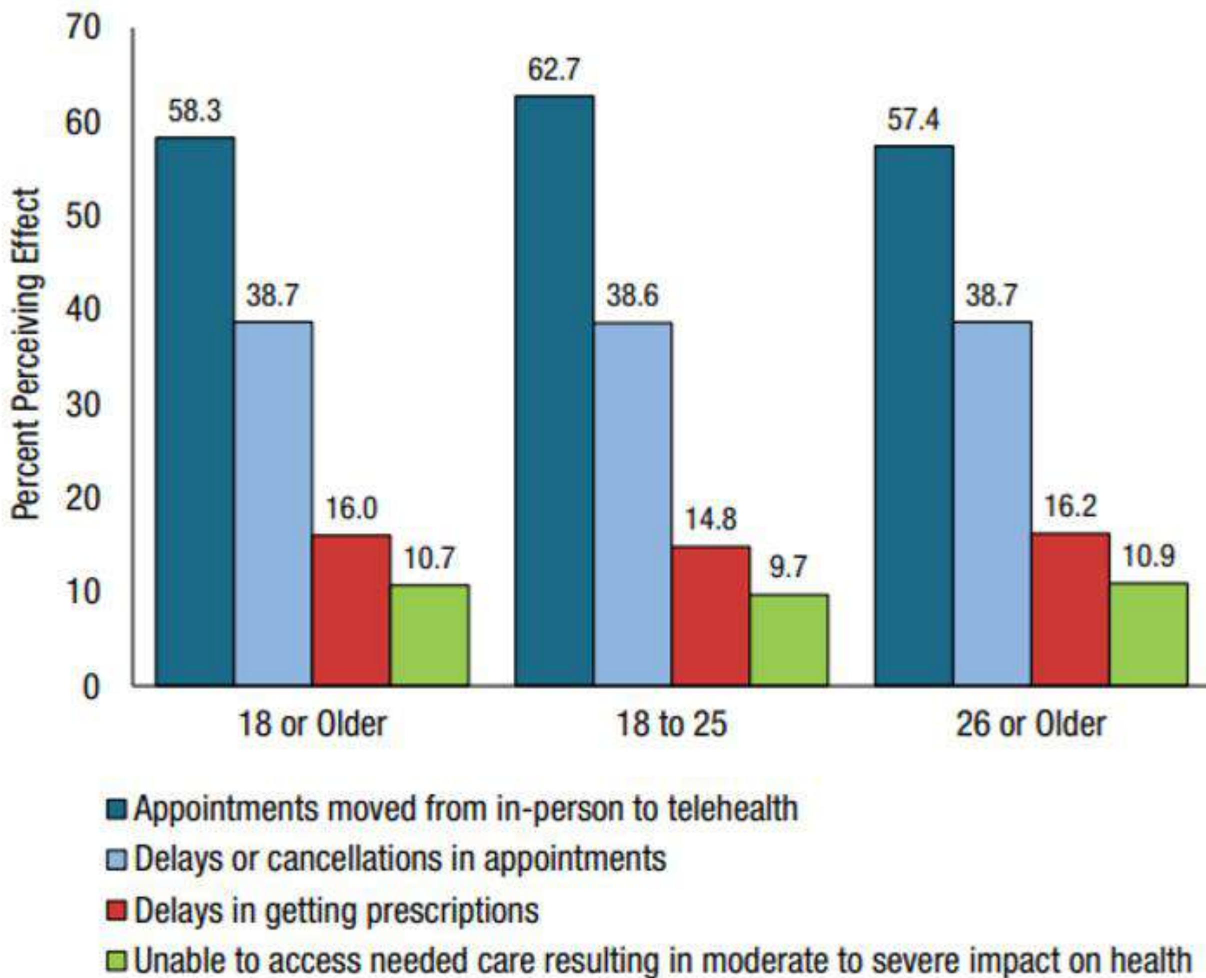


Note: The percentages do not add to 100 percent due to rounding.

Further, the NSDUH survey stated that there were still many in all age groups with 'any mental illness' who felt they had unmet needs for services (data not shown). At least 47% of those aged 18 to 25 who had mental health symptoms in the past year perceived they had unmet needs for MH services, 30.5 % of those aged 26 to 49 had unmet needs, and 20.3% of those aged 50 and over felt they had unmet needs.

Perhaps not surprisingly, the NSDUH Survey reported that many individuals voiced concerns about the services they had received, or failed to receive, due to scheduling delays, cancellations, or other problems, as shown in the next figure. Difficulty with scheduling and other delays indicate problems with timeliness of services, a critical issue for persons in crisis.

<u>Figure 13</u>. Perceived Covid-19 Pandemic Effect on Mental Health Services, Among Adults Aged 18 and Over Who Received Services; Quarter 4, 2020. (NSDUH, 2021).



During this period, similar to the challenges at the national level depicted in the figure above, those effects and many other factors were found to have impacted mental health service delivery in California. External quality reviews (EQRO)[26] of services that had been provided during the first half of 2020 by county behavioral health departments found that operations were affected by multiple factors. These factors included changes in methods of service delivery and procedures, rapid shift to telehealth, impacts to the workforce, changes in timeliness of appointments for services, suspension of focus groups and impaired ability of advisory boards to meet as desired, and other factors. (For further details, see the Cal-EQRO report for your county for 2021).[8]

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[26] EQRO= External Quality Review Organization, www.calegro.com. These external, or outside, reviews of county Behavioral Health Departments are required by federal law, and are contracted by the California Department of Health Care Services with this outside agency, the EQRO.

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health Planning Council

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, resilience, and wellness of Californians living with severe mental illness.

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CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the CBHPC. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Council staff to create an annual report to inform policy makers, stakeholders and the public.

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

- To help local boards meet their legal mandates[1] to review and comment on the county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

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

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

[2]See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.
[3]SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.

Part I: Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[4]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2021-2022 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[5] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[6] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

[4] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[5] Search for Adult Residential Facilities using the following Department of Social Services link: https://www.ccld.dss.ca.gov/carefacilitysearch/
[6] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

* 1. Please identify your County / Local Board or Commission.

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?

3. What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

5. Does your county have any "Institutions for Mental Disease" (IMDs)?

- No
- Yes (If Yes, how many IMDs?)

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-County

Out-of-County

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[7] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.

Preliminary data for January, 2021 had been posted in early February 2022, but those only contained data for the individuals in shelters or other temporary housing. There was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. The count for 2022 took place in many communities during the last week in February. The federal analysis and publication of that data will not be available for at least six to twelve months. Therefore, we are presenting the previous year's data for January 2020 in Table 3 as a baseline reference for comparison to the most recent year's data for 2021 and/or 2022, whenever that data becomes available. (Please refer to your 2022 Data Notebook pdf document for Table 3.)

[7]Link to data for yearly Point-in-Time Count:
https://www.hudexchange.info/programs/coccoc-homeless-populations-and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=CA&filter_CoC=&program+Coc&group=PopSub

8. During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)

- [ ] Emergency Shelter
- [ ] Temporary Housing
- [ ] Transitional Housing
- [ ] Housing/Motel Vouchers
- [ ] Supportive Housing
- [ ] Safe Parking Lots
- [ ] Rapid re-housing
- [ ] Adult Residential Care Patch/Subsidy
- [ ] Other (please specify)

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Child Welfare Services: Foster Children in Certain Types of Congregate Care

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Examples of the foster care CDSS data for Q4, 2020, in CA:

- **Total foster youth and children: 53,180**
- **Total placed in an STRTP: 2,444 (or 4.6% of foster youth)**
- **Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)**
- **Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)**

9. Do you think your county is doing enough to serve the children/youth in group care?

- ◯ Yes
- ◯ No (If No, what is your recommendation? Please list or describe briefly)

Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

10. Has your county received any children needing "group home" level of care from another county?

- No
- Yes (If Yes, how many?)

11. Has your county placed any children needing "group home" level of care into another county?

- No
- Yes (If Yes, how many?)

Part II: Impact of the Covid-19 Public Health Emergency on Behavioral Health Needs and Services

Background and Context

The Planning Council selected this year's special topic for the Data Notebook to focus on questions regarding the impact of the Covid-19 public health emergency on the behavioral health system during 2020 through 2021. Our goal for the choice of this topic is to evaluate effects of the pandemic on (1) the behavioral health of vulnerable populations in California, and (2) the impact on county behavioral health departments' ability to provide mental health and substance use disorder (SUD) treatment services in 2020 and 2021.

The major themes are as follows:

1. **The major effects on behavioral health in the vulnerable populations of adults, children and youth served by California's public mental health system. We will present some national data that describes some of the major effects.**
2. **The effects of the Covid-19 pandemic on the ability of county behavioral health departments to provide mental health and substance use treatment services.**
3. **The lessons learned and successes achieved during a time when everyone was challenged to be flexible and to devise new ways to support mental health while implementing Covid-19 public health protocols.**

This 2022 Data Notebook includes questions about effects of the pandemic on BH needs and services for children and youth, adults, and finally, some questions about potential county staffing challenges. To provide background and context for this part, we will discuss some of the limited public health data available thus far. The national data show that reports of serious behavioral health challenges were already trending upward in the two years prior to 2020. Further, the numbers of children, youth, and adults who need BH services appear to have increased further during both 2020 and 2021. Newer reports from California agencies that address similar issues have evaluated data collected in 2020 and 2021. Reports containing analyses of the most recent data are expected sometime in the second half of 2022.

In the strictest sense, we may not be able to establish that any of the changes in 2020-2021 were due to effects of the pandemic itself. Nonetheless, the continuing trends in 2020 and 2021 are cause for concern and attention, regardless of the difficulty of distinguishing cause from correlation and mere chance. Note that in our questions and discussion we often use the shorthand of speaking about the effects of Covid-19 on clients' mental health or on a county system's ability to respond to the larger challenges of the pandemic. We are not speaking in the biologic sense of what this virus does to a person's body, but rather the totality of the pandemic experience as we face this ongoing public health emergency.

We may find from the data we plan to collect through this Data Notebook that the pandemic had significant effects on system capacity to provide quantity, quality, or timeliness in the provision of many types of services, especially during the transition to online and telehealth services. Efforts to maintain Covid-19 protocols, (including social distancing), and limited access to technology may have increased barriers to access and impaired service delivery to our most vulnerable populations and to historically disadvantaged communities.

What were the Behavioral Health Impacts of the Covid-19 Pandemic on Children and Youth?

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Most recently, this urgency led the U.S. Surgeon General to issue a special health advisory[8]:

"Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade." said Surgeon General Vivek Murthy. "The COVID-19 pandemic further altered their experiences at home, school, and in the community, and the effect on their mental health has been devastating. The future wellbeing of our country depends on how we support and invest in the next generation. Especially in this moment, as we work to protect the health of Americans in the face of a new variant, we also need to focus on how we can emerge stronger on the other side. This advisory shows us how we can all work together to step up for our children during this dual crisis."

Before the COVID-19 pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people, with up to 1 in 5 children ages 3 to 17 in the U.S. having a mental, emotional, developmental, or behavioral disorder. Additionally, from 2009 to 2019, the share of high school students who reported persistent feelings of sadness or hopelessness increased by 40%, to more than 1 in 3 students. Suicidal behaviors among high school students also increased during the decade preceding COVID, with 19% seriously considering attempting suicide, a 36% increase from 2009 to 2019, and about 16% having made a suicide plan in the prior year, a 44% increase from 2009 to 2019. Between 2007 and 2018, suicide rates among youth ages 10-24 in the U.S. increased by 57%, - PDF and early estimates show more than 6,600 suicide deaths - PDF among this age group in 2020.

The pandemic added to the pre-existing challenges that America's youth faced. It disrupted the lives of children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic's negative impacts most heavily affected those who were vulnerable to begin with, such as youth with disabilities, racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall, a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

The Surgeon General's Advisory on Protecting Youth Mental Health outlines a series of recommendations to improve youth mental health across eleven sectors, including young people and their families, educators and schools, and media and technology companies.

[8]"Protecting Youth Mental Health: The Surgeon General's Advisory", by Dr. Vivek Murthy, M.D., U.S. Public Health Service, pages 1-53. December 7, 2021. https://www

Challenges, Resilience, and Possible Lessons Learned while Addressing Behavioral Health Impacts during the Covid-19 Pandemic

Many agencies of the state have held discussions regarding the challenges and lessons learned from our collective experiences of continuing to provide services or a variety of administrative supports for those involved in provision of direct services. These discussions or assessments are an ongoing process at multiple levels.

In the 2020 Data Notebook, the Planning Council asked questions about the use of telehealth for mental health therapy to adults during early stages of the pandemic. Some service providers and clients encountered problems of access, such as technology issues, lack of home internet, or lack of adequate bandwidth, especially in rural areas. Other issues included the challenges of learning to work with the virtual therapy platform for both providers and clients. Some individuals had disabilities with impaired hearing and/or impaired vision (hard to see keys to type), which led to difficulties in access or to being completely unable to access telehealth. Also, there were language challenges for some individuals.

However, as we saw in the analyses of the responses collected from the 2020 Data Notebook, for clients who were able to overcome any technology barriers to access, they reported a fair degree of success in being able to improve their handling of mental health issues. Some clients were also able to get tele-health appointments for medication evaluation and prescriptions. Tele-health is an example of a rapid system-wide adaptation enabled by rapid policy changes for Medicaid/Medi-Cal at the federal and state levels, and rapid adaptation by local government and care providers.

The Planning Council advocates for a behavioral health system that can meet the needs of vulnerable populations and historically disadvantaged groups. Systemic, economic, or other societal factors that can reduce access to behavioral health services likely overlap with those factors that reduce access to medical care and preventative public health measures.

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African-American, and Native-American people.[9] Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. And due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"[10] symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including better adapting our outreach and messaging.

Next we turn to the discussion questions for Part II regarding the provision of behavioral health services in your community during the Covid-19 pandemic. Two questions ask for optional comments about either services for Children and Youth, or those for Adults. These 'open comment' questions could address unique county successes, continuing challenges, or lessons learned to aid future resilience, or any other com

12. Please identify the points of stress on your county's system for children and youth behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of youth receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions of youth for episodes of self-harm and/or suicide attempts.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among youth.
- [ ] Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).
- [ ] Decreased access/utilization of mental health services for youth.
- [ ] None of the above
- [ ] Other (please specify)

13. Of the previously identified stressors, which are the top three concerns for your county for children and youth services? (Please select your county's top three points of impact in descending order)

	Top concerns for children and youth services
1st	
2nd	
3rd	

14. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, mental health services for children and youth in your county during the Covid-19 pandemic?

15. Please identify the points of stress on your county's system for all adult behavioral health services during the pandemic (mark all that apply)

- [ ] Increased numbers of adults presenting for services who report thoughts of suicide or other thoughts of self-harm.
- [ ] Increased numbers of adults receiving services who reported significant levels of anxiety, with or without severe impairment.
- [ ] Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.
- [ ] Increased Emergency Department admissions for episodes of self-harm and suicide attempts among adults.
- [ ] Increased Emergency Department visits related to misuse of alcohol and drugs among adults.
- [ ] Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).
- [ ] Decreased access/utilization of mental health services for adults.
- [ ] None of the above
- [ ] Other (please specify)

16. Of the previously identified stressors, which are the top three concerns for your county for all adults services? (Please select your county's top three points of impact in descending order)

	Top concerns for all adults
1st	
2nd	
3rd	

17. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for all adults in your county during the Covid-19 pandemic?

18. Since 2020, has your county increased the use of telehealth for all adult behavioral health therapy and supportive services?

- Yes
- No

19. Since 2020, has your county increased the use of telehealth for psychiatric medication management for all adults?

- Yes
- No

20. Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders?

- Yes
- No
- Not applicable (if your board does not oversee SUD along with mental health)

21. Many or most MAT programs rely on in-person visits by necessity in order to get certified to provide these services. [Some of these medications include buprenorphine, methadone, suboxone, emergency use Narcan]. As part of SUD treatment services, are you able to coordinate routine drug testing with clinics near the client?

- Yes
- No
- Not Applicable (if your board does not oversee SUD along with mental health)

If Yes, how has this been useful in promoting successful outcomes?
If No, do you have alternatives to help clients succeed?

22. Have any of the following factors impacted your county's ability to provide crisis intervention services? (Check all that apply)

- Increase in funding for crisis services
- Decrease in funding for crisis services
- Issues with staffing and/or scheduling
- Difficulty providing services via telehealth
- Difficulty implementing Covid safety protocols
- None of the above
- Other (please specify)

23. Did your county experience negative impacts on staffing as a result of the pandemic? (Please select your county's top points of impact from the dropdown menus, all in descending order of importance)

	negative impacts on staffing as a result of the pandemic
1st	
2nd	
3rd	
4th	

24. Has your county used any of the following methods to meet staffing needs during the pandemic? (please mark all that apply)

- [ ] Utilizing telework practices
- [ ] Allowing flexible work hours
- [ ] Bringing back retired staff
- [ ] Facilitating access to childcare or daycare for worker
- [ ] Hiring new staff
- [ ] Increased use of various types of peer support staff and/or volunteers
- [ ] None of the above
- [ ] Other (please specify)

25. Consider how the pandemic may have affected your county's ability to reach and serve the behavioral health needs of clients from diverse backgrounds. Has the pandemic adversely affected your county's ability to reach and serve clients and families from the following racial/ethnic communities? (Check all that apply.)

- [ ] Asian American / Pacific Islander
- [ ] Black / African American
- [ ] Latino/ Hispanic
- [ ] Middle Eastern & North African
- [ ] Native American/Alaska Native
- [ ] Two or more races
- [ ] None of the above
- [ ] Other (please specify)

26. Based on your experience in your county, has the pandemic adversely impacted your county's ability to reach and serve behavioral health clients and families from the following communities and backgrounds? (Check all that apply.)

- [ ] Children & Youth
- [ ] Foster Youth
- [ ] Immigrants & Refugees
- [ ] LGBTQ+ people
- [ ] Homeless individuals
- [ ] Persons with disabilities
- [ ] Seniors (65+)
- [ ] Veterans
- [ ] None of the above
- [ ] Other (please specify)

27. Which of the following pandemic-related challenges have presented significant barriers to accessing behavioral health services in your county? (Please check all that apply.)

- ☐ Difficulty with or inability to utilize telehealth services
- ☐ Concerns over Covid-19 safety for in-person services
- ☐ Inadequate staffing to provide services for all clients
- ☐ Lack of transportation to and from services
- ☐ Client or family member illness due to Covid-19
- ☐ Client disability impairs or prevents access
- ☐ Mistrust of medical and/or government services
- ☐ Language barriers (including ASL for hard-of-hearing)
- ☐ None of the above
- ☐ Other (please specify)

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (please select all that apply)

- ☐ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions
- ☐ MH Board completed majority of the Data Notebook
- ☐ Data Notebook placed on Agenda and discussed at Board meeting
- ☐ MH board work group or temporary ad hoc committee worked on it
- ☐ MH board partnered with county staff or director
- ☐ MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function
- ☐ Other (please specify)

29. Does your board have designated staff to support your activities?

- ○ No
- ○ Yes (if Yes, please provide their job classification)

30. Please provide contact information for this staff member or board liaison.

Name

County

Email Address

Phone Number

31. Please provide contact information for your Board's presiding officer (Chair, etc.)

Name

County

Email Address

Phone Number

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?