CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1340 Arnold Drive, Suite 200
Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

Mental Health Commission
MHSA-Finance Committee Meeting
Thursday, January 20, 2022, 1:30-3:00 PM

Via: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481

Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from the December 16, 2021 MHSA-Finance Committee meeting**

VI. **DISCUSS the 2021-2022 MHSA Plan update. Presentation by Jennifer Bruggeman, Contra Costa Behavioral Health Services MHSA Program Manager**

VII. **DISCUSS Housing, Treatment, and Services needed for the 50+ persons adjudged Felony Incompetent to Stand Trial (FIST) and LPS Murphy Conservatees returning to the county within the next several years.**
Presentation & Discussion moderator: Douglas Dunn, Chair, Commission MHSA-Finance Chair

VIII. **MOTION: Ask Behavioral Health to include the necessary Housing, Treatment, and Services needed for this most vulnerable and highest need population, including:**
   a. **Multi-Service level Forensic and Civil Mental Health Rehabilitation Center (MHRC) treatment and services**
   b. **Multi-level step down housing, treatment, and services**

IX. **Adjourn**

Felony Incompetent to Stand Trial & LPS Murphy Conservatorship MHSA-Finance Agenda Item Notes—Douglas Dunn 1

NOTE: 60%+ of the 70-95 person population discussed below are Black, and Indigenous People of Color.

This agenda item discusses the Housing, Treatment, and Services needs of this highest need population. On June 15, 2021, the 5th District Appellate Court upheld the Stiavetti vs. Ahlin and now Clendenin lawsuit decision requiring the Dept. Of State Hospitals (DSH) to accept person into a DSH bed within 28 days of a person being adjudged IST. As a result, the state legislature passed legislation, AB 133 and Welfare and Institutions Code 4147 which established a statutory time limited (11/30/2021) IST Solutions Workgroup seeking to clear out the now 1,800+ person and daily growing waitlist which has been tremendously impacted by the COVID-19 pandemic. Because of the fast spreading Omicron variant, the DSH now has another 30 day stop on any admissions until at least February 1, 2022.

Very briefly, a person adjudged Incompetent to Stand Trial (IST):

- Does not rationally understand the criminal charges against him or her, AND/OR
- Cannot rationally help with defense counsel (usually a public defender) in presenting a defense against the criminal charge(s).

Per several US Supreme Court decisions, the legal standard of proof is: Preponderance of the Evidence.

Ms. Stephanie Regular, JD, Supervisor of the Contra Costa Public Defender's 7 attorney Mental Health unit, was a formal member of this workgroup. I participated as a member of the public in this state level workroup and its several working group meetings which were generally biweekly from August 17 thru November 19, 2021. Attached is the Workgroup's 11/30/2021 final report.

In summary, as a result of these developments the following developments have either occurred or will occur:

- Persons adjudged Misdemeanor Incompetent to Stand Trial (MIST) can no longer be referred to any state hospital. They remain in their "county of origin" in which the alleged crime(s) was/were committed. For Contra Costa County, this means 22 persons currently adjudged MIST remain in this county. Per recently passed SB 317, persons with this legal status are eligible for either:
  1. Mental Health Diversion (MHD), or
  2. Assisted Outpatient Treatment (AOT), or
  3. Case Dismissed if an MHD or AOT slot is not available.

  To make matters worse, their minimal county Behavioral Health psychiatric services ended January 1, 2022 As a result, the Mental Health Commission's (MHC) MHSA-Finance Committee recently asked Mental Health Services (MHS), Inc., the contracted AOT service provider to prepare an attached real life "what-if" budget for this population's, Housing, Treatment, and Services. Their projected cost is $3M annually.

Felony Incompetent to Stand Trial & LPS Murphy Conservatorship MHSA-Finance Agenda Item Notes (cont'd)—Douglas Dunn 2

- Persons adjudged Felony Incompetent to Stand Trial (FIST) will return to this county over the next several years, definitely by early 2025. The size of this population is 50+ persons. Because of this group's heavy criminal justice system involvement, the needed Housing, Treatment, and Services required are very complex on multiple levels. For example, because of the nature of their felony criminal charges, they have to initially, at least, be housed in a multi-treatment level Forensic Mental Health Rehabilitation Center (FMHRC). From personal observations, I know the District Attorney's (DA) Deputy in charge of Mental Health Litigation will not allow these persons to be initially placed, at least, in an unlocked high treatment and rehabilitation services housing setting. Because of the serious nature of the felony charges involved, I've personal watched her persuade the presiding judge to deny these persons MHD. <u>Afterward, I've counseled the families who are absolutely devastated!!</u>

- In addition, a smaller subgroup are persons have been both civilly adjudged "Gravely Disabled" and charged with the most dangerous felony charges, namely:
  1. Murder, or
  2. Attempted Murder, or
  3. Have threatened a person or persons "within an inch of their lives."

  These persons are classified as LPS Murphy Conservatees. The reach this status after having been FIST in a state hospital setting for 2 consecutive years. The legal standards of Proof for an LPS Murphy Conservatorship are:
  - Gravely Disabled—Beyond a Reasonable Doubt
  - Incompetent to Stand Trial (IST)—Preponderance of the Evidence

  Currently, 5-7 persons from Contra Costa County are classified as LPS Murphy Conservatees.

  Finally, under a CCBHS approx. $7M/yr. contract, 20 persons in a civil LPS 1 Year Renewable Conservatorship are currently in state hospital beds. They may also be coming back to Contra Costa County.

  As stated, housing and treatment and services and reimbursement costs are complex for these populations because of the Institute of Mental Diseases (IMD) Medi-Cal Reimbursement Exclusion for persons 21-94 years of age. This means that Contra Costa Behavioral Health Services (CCBHS) only receives state Medi-Cal, <u>not any dollar for dollar matching Federal Financial Participation (FFP) matching reimbursement funding for persons in any MHRC or state DSH bed.</u> This currently costs CCBHS about $15M annually in "lost" FFP reimbursement.

  There is some hope with $2.2B available in a one-time competitive grant process available from the approved 2021-2022 state budget However, CCBHS will have to bid which could be a tall order given its previously very uneven success in such endeavors.

  <u>If these efforts fail, most of these persons could wind up re-incarcerated!!</u>

4147. (a) To confront the crisis of individuals found incompetent to stand trial (IST) and in recognition of the importance of these defendants who are committed to the State Department of State Hospitals to begin receiving competency treatment as soon as practicable, the California Health and Human Services Agency along with the State Department of State Hospitals shall convene an Incompetent to Stand Trial Solutions Workgroup to identify short, medium, and long-term solutions to advance alternatives to placement at the State Department of State Hospitals.

(b) Workgroup members shall be appointed by the Secretary of California Health and Human Services and the workgroup shall be chaired by the Director of the State Department of State Hospitals. Members of the workgroup shall serve without compensation. Members may include, but are not limited to, representatives from the following entities and interested parties:

(1) California Health and Human Services Agency.

(2) State Department of Health Care Services.

(3) State Department of Developmental Services.

(4) Department of Corrections and Rehabilitation.

(5) Department of Finance.

(6) Other state agencies, as needed.

(7) Judicial Council.

(8) Other partners, including local government and justice system representatives of entities involved in the commitment of IST defendants to the State Department of State Hospitals and representatives of patients and their family members, as needed.

(c) The workgroup shall submit recommendations to the California Health and Human Services Agency and the Department of Finance no later than November 30, 2021, outlining short-term solutions that can be accomplished by April 1, 2022, medium-term solutions that can be accomplished by January 10, 2023, and long-term solutions that can be accomplished by January 10, 2024, and January 10, 2025, to support the State Department of State Hospitals in serving individuals with the most intensive behavioral health treatment needs and providing timely access to treatment for individuals found IST on felony charges.

(d) The workgroup may meet as often as bi-weekly until the workgroup is disbanded by the Secretary of California Health and Human Services.

(e) The workgroup may consider, but is not limited to, recommendations that accomplish any of the following:

(1) Reduce the total number of felony defendants determined to be IST.

(2) Reduce the lengths of stay for felony IST patients.

(3) Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.

(4) Support increased access to felony IST diversion options.

(5) Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.

(6) Create new options for treatment of felony IST defendants including community based, locked and unlocked facilities.

(7) Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk or acuity are treated in appropriate community settings.

(f) (1) Until December 31, 2024, if the Secretary of California Health and Human Services determines that either of the conditions stated in subparagraphs (A) or all of the conditions stated in subparagraph (B) have occurred, the State Department of State Hospitals may take the actions described in paragraph (2), if authorized by the Secretary of California Health and Human Services and the Department of Finance, and after Department of Finance has provided no less than a 30-day notification to the Joint Legislative Budget Committee and the State Department of State Hospitals has provided notification to the county public guardian and county behavioral agencies.

(A) The recommendations required to be completed by subdivision (c) cannot be completed due to reasons outside of the control of the California Health and Human Services Agency or the State Department of State Hospitals.

(B)(i) Insufficient progress has been made in implementing the recommendations in a timely manner to provide timely access to competency treatment for IST defendants committed to the State Department of State Hospitals.

(ii) IST commitments to the State Department of State Hospitals continues to exceed the capacity available, in facilities the department has jurisdiction over pursuant to Section 4100, to provide restoration of competency treatment.

(iii) The State Department of State Hospitals continues to maintain an IST admission waitlist that exceeds the capacity of the facilities within its jurisdiction pursuant to Section 4100 to admit IST commitments.

(iv) As a result of the conditions described in clauses (i) through (iii), inclusive, IST defendants committed to the State Department of State Hospitals are not able to receive timely access to restoration of competency treatment and no reasonable state solutions are available, including timely solutions to increase capacity within the facilities within its jurisdiction pursuant to Section 4100 that may admit IST commitments.

(2) If the requirements of paragraph (1) are met, the State Department of State Hospitals may take the following actions:

(A) The State Department of State Hospitals may discontinue admissions for new patients committed to a state hospital pursuant to Section 5358.

(B) The State Department of State Hospitals may, following the determination by the Secretary of California Health and Human Services pursuant to paragraph (1), impose patient reduction targets over the next three fiscal years for patients committed to a state hospital pursuant to Section 5358. Reduction targets shall only be to the minimum level necessary to achieve timely access to treatment for IST commitments, as determined by the State Department of State Hospitals and the Secretary of California Health and Human Services and will allow no less than a minimum of six months for the first reduction target to be achieved.

(C) The State Department of State Hospitals may charge 150 percent of the daily bed rate for counties, pursuant to Section 4330, that exceed the bed usage for patients admitted pursuant to

Section 5358 and that are above the specified patient reduction targets made pursuant to subparagraph (B).

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of State Hospitals may implement, interpret, or make specific this section by means of a departmental letter or other similar instruction, as necessary.

(h) Contracts awarded pursuant to this section, including contracts to implement solutions developed by the Incompetent to Stand Trial Solutions Workgroup, shall be exempt from the requirements contained in the Public Contract Code, Section 19130 of the Government Code, Section 4101.5, and the State Administrative Manual and shall not be subject to approval by the Department of General Services.

INCOMPETENT TO STAND TRIAL
SOLUTIONS WORKGROUP
Report of Recommended Solutions

A report of recommended solutions presented to the California Health and Human Services Agency and the California Department of Finance in Accordance with Section 4147 of the Welfare and Institutions Code

November 2021

TABLE OF CONTENTS

I. Purpose of Workgroup and Report

The Legislature enacted Welfare & Institutions Code (WIC) section 4147 through the passage of Assembly Bill 133 (Chapter 143, Statutes of 2021) and the Budget Act of 2021 (Chapter 69, Statutes of 2021), which charged the California Health & Human Services Agency (CalHHS) and the Department of State Hospitals (DSH) to convene an Incompetent to Stand Trial Solutions (IST) Workgroup (Workgroup) to identify actionable solutions that address the increasing number of individuals with serious mental illness who become justice-involved and deemed Incompetent to Stand Trial (IST) on felony charges.

The purpose of the Workgroup is to identify solutions to advance alternatives to placement in DSH restoration of competency programs and includes strategies for reducing the number of individuals found incompetent to stand trial; reducing lengths of stay for felony IST patients; providing early access to treatment prior to transfer to a DSH program; and increasing diversion opportunities and treatment options, among other solutions. Per WIC Section 4147, the Workgroup must submit recommendations to CalHHS and the Department of Finance on or before November 30, 2021, for short-term, medium-term, and long-term solutions that provide timely access to treatment for individuals found IST on felony charges. The IST Workgroup convened between August 2021 and November 2021 and held five meetings and nine topic-focused sub-working group meetings with a number of representatives and stakeholders from several state agencies, the Judicial Council, local government and criminal justice system representatives, and representatives of IST patients and their family members.

This report describes: 1) the background of the increasing numbers of referrals of individuals committed as IST in California and across the nation, 2) an overview of the IST Workgroup and the process utilized to develop the recommended solutions, and 3) a census of recommendations provided by the members of IST Workgroup and stakeholders to the CalHHS and Department of Finance.

The census of recommendations provided in Section V represents the gathering of the collective discussion and recommendations from members of the IST Solutions Workgroup and sub-working groups and input from public participation in the meetings of these groups. Consistent with the direction provided by statute, any recommendations that did not represent actionable short, medium, or long-term solutions are not included. These recommendations do not represent the viewpoints or opinions of any one entity or the State, nor do they represent consensus of the members of IST Solutions Workgroup. Some IST Solutions Workgroup members may support or oppose specific recommendations. All recommendations received by the Workgroup, meeting minutes and specific support, opposition, and feedback by individual IST Solutions Workgroup members and the public may be found at the IST Solutions Workgroup website**:**

- https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/

IST Solutions Workgroup Members and their affiliations:

- **Chair: Stephanie Clendenin**, Director, California Department of State Hospitals (DSH)
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
- **Nancy Bargmann**, Director, California Department of Developmental Services
    - On occasion Director Bargmann was represented by Carla Castaneda, Chief Deputy Director of Operations, California Department of Developmental Services; and Dawn Percy, Deputy Director, Department of Developmental Services
- **Adam Dorsey**, Program Budget Manager, California Department of Finance
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation, Office of the Secretary
    - On occasion, Executive Officer Grealish was represented by Monica Campos, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation, Office of the Secretary
- **Tyler Sadwith**, Assistant Deputy Director, Behavioral Health, California Department of Health Care Services
    - On occasion Assistant Deputy Director Sadwith was represented by Jim Kooler, Deputy Assistant Director, California Department of Health Care Services; and Elise Devecchio-Cavagnaro, Consulting Psychologist, California Department of Health Care Services
- **Brandon Barnes**, Sheriff, Sutter County Sheriff's Office
    - On occasion Sheriff Barnes was represented by Cory Salzillo, Legislative Director, California State Sherriff's Association
- **John Keene**, Chief Probation Officer, San Mateo County & President-Elect, Chief Probation Officers of California
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association
- **Veronica Kelley**, Director, San Bernardino County Department of Behavioral Health & Board President, California Behavioral Health Directors Association
    - On occasion, Director Kelley was represented by Michelle Cabrera, Executive Director, California Behavioral Health Directors Association (CBHDA)
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
    - On occasion Josh Gauger, Legislative Representative, California State Association of Counties (CSAC) also represented CSAC

- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators
- **Jessica Cruz**, Executive Director, National Alliance of Mental Illness – California
- **Pamila Lew**, Senior Attorney, Disability Rights California
    - On occasion, Kim Pederson, Senior Attorney, represented Disability Rights California
- **Francine Byrne**, Judicial Council of California
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County

II. Incompetent to Stand Trial Crisis – a History

Overview

Over the last decade, the State of California has seen significant year-over-year growth in the number of individuals charged with a felony offense who are found Incompetent to Stand Trial (IST) and committed to the State Department of State Hospitals (DSH) for competency restoration services. The State of California has responded to the substantial growth in the felony IST population through multiple investments to increase DSH's capacity to serve these individuals with serious mental illness. However, the growth in the felony IST patients has exceeded the capacity and outpaced other efforts to respond to the growth in the felony IST population, resulting in growing waitlist and wait times to admission. In 2015, the American Civil Liberties Union sued DSH (Stiavetti v. Ahlin[1]) regarding the amount of time IST defendants were waiting for admission into a DSH treatment program alleging violations of individuals' due process rights. The Alameda Superior Court ultimately ruled that DSH must commence substantive treatment services in 28 days for felony IST patients. DSH appealed this ruling and ultimately in the summer of 2021, the Superior Court's order was affirmed. Meanwhile, the worldwide COVID-19 pandemic has significantly exacerbated DSH's ability to meet the IST demands and as of November 2021 over 1,700 individuals are awaiting restoration of competency treatment.

The IST Process

IST defendants are determined by a court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense. When the court finds a felony defendant incompetent to stand trial in California, they can be committed to DSH to provide clinical and medical services with the goal of restoring their competency and enabling them to return to court to resume their criminal proceedings.

As court proceedings in a defendant's trial are beginning, the defense attorney may raise a doubt with the court that the defendant may be incompetent (doubt can also be

[1] As of 12/01/2021 this case will be renamed *Stiavetti v. Clendenin*

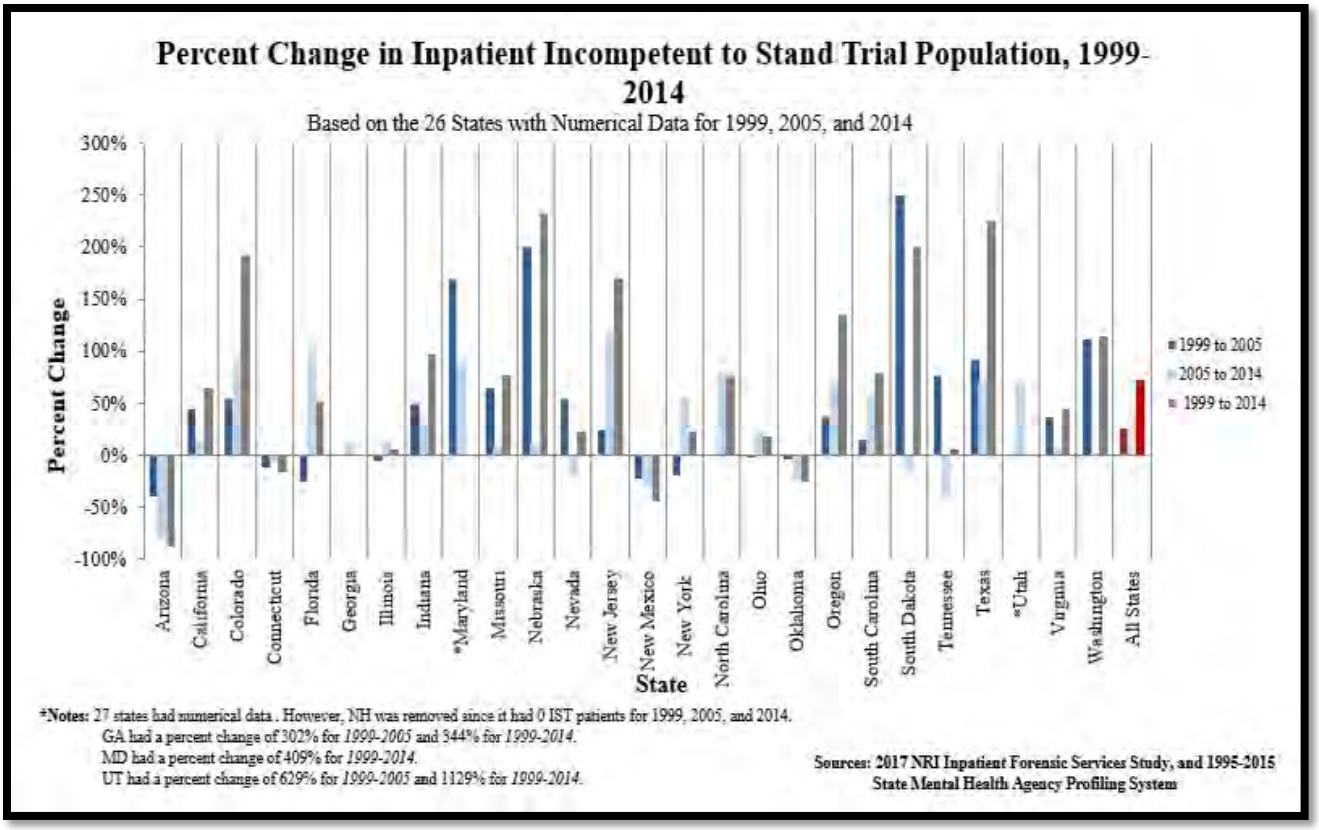
raised by the prosecution and by the court itself). Once a doubt is declared, the court will order an independent evaluation of the defendant by a court-appointed psychiatrist or psychologist (also known as an Alienist). If the alienist finds that the individual is incompetent, the court defers the current legal proceedings and orders a placement evaluation by the CONREP Community Program Director to determine if the felony IST should be treated in a DSH inpatient facility or an outpatient program.

The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner so that the deferred legal proceedings can resume, not to establish long-term mental health treatment for an individual. To this end, the training of criminal procedures is continuously the focus of the treatment milieu for IST patients. Once specific mental health issues and medication needs are addressed, patients are immersed in groups or individualized sessions that train them in various aspects of court proceedings. Each patient receives instruction as to what they are charged with, the pleas available, the elements of a plea bargain, the roles of the officers of the court, the role of evidence in a trial, and their constitutional protections. Knowledge of these areas is assessed using a competency assessment instrument. Additionally, an IST patient may participate in a mock trial where staff members act as judge, jury, district attorney, and defense attorney to assess the patient's ability to work with counsel. At any point during the treatment program, the patient may be evaluated to confirm they are competent to stand trial. After evaluation, if there is concurrence that the patient is competent, a forensic report is sent to the court, identifying that the patient is competent and ready to stand trial. Because the focus of IST treatment programs is the rapid restoration of competency for the purposes of criminal proceedings, individualized, comprehensive treatment of patients' mental health disorders is not provided by this treatment pathway.

National Data and California Data

The exponential increase in individuals found IST across the country has left State-run mental health systems, including the California Department of State Hospitals (DSH), challenged to meet the demands of year-over-year increases in the number of IST referrals to their systems. A 2017 study conducted by the National Association of State Mental Health Program Directors Research Institute (NRI)[2] found that from 1999 to 2014, the overall number of forensic patients in state hospitals increased by 74% while the number of IST patients increased by 72% during that same period. The following chart displays the percentage change overtime for 26 states:

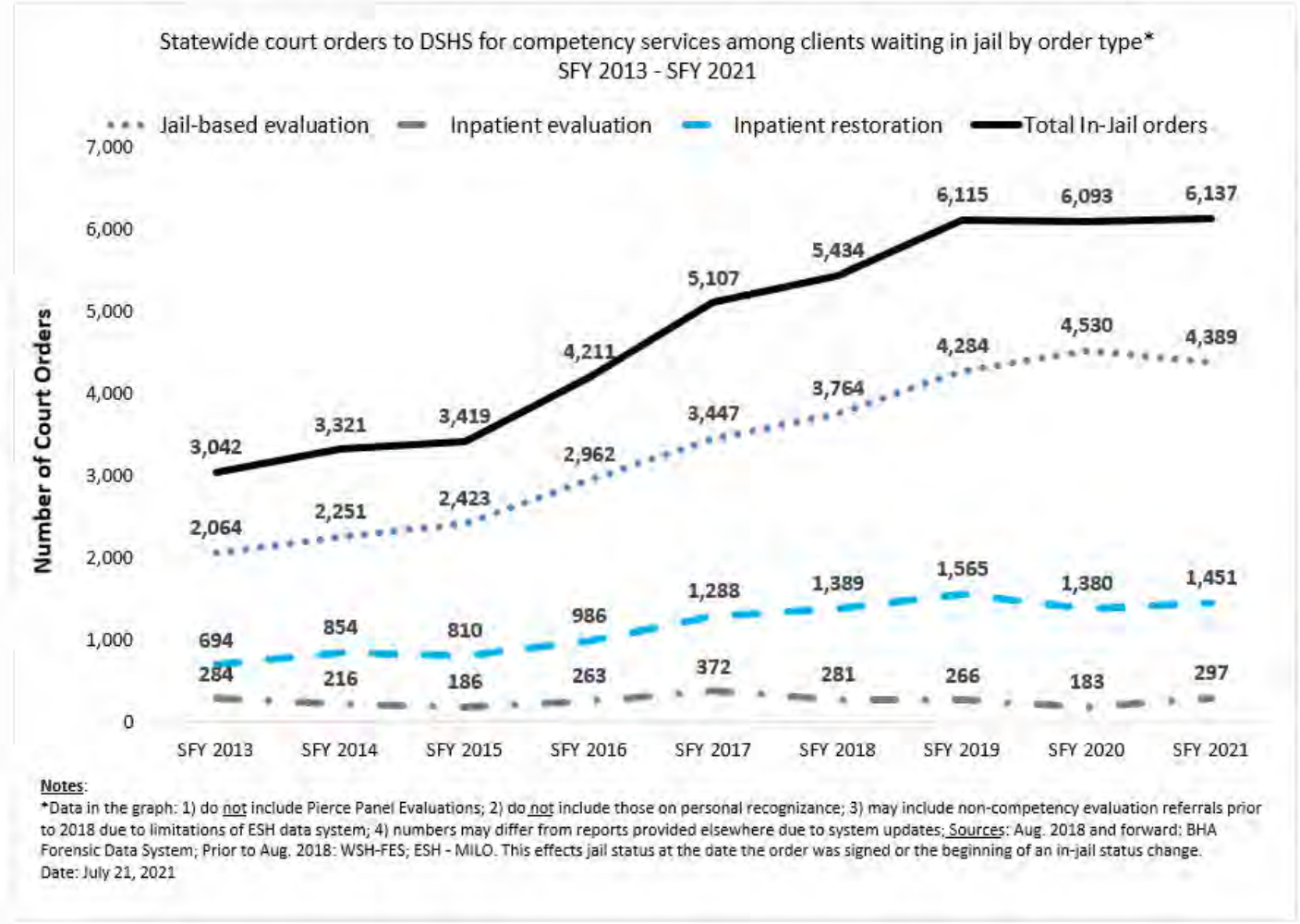
[2] Wik, A., Hollen, V., Fisher, W.H. (2017) Forensic Patients in State Psychiatric Hospitals: 1999-2016. https://www.nasmhpd.org/sites/default/files/TACPaper.10.Forensic-Patients-in-State-Hospitals_508C_v2.pdf.



Multiple state hospital systems across the country are facing lawsuits because of their inability to continuously increase the number of forensic inpatient beds available to admit and treat IST patients within court mandated timeframes, including here in California (*Stiavetti v. Ahlin*) which has set a 28-day post commitment deadline for DSH to begin substantive treatment of an IST ordered to DSH. Most notably, in the State of Washington (Trueblood v. Washington (2015)), the State has paid over $100,000,000 in contempt fines because of its inability to meet court ordered timeframes for admission into treatment programs largely because the demand for IST services has outpaced the state's efforts to develop capacity[3]. Under a recent change to the settlement agreement, the fines are being redirected to support improved access to appropriate behavioral health services that are designed to dramatically reduce the number of people entering the criminal court system. However, as the following chart shows, as Washington State has built out its forensic system in response to this suit, the referrals

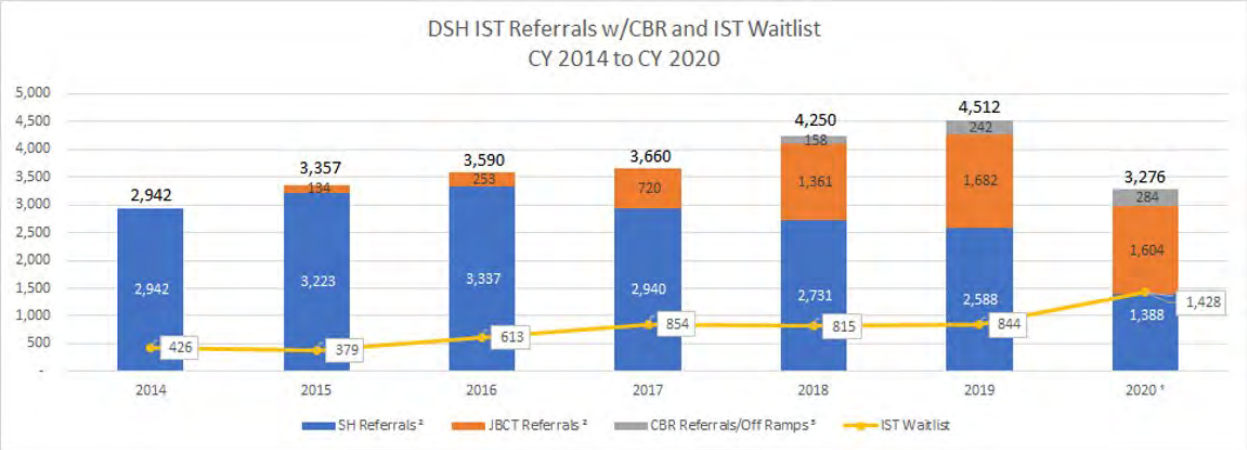
[3] From "Trueblood et al v. Washington State DSHS," by Washington State Department of Social and Health Services, https://www/dsjs/wa/gov/bha/trueblood-et-al-v-washington-state-dshs. Retrieved November 22, 2021.

of IST patients have only continued to increase and, regardless of the funding made available to the state system, capacity cannot keep up with demand[4]:



Unfortunately, the IST crisis in California has mirrored the crisis experienced across the country. However, the size of California's population has magnified the IST crisis in this state. DSH first noted a substantial increase in IST referrals around 2013. Each year since then, DSH has experienced growth in the number of IST referrals to the department's felony IST programs that has outpaced DSH's efforts to increase capacity to meet the demand for services resulting in a growing waitlist as displayed in the following graph:

[4] Chart displays growth in competency referral rates received by the Washington State Department of Social and Health Services. From "Trueblood et al v. Washington State DSHS," by Washington State Department of Social and Health Services, https://www/dsjs/wa/gov/bha/trueblood-et-al-v-washington-state-dshs. Retrieved November 22, 2021.



In 2020, while IST referrals decreased due to the global COVID-19 pandemic and statewide Stay-in-Place orders, the IST treatment programs' ability to admit new IST patients were also significantly impacted by COVID-19 outbreaks and the necessary infection control procedures implemented to protect patients and staff. In 2021-22, DSH is again experiencing a high number of referrals from the courts that exceeds the pre-pandemic referral rates, however, DSH must still maintain its implementation of COVID-19 infection control practices as required by the California Department of Public Health. These infection control measures as well as intermittent COVID-19 outbreaks continue to limit the efficiency and the rate of admissions to its programs. As such, the waitlist has grown to over 1700 individuals as of November 2021.

Individual Patient Characteristics

To better understand what was potentially driving the sustained increase in felony IST referrals, DSH partnered with the University of California, Davis to study the IST patients being admitted to Napa State Hospital. This review of DSH IST admissions found the following:

- Between calendar years 2009 and 2016, the percent of IST patients admitted to Napa State Hospital diagnosed with a psychotic disorder, psychosis NOS, or mood disorder ranged from 72.5% to 84.1%. A small percentage of IST patients were found to have a primary substance use disorder, cognitive disorder, or were malingering.
- In 2009, 17.7% of IST patients admitted to Napa State Hospital had 16 or more prior arrests. By 2016, the percentage of IST patients admitted to Napa State Hospital with 16 or more prior arrests had increased to 46.4%.
- In 2016, approximately 47% of IST patients admitted to Napa State Hospital were unsheltered homeless prior to their arrest. Between 2018 and 2020, 65.5% of IST patients admitted to Napa State Hospital were homeless (sheltered or unsheltered) prior to arrest.

- On average, 47% of IST patients admitted to Napa State Hospital had received no Medi-Cal billable mental health services in the six months prior to arrest; 23% had received one to two mental health services in emergency departments (EDs); 20% had received three or more mental health ED services; and 10% received no mental health ED services.

To provide some context to these findings, DSH and UC Davis conducted a national survey asking state mental health officials about their states' crisis. The responses received were another indicator of the scale of the problem facing the nation: 68.8% of survey respondents indicated the rate of referrals for competency restoration for misdemeanor offenses was increasing in their state, 65.3% of respondents indicated that the rate of referrals for competency restoration for felony offenses was increasing in their state, and 78% of respondents indicated the rate of referrals for competency restoration for felony and misdemeanor offenses were both increasing in their state. In addition, 70.8% of respondents shared that their state hospital system has a waitlist for admitting IST patients and 38.8% of respondents indicated that their state is currently facing litigation related to the admission of IST patients into their system of care. Finally, the survey asked respondents to rank what, in their experience, were the leading causes of this crisis. Here are the top four responses ranked in order of impact to the crisis:

- Inadequate general mental health services
- Inadequate crisis services in community
- Inadequate number of inpatient psychiatric beds in community
- Inadequate ACT services in community

The results of this national survey and the clinical review of the IST patients admitted to DSH has led DSH to hypothesize that the drivers of this crisis are as follows:

- Individuals with Schizophrenia Spectrum Disorders are drifting into an untreated, unsheltered condition.
- These conditions are leading to increased contact with police and criminal charges.
- This increased contact is leading to a surge in IST referrals to state hospitals.
- Building more state hospital beds will only exacerbate the problem long term.
- IST restoration of competency treatment is not an adequate long-term treatment plan.

Finally, DSH wanted to know if currently designed IST treatments impact or change the trajectory of IST patients' lives subsequent to discharge from DSH. DSH worked with the California Department of Justice (DOJ) to obtain criminal offender record information

for IST patients discharged from DSH. The offender record information was then matched with DSH discharge data and used to determine disposition outcomes for the original IST commitment as well as to determine the rates of recidivism of individuals post competency restoration at DSH. The analysis of DOJ and DSH data reflects how the treatment provided by law to IST patients to restore competency does not have a long-term positive impact for the individual and the community. Under existing law, competency treatment is focused on the stabilization of an individual's psychiatric symptoms and basic legal education which together are intended to allow the defendant to work with their attorney, understand the charges against them, and effectively participate in their own defense.

DSH looked at the 3-year post discharge recidivism rates utilizing DOJ criminal offender record information data and found a:

- 69% recidivism rate[5] for IST patients discharged from DSH in FY 2014-15
- 72.3% recidivism rate for IST patients discharged from DSH in FY 2015-16
- 71% recidivism rate for IST patients discharged from DSH in FY 2016-17

In examining the legal pathways of IST patients post competency restoration treatment at DSH state hospitals and jail-based competency treatment programs, the data shows that from FY 2016-17 through FY 2018-19 (6,048 IST discharges in total), 15% of felony IST patients had a single offense and post discharge from DSH 35% had their charges dropped (includes case dismissed, proceedings suspended, not guilty, acquitted). Over the same period, 85% of felony IST patients had multiple offenses and post discharge from DSH 24% had some or all their charges dropped. The full range of disposition outcomes for the felony IST patients discharged over this period include the following: 27.8% were sentenced to jail/probation (served either concurrently or consecutively), 25.9% had their cases dismissed, 24.3% were sentenced to prison, 14.2% were sentenced only to jail and 0.2% were found guilty of some or all of their charges but found not guilty by reason of insanity (NGI) and committed to DSH for treatment rather than prison.

In summary, what this analysis shows is that most individuals committed to DSH as an IST are not sentenced to state prison or committed to DSH for longer-term treatment. Most IST patients restored by DSH return to their county of commitment and serve time in jail, are released on probation, or are simply released. The rate of arrests of discharged IST patients shows that whatever circumstances led to an individual's prior arrest have likely not changed and most IST patients are stuck looping through the criminal justice system and DSH.

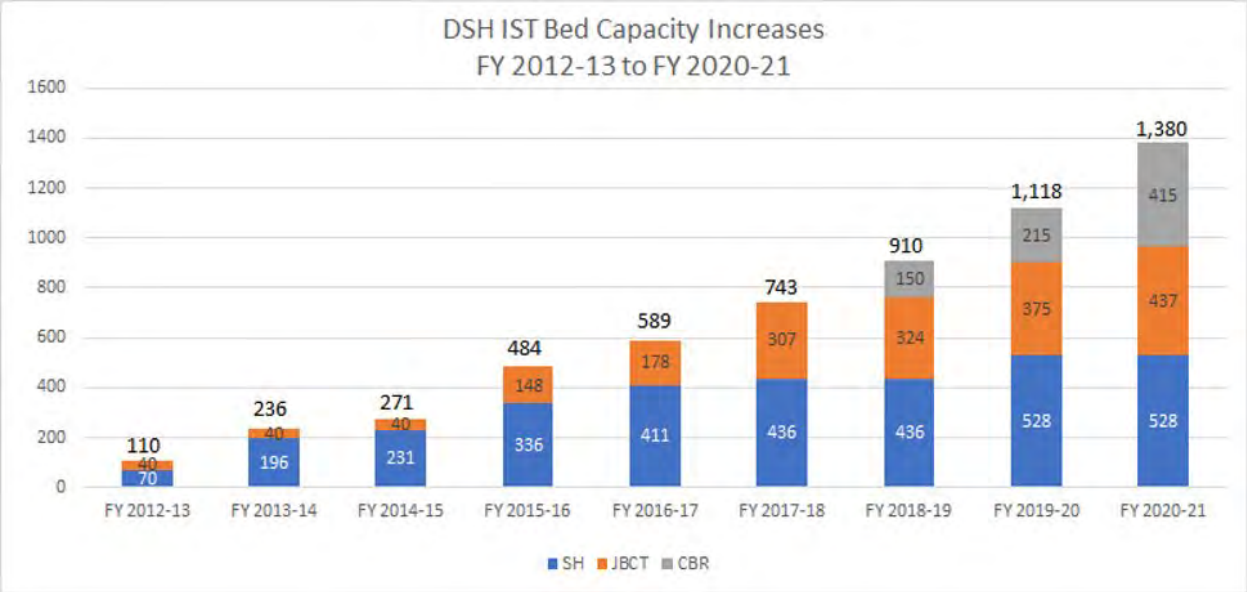
[5] Recidivism rate reflects percentage of individuals with new arrests after discharge from DSH. DSH focuses on arrests instead of convictions because defendants are committed to DSH post-arrest but pre-conviction.

III. Department of State Hospitals' Efforts to Date

Since FY 2012-13, DSH has made multiple efforts to mitigate the effects of increasing IST referrals through capacity expansion, system improvements, and legislative changes.

Increased Capacity at DSH

Since the beginning of the IST crisis, DSH has established new IST capacity through the activation of 528 new state hospital beds, 445 jail-based treatment beds, 415 community-based restoration (CBR) beds, and a 78-bed Conditional Release Program (CONREP) step down program (currently in progress). DSH is also in the process of establishing 352 additional CBR beds and a CONREP Mobile Forensic Assertive Community Treatment (FACT) Team to further expand DSH's capacity to serve IST patients. As the following table shows, in the first year of the crisis DSH added 110 beds for IST treatment and by FY 2020-21 DSH had added a total of 1,380 beds between State Hospitals (SH), Jail Based Competency Treatment (JBCT) programs, and the Community Based Restoration (CBR) program:



In the 2021-22 budget, DSH was appropriated $255 million to create new sub-acute capacity across the state to serve felony IST patients; $32.8 million to expand the CBR program by 552 beds (300 in LA, of which 200 activated in spring 2021, and 252 across the rest of the state); $47.6 million to expand the DSH Felony Mental Health Diversion (Diversion) program (see pp. 17-18 for a detailed description of this program); $13.1 million to expand the department's Jail Based Competency Treatment program expansion and; $9.7 million to establish a Forensic Assertive Community Treatment

(FACT) program in CONREP to serve higher acuity patients, such as ISTs, in the community.

In this budget, DSH also received $12.7 million to establish a four year, limited-term IST Re-evaluation Program. This program establishes a temporary team of forensic evaluators who will re-evaluate IST patients for competency who have been committed to DSH and have been in jail for over 60 days. If an IST is evaluated and found to have regained competency while in jail the IST Re-evaluation team will submit the appropriate reports to the courts. Additionally, if the IST Re-evaluation identifies an IST who has not restored to competency may be appropriate for the DSH Felony Mental Health Diversion program or community-based restoration, the IST Re-evaluation team can make a referral to these programs. The goal of this program is to address the current waitlist of over 1,700 IST patients by bridging the gap between DSH's current capacity, the current rate of IST referrals, and the ongoing impacts of COVID-19 to admissions and discharges to the State Hospitals while the department's new investments in community-based treatment are implemented.

As part of its efforts to increase the number of felony IST patients that receive treatment each year, the Department contracts with 21 California counties to provide restoration of competency services to IST patients in county jail facilities. Jail-Based Competency Treatment (JBCT) programs are designed to treat IST patients with lower acuity and to quickly restore them to trial competency, generally within 90 days. If a JBCT program is unable to restore an IST patient to trial competency quickly, the patient can be referred to a state hospital for longer-term IST treatment. DSH currently operates three JBCT program models:

1. Dedicated bed model – serves IST patients from one specific county with an established number of dedicated program beds.
2. Regional model - serves IST patients from multiple counties statewide with an established number of dedicated program beds.
3. Small county model – serves 12 to 15 IST patients annually and does not have dedicated program beds.

Funding for these programs includes patients' rights advocacy services. The funding for the patients' rights advocacy services complies with Assembly Bill (AB) 103 (Statutes of 2017). AB 103 requires that all DSH patients have equal access to patients' rights advocacy resources, including IST patients who are admitted to JBCT programs.

Over the last few fiscal years, the Department has also focused efforts on expanding the capacity of its CONREP program with the goal of stepping down more patients committed to DSH as NGI or as Offenders with Mental Health Disorders (OMDs) to free up additional beds within the State Hospitals for IST patients. CONREP is DSH's statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health

Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system. The CONREP Non-Sexually Violent Predator (Non-SVP) population includes:

- Not Guilty by Reason of Insanity (NGI) (Penal Code (PC) 1026)
- Offender with a Mental Health Disorder (OMD) (both PC 2964 parolees who have served a prison sentence and PC 2972 parolees who are civilly committed for at least one year after their parole period ends). This category also includes the Mentally Disordered Sex Offender (MDSO) commitment under WIC 6316 (repealed).
- Felony Incompetent to Stand Trial (IST) (PC 1370 patients who have been court-approved for outpatient placement in lieu of state hospital placement)

Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and eight private organizations to provide outpatient treatment services to non-Sexually Violent Predator clients in all 58 counties of the state.

DSH is partnering with several community-based providers to build out the continuum of care and increase the availability of placement options dedicated to CONREP clients. This expands the number of community beds available for patients who are ready for outpatient treatment but still need a higher level of care within CONREP. These facilities allow patients to step down into a lower restrictive environment and focus on the skills necessary for independent living when transitioning to CONREP. The expansion of CONREP capacity and patient placement allows DSH to backfill vacated state hospital beds with pending IST placements who are not eligible for outpatient treatment. Expanding the availability of beds to treat DSH patients is critical to providing timely access to those requiring and awaiting treatment in higher acuity state hospital settings.

Current efforts in expanding residential placement options include:

- Authority to establish a dedicated 78-bed step-down program intended to address higher-level needs and patient acuity and operated in a secured Institute for Mental Disease (IMD) facility. The program was designed for state hospital patients ready for CONREP in 18-24 months. This setting allows for OMD and NGI patients to step down into a lower restrictive environment and provide the skills necessary for a more independent living setting when transitioning to CONREP, thereby allowing for the vacated state hospital beds to be backfilled by IST patients. This program is pending official regulatory approval and necessary modifications to the facility but is expected to be activated in late summer 2022.
- Recognizing the need for more step-down CONREP beds in northern California, DSH received authority to partner with a new provider to establish a 10-bed IMD

program. Activation began in July 2020 and was expanded by an additional 10 beds in July 2021.

- Authorized in 2021 Budget Act, DSH received authority to partner with a provider to establish a 180-bed Forensic Assertive Community Treatment (FACT) model of care in CONREP that will provide 60 beds each in Northern California, Southern California, and the Bay Area. This new level of care for CONREP will establish residential beds where services will be delivered onsite allowing for placement of individuals with higher needs. The program is designed to provide 24/7 services to clients as needed to support client success and reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices. Additionally, a FACT model of care can be used to place IST patients ordered to CONREP where a community-based restoration program is not available. DSH estimates program activation of the 60 Northern CA beds to occur in January 2022, the 60 Southern CA beds to activate in early spring 2022, and the 60 Bay Area beds to activate in early winter 2022.

- An augmentation of $1 million in the 2019 Budget Act to support general housing costs being absorbed by CONREP providers.

Systems Improvements

The second strategy DSH has employed in its attempt to manage the escalating IST crisis has been the implementation of multiple systems improvements that increase DSH's efficiency in admitting, treating, and discharging IST patients. Through these efforts, the department has reduced the average length of stay (ALOS) for IST patients to 148.7 days in a state hospital bed and 69.7 days in a jail-based competency bed. The decrease in the ALOS for IST patients is the result of improved utilization management at the state hospitals (a process by which treatment is matched to a patient's specific clinical needs), the creation of the Patient Management Unit, and multiple legislative changes that supported each of these efforts.

The Patient Management Unit (PMU) was established in June 2017 in the Welfare and Institutions Code 7234 through Assembly Bill 103 (Chapter 17, Statutes of 2017) to provide centralized management, oversight, and coordination of the referral and patient pre-admission processes to ensure placement of patients in the most appropriate setting based on clinical and safety needs. Prior to the establishment of the PMU, the court system was able to order commitments to any DSH hospital of its choosing, creating admission backlogs and inefficiencies. Now, PMU receives all court commitments to the department and utilizes DSH's Patient Reservation Tracking System (PaRTS) to manage the admissions of all DSH patients.

Finally, multiple legislative changes have been made to support the department's efforts to maximize the use of each DSH-funded bed:

- AB 2186 (Chapter 733, Statutes of 2014) – Involuntary Medication Orders and Court Reports

- Amended the law to require courts to reassess the authorization of Involuntary Medication Orders (IMOs) upon the filing of the initial competency progress report and any ongoing progress reports to the court and that a petition may be filed within 60 days of the expiration of the one-year IMO. This change created efficiency and consistency in the application for and use of IMOs at DSH. The use of medications is a core component of the treatment of IST patients

- AB 2625 (Statutes of 2014) – Unlikely to Regain Competency and Unrestored Defendants – 10 Days to Return to Court
    - Amended the law to require that IST patients who are determined to be unlikely to restore to competency be returned to court within 10 days and required that IST patients who had been committed to DSH up to the maximum time allowed by law (in 2014, the maximum length of commitment to DSH for an IST defendant was 3 years) to be returned to court 90 days prior to the expiration of their commitment. This change was intended to help DSH discharge patients more quickly so additional IST patients could be admitted into the system, increasing the number of IST patients that could be treated per year.

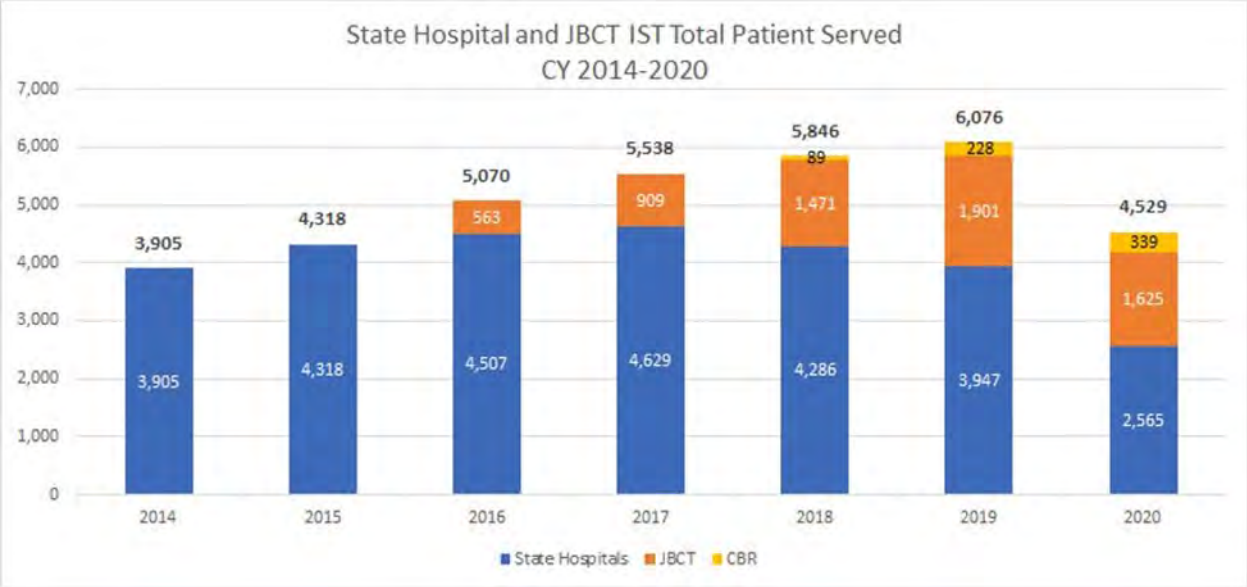
- AB 1810 (Statutes of 2018) – Prevents Transfer of Competent Defendants to DSH
    - Amended the law to allow courts to order a re-evaluation of an IST defendant pending transfer to a State Hospital if they receive information from the jail treatment provider or defendant's counsel that the defendant may no longer be incompetent. DSH found that a significant number of IST patients committed to DSH had regained competency prior to admission to DSH; this change was intended to prevent the transport and admission of IST patients who had regained competency and maintain limited DSH resources for those who were still IST.

- SB 1187 (Statutes of 2018) - Reduced the maximum length of stay for felony IST patients from 3 years to 2 years.
    - Amended the law to reduce the maximum commitment of IST patients to DSH from 3 years to 2 years. This change was intended to discharge patients from limited DSH beds more expeditiously to admit additional IST patients and increase the potential number of IST patients served in a year.

- Assembly Bill 133 (Statutes of 2021) – Misdemeanor IST Patients and Charges for Non-Restorable IST Patients
    - Amended the law to remove DSH as a county placement option for IST patients with misdemeanor charges to preserve all appropriate state

hospital beds for felony IST patients. Also amended law to charge counties a daily bed rate for IST patients that have been found non-restorable that are not transported from DSH by the county within the statutorily required 10-day timeframe.

Each of these systems improvements has helped DSH reduce the length of stay of IST patients in a DSH bed and, in conjunction with the capacity DSH has added to its system of care, allowed the department to increase the number of IST commitments served year-over-year[6]:



However, the demand for IST treatment has continued to outpace all efforts to create enough capacity and system efficiency to reduce the number of IST patients pending placement to DSH and reduce the length of time between commitment to the department and receipt of substantive competency treatment.

Demand

By FY 2017-18, DSH recognized that the demand for IST treatment services was not going to be met by capacity created within the State Hospital system. At this time the department began working to establish treatment pathways in the community with the long-term goal of decreasing demand for State Hospital services by connecting more people with Serious Mental Illness into ongoing community care. The Budget Act of 2018 included funding for two major new programs to help DSH realize this vision.

The Budget Act of 2018 allocated $13.1million for DSH to contract with the Los Angeles County Office of Diversion and Reentry (ODR) for the first community-based restoration

[6] The table below, "State Hospital and JBCT IST Total Patients Served" reflects a drop in total patients served in 2020; this anomaly was caused by the SARS COVID-19 pandemic. State Hospitals ability to admit and discharge patients during the first twelve months of the pandemic was significantly limited by necessary infection-control measures taken by the Department to protect patients and staff in its congregate living treatment environment.

(CBR) program in the state. In this program, ODR subcontracts for housing and treatment services for IST patients in the community. Most IST patients in this program live in unlocked residential settings with wraparound treatment services provided on site. The original CBR program provided funding for 150 beds; investments in the LA program since 2018 has increased the program size to 515 beds. In addition, DSH has received funding to implement additional CBR programs across the state. The Budget Act of 2021 included ongoing funding to add an additional 252 CBR beds in counties outside of Los Angeles, bringing the total number of funded CBR beds to 767.

The Budget Act of 2018 also allocated DSH $100 million (one-time) to establish the DSH Felony Mental Health Diversion (Diversion) pilot program. Of this funding, $99.5 million was earmarked to send directly to counties that chose to contract with DSH to establish a pilot Diversion program (the remaining $500,000 was for program administration and data collection support at DSH). Assembly Bill 1810 (2018) established the legal (Penal Code (PC) 1001.35-1001.36) and programmatic (Welfare & Institutions Code (WIC) 4361) infrastructure to authorize general mental health diversion and the DSH-funded Diversion program. The original Diversion pilot program includes 24 counties who have committed to serving up to 820 individuals over the course of their three-year pilot programs. In FY 2021-22, DSH received additional funding to expand this pilot program as follows:

- $17.4 million to expand current county contracts by up to 20%; WIC 4361 updated to require any expansion be dedicated to diverting defendants who have been found IST by the courts and committed to DSH
- $29.0 million to implement diversion programs in any other county interested in contracting with DSH

The goal of both the CBR and Diversion programs is to demonstrate that many of the individuals committed to DSH as IST patients can be treated effectively and safely in the community. Since launching these programs in 2018, DSH has partnered with some of the most preeminent authorities in the treatment of individuals with Serious Mental Illnesses and criminal justice involvement to provide technical assistance and training for counties across the state implementing a DSH Diversion program and has shared many of those resources with all counties, regardless of their participation in the DSH program, through the Diversion program's public webpage:

https://www.dsh.ca.gov/Treatment/DSH_Diversion_Program.html

Since 2018, DSH has provide over 100 hours of free training and technical assistance to counties and continues to build out the resources it has to offer as the CBR and Diversion programs grow. As of June 30, 2021, counties participating in the Diversion pilot had diverted 458 individuals (some had been found IST and some were defendants the county determined to be likely-to-be IST) and the Los Angeles CBR program had served 641 IST patients.

IV. IST Solutions Workgroup Process

In accordance with Assembly Bill 133 and the 2021 Budget Act, the California Health and Human Services Agency (CalHHS) and DSH established a statewide IST Solutions Workgroup in August 2021. The IST Solutions Workgroup members were appointed by CalHHS Secretary Mark Ghaly and the composition of the Workgroup, as required in statute, included representatives from several state agencies, the Judicial Council, local government and criminal justice system representatives, and representatives of IST patients and their family members.

This Workgroup met five times (8/17/2021, 8/31/2021, 10/12/2021, 11/5/2021, 11/19/2021) as part of the IST solutions development process. To advance the development of short-, medium-, and long-term strategies, three sub-working groups were established that focused on specific areas of opportunity (See Appendix A for a full list of working group members). All three groups were called on to focus all recommendations of short-term solutions on the individuals currently on the waitlist. These three working groups generated strategies for consideration by the full IST Solutions Workgroup for inclusion in the final report to CalHHS and DOF. The three topic-focused working groups included:

Working Group 1: Early Access to Treatment and Stabilization for Individuals Found Felony IST

The goal of Working Group 1 was to identify short-term solutions to provide early access to treatment and stabilization in jail or via Jail Based Competency Treatment (JBCT) programs to maximize re-evaluation, diversion or other community-based treatment opportunities and reduce IST length-of-stay in jails. Working Group 1 met on 9/21/2021, 9/28/2021, and 10/26/2021.

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

The goal of Working Group 2 was to identify short, medium, and long-term strategies to maximize the implementation of IST Diversion and Community-Based Restoration (CBR) programs across the state. Working Group 2 met on 9/24/2021, 10/1/2021, and 10/22/2021.

Working Group 3: Initial County Competency Evaluations

The goal of Working Group 3 was to identify solutions to reduce the overall number of individuals found IST by strengthening the quality of the initial competency evaluations ordered by the courts (also known as alienist evaluations). Working Group 3 met on 9/17/2021, 9/24/2021, and 10/15/2021.

Due to COVID restrictions and the tight time frame of the process, meetings were held virtually using Zoom technology that enabled full participation of all members, as well as the public, who were routinely invited to comment using the Zoom “chat” feature, as well

as verbally as time permitted. The goal was to establish a transparent and inclusive process that allowed active participation from a diverse spectrum of participants. All meetings followed the requirements of the Bagley-Keene Open Meeting Act.

Meeting agendas, presentations, written input from members and the public, responses to information requests, and meeting minutes from the IST Solutions Workgroup and the three topic-focused working groups are available on the IST Solutions Workgroup web site.

Guiding Principles for Generating Recommendations

The statute provided guidance for what the IST Workgroup solutions should focus on when generating solutions to the IST crisis. This guidance included:

1. Reduce the total number of felony defendants determined to be IST
2. Reduce the lengths of stay for felony IST patients
3. Support felony IST defendants to receive early access to treatment before transfer to a restoration of competency treatment program to achieve stabilization and restoration of competency sooner.
4. Support increased access to felony IST diversion options.
5. Expand treatment options for felony IST individuals, such as community-based restoration programs, jail-based competency treatment programs, and state hospital beds.
6. Create new options for treatment of felony IST defendants including community-based, locked, and unlocked facilities.
7. Establish partnerships to facilitate admissions and discharges to reduce recidivism and ensure that the most acute, high-risk, and at need patients receive access to State Department of State Hospitals beds, while patients with lower risk of acuity are treated in appropriate community settings.

In addition to this statutory guidance, the IST Solutions Workgroup adopted the following guiding principles to frame its recommendations:

- Mental health treatment should be delivered in community-based treatment options to the greatest extent possible.
- While jail is not the appropriate setting for mental health treatment, jails need to be able to provide mental health treatment for individuals who are in jail and require treatment.
- Engagement of individuals with lived experience and family members in planning and implementing solutions and programs is critical.

- Short-term solutions focus on treating the 1700+ individuals found incompetent to stand trial on felony charges and waiting in jail for access to treatment or diversion programs.
- Medium-term solutions focus on increasing access to community-based treatment and diversion for individuals found incompetent to stand trial on felony charges.
- Long-term solutions aim for system transformation and to reverse the trend of criminalizing mental illness.
- Implementing solutions to achieve the short-, medium- and long-term goals requires collective, multi-sector solutions and collaboration.
- To address the current IST crisis, implementation of short-term strategies that are not in alignment with long-term goals may be needed, but should be time-limited, phased out when medium- and long-term solutions are implemented, and not detract from the focus and implementation of the long-term goals.

Process for Synthesizing Recommended Solutions

Over the course of the topic-focused working group meetings, more than 100 potential solutions were generated by members and the public through an iterative process of idea generation, reflection, and refinement within each of the three working groups, as well as the larger Workgroup. Additionally, these solutions were assessed to determine which were most feasible, actionable, and relevant to addressing the short-, medium-, and long-term timeframes and goals, which enabled the team to reduce and consolidate the total number of potential solutions from 100 to ~35. Any recommendation that did not represent an actionable solution was not included. A draft compilation of the solutions was presented to the full workgroup for discussion. Through that discussion and additional solutions submitted from workgroup members and other organizations and members of the public who participated in the meetings, a final list of 41 recommended solutions was generated to be presented to the CalHSS and DOF.

V. Census of Recommended Solutions from the IST Workgroup Meetings for Submission to CalHHS and Department of Finance

Short Term Strategies: Solutions that can begin implementation by April 1, 2022

Goals:

a. Provide immediate solutions for 1700+ individuals currently found incompetent to stand trial on felony charges and waiting in jail for access to a treatment program.
b. Provide quick access to treatment in jail, the community, or a diversion program.
c. Identify those who have already restored.
d. Reduce new IST referrals.

#	Strategy	Type	Potential Impact	Other Considerations
S.1	Support increased access to psychiatric care, including stabilizing medications in jail for felony ISTs while pending transfer to other IST treatment programs or when returning from IST treatment programs to jail pending court proceedings, including: • Provide funding to jails to expand the use of long-acting injectable psychiatric medications (LAIs) in jail settings. • Use of technology/telehealth for jail clinicians to access tele-	Funding/ Policy	Provides opportunities for faster stabilization of mental health symptoms in jail and increase opportunities for individuals to be candidates for Diversion or community-based restoration programs. While jails are not the recommended treatment setting, recognizes there is an immediate crisis	Jails do not receive state funding support for treatment and housing of individuals found IST on felony charges unless they have been admitted to a DSH-funded jail-based competency treatment program. However, individuals who have been deemed incompetent to stand trial on felony charges and are not yet transferred to a Diversion or other treatment program should receive appropriate mental health treatment until they are transferred to a treatment program. Funding to jails to support the resources and costs to providing these services may also need to be considered. Jail formularies may need to be updated to include long-acting injectable medications (LAIs).

	psychiatrists to provide medication/treatment determinations, including involuntary medications, when necessary, ordered by the court and appropriate due process procedures are followed. • Increase opportunities to rapidly connect a court-appointed competency evaluator's opinion that a patient needs medication to jail providers for consideration in an individual's treatment plan. • Support training opportunities for jail clinicians on patient engagement, including rapport building skills and motivational interviewing.		and responses must address the crisis in the short-term. There is not currently sufficient community capacity for stabilization of acute mental health conditions. Individuals who are currently waiting in jail for admittance to treatment programs are more likely to access treatment in existing Diversion and community-based restoration programs if their acute mental health symptoms are rapidly stabilized. Lack of symptom stabilization has been identified as the primary barrier to Department of State Hospitals (DSH) IST Diversion Program placement.	
S.2	Improve coordination between State, criminal justice	Operations/ Funding	Increased partnership and	Short-term bridge solutions may need to be implemented to advance these solutions until

	partners, county behavioral/mental health directors, and county public guardians, for IST patients, including: • Transition/treatment planning to ensure continuity of care between systems and providers. • Providing a 90-day medication supply for individuals discharging to the community from jail, Diversion, or restoration of competency treatment programs. • Use of common drug formularies, wherever possible. • Data sharing/use of business associate agreements. • Identifying community based and Diversion alternatives.		opportunities for Diversion and community-based treatment for felony ISTs. Increased support for transitions and re-entry after felony IST finding or release to reduce destabilization and re-arrest.	the CalAIM reforms, addressing enrollment in Medi-Cal prior to release and enhanced care management, noted in Strategy L.2 are implemented. Individuals with mental illness, family members, and advocates should be included in stakeholder discussions about how best to coordinate these efforts.
S.3	Provide training and technical assistance and develop best practice guides (toolkits) for jail clinical staff, criminal justice partners, boards of supervisors, and county	Training	Increased early treatment engagement and stabilization of individuals will reduce the	DSH Clinical Operations is actively providing technical assistance and training, as well as psychopharmacology consultation, to any county partners who request it.

	administrators for understanding and implementing effective treatment engagement strategies including: • Seeking treatment and medication histories from family members. • Utilization of incentives and other strategies to engage treatment including best practices for developing patient/clinician rapport, continuity, and securing the voluntary consent to medication whenever possible. • Obtaining involuntary medication orders and administering involuntary medications, when necessary, ordered by the court, and appropriate due process procedures are followed.		symptoms of psychosis such as hallucinations, delusions, and disorganized thinking. This will provide increased opportunity for placement in Diversion or community-based restoration programs, as well as decrease the length of stay for individuals on the pathway to JBCT or State Hospital placement.	This recommendation focuses primarily on training and technical assistance needs. Implementation of these strategies may require funding or other support.
S.4	Re-assess the DSH current waitlist, in partnership with DSH, county behavioral health, jail treatment providers, and criminal justice	Operations	Reduce current waitlist and increase access to community-based	The 2021 Budget Act included funding for DSH to re-evaluate individuals on the IST waitlist after 60 days to determine if an individual has been restored to competency or stabilized enough to be considered for

	partners to identify individuals who may be eligible for release into community treatment programs such as MH Diversion, DSH IST Diversion, CONREP or community-based restoration, address medication/treatment needs to stabilize mental health symptoms in jail, identifying individuals who, due to their psychiatric acuity, may need priority transfer to a state hospital pursuant to California Code of Regulations Section 4177, and swiftly move individuals into these programs to maximize their utilization.		treatment for felony ISTs.	Diversion or CONREP placement. Further opportunities exist to actively partner with counties prior to 60 days to identify individuals who may be candidates for placements in Diversion/CONREP.
S.5	Expand technical assistance for Diversion and community-based Restoration, including: • Developing best practice guides in partnership with key stakeholders. • Providing training and technical assistance to newly developing programs. • Providing training and technical assistance on	Training	Supports increased utilization and expansion of Diversion and community-based treatment options for felony ISTs.	DSH developed and implemented a Diversion Academy for counties who plan to implement DSH Diversion programs for ISTs. This was offered in the fall 2021 to counties who have applied for funding to establish new Diversion programs. DSH also maintains a website of technical assistance resources to support Diversion. Additionally, DSH plans to expand technical assistance opportunities to counties to support implementation of community-based restoration programs.

	options to assess and mitigate public safety risks.			
S.6	Provide training and technical assistance for Court appointed evaluators to improve the quality of the reports used by courts in determining a defendant is incompetent to stand trial: • Develop checklists for court appointed evaluators to follow of items to be considered when making competency recommendations, including American Academy of Psychiatry and the Law guidelines and/or Judicial Council rules of Court and considering defense counsel observations and concerns regarding their client's ability to participate rationally in their defense. • Develop template evaluation reports that include all checklist items, including short-form report options for	Training	Improves quality of court-appointed evaluator reports to inform the court whether an individual may be incompetent to stand trial and the basis of that determination including an individual's diagnosis, whether they require an involuntary medication order (IMO), or if they are malingering symptoms. May reduce the number of individuals found incompetent to stand trial and increase access to treatment and stabilization when treatment engagement is difficult due to an individual's severe symptoms of psychosis.	This recommendation focuses primarily on training and technical assistance needs. Implementation of these strategies may require funding or other support.

	when clinically appropriate • Develop technical assistance and training videos to increase knowledge and skills for existing court appointed evaluators, including principles of community based mental healthcare, which can be available on DSH website. • Ensure training and technical assistance includes information on discrepancies and biases in evaluations.			
S.7	Prioritize community-based restoration and Diversion by: • Allowing individuals placed into Diversion to retain their place on the waitlist should they be unsuccessful in Diversion and need inpatient restoration of competency services. • Improving communication between DSH and local courts in collaboration	Policy	Addresses concerns from Diversion providers that individuals will not have timely access to a DSH treatment program if the individual's mental health symptoms and community safety risk significantly increases. Additionally, reduces	DSH issued Departmental Letter 21-001 on November 3, 2021, to implement this recommendation. It outlines the process to facilitate coordination between Diversion programs, the courts, and DSH when an individual is being considered for Diversion to ensure the individual is not inadvertently transferred to a DSH hospital or jail-based competency treatment program. It also establishes the procedure for a Diversion program client to reenter the waitlist with their original commitment date when an individual is revoked from Diversion and needs to be transferred into a secure treatment program.

	with the Judicial Council so that a person on the waitlist is not removed from Diversion consideration prematurely when a bed becomes available at DSH.		instances where individuals are transferred to a DSH hospital or JBCT pre-maturely when an individual is being considered for Diversion.	
S.8	Prioritize and/or incentivize DSH Diversion funding to support diverting eligible individuals from the DSH waitlist.	Policy/ Statutory	Assists in reducing the DSH waitlist by prioritizing individuals on the waitlist for Diversion over individuals likely to be found incompetent to stand trial. Individuals likely to be found incompetent to stand trial are also eligible for DSH Diversion.	The 2021 Budget Act included funding for existing programs to expand Diversion programs to divert individuals who have been found incompetent to stand trial on felony charges from DSH waitlist. Welfare and Institutions Code 4136 by trailer bill, SB 129 (Committee on Budget, Statutes of 2021), also amended to prioritize expansion funding to individuals found incompetent to stand trial.
S.9	Include justice-involved individuals with serious mental illness as priorities in state-level homelessness housing, behavioral health, and community care infrastructure expansion funding opportunities	Policy	Supports increased access to community-based treatment for justice-involved individuals including felony ISTs.	While funding and capacity expansion are longer-term strategies, inclusion in priorities and planning that is underway now or in the short-term should occur.
S.10	Augment funding in DSH Diversion contracts with counties to provide for interim housing, including subsidies,	Funding	Addresses concerns of DSH Diversion program providers about insufficient	

	and housing-related costs to support increased placements into Diversion.		funding to access housing for the DSH Diversion population	
S.11	Local planning efforts for homelessness housing, behavioral health continuum, and community care expansion should include behavioral health and criminal-justice partners and consider providing services for justice-involved individuals with Serious Mental Illness to reduce homelessness and the cycle of criminalization.	Policy	Supports local efforts and inclusion of justice-involved individuals in planning and strategy development for local investments and state-level grants.	

Medium-Term Strategies: Solutions that can begin implementation by January 10, 2023

Goals:

a. Continue to provide timely access to treatment.
b. Begin to implement other changes that address broader goals of reducing the number of ISTs.
c. Increase IST treatment alternatives.

#	Strategy	Type	Potential Impact	Other Considerations

	Statutorily prioritize community outpatient treatment and Diversion for individuals found incompetent to stand trial on felony charges for individuals with less severe behavioral health needs and criminogenic risk, and reserve jail-based competency and state hospital treatment for individuals with the highest needs. Options include: • Require consideration of Diversion for anyone found incompetent to stand trial on felony charges. • Treat penal code 1170(h) felonies, for which the maximum penalty is a prison term served in the county jail rather than in state prison, consistent with SB 317 (Chapter 599, Statutes of 2021) which requires a hearing for Diversion eligibility, if not	Statutory/ Funding	Establishes priority for Diversion and community-based treatment for felony ISTs whenever appropriate based on an individual's treatment needs and criminogenic risk. Prioritizes utilization of state-hospital and jail-based competency treatment programs for those with the highest needs.	Corresponding operational changes could be implemented to also develop clinical factors for determination of treatment in State hospitals versus jail-based competency treatment programs. Currently, over referral to state hospitals and jail-based competency treatment programs and under-utilization of Diversion programs and lack of community-based treatment programs results in lengthy waitlists and inefficient utilization of inpatient and jail-based beds. Implementation of statutory changes may require funding or other supports related to court hearings and treatment capacity.

	Diversion eligible, a hearing to consider assisted outpatient treatment, conservatorship, or dismissal of the charges. • Change presumption of appropriate placement to outpatient treatment or Diversion for felony IST, require judicial determination based on clinical needs or high community safety risk for placement at DSH or in a jail-based treatment program, and a determination that community resources are available to meet the treatment needs of the individual. • Reform exclusion criteria of Diversion under PC 1001.36 to "clear and present risk to public safety" rather than			

	"unreasonable risk to public safety." • Statutorily require the use of structured mental health risk assessments to assist in identifying defendants that should be eligible for Diversion or community treatment. • Require judicial consideration of Diversion at the outset of criminal proceedings for mentally ill defendants. • Eliminate the requirement of a nexus between the defendant's mental disorder and the charged offense for individuals diagnosed with a serious mental illness or establishing a rebuttable presumption of nexus. • Establish a presumption of			

	Diversion eligibility if an individual is determined to be incompetent to stand trial and meets clinical and legal eligibility, subject to the availability of a treatment plan.			

M.2	Provide increased opportunities and dedicated funding for intensive community treatment models for individuals found IST on felony charges. Options include: • Assisted Outpatient Treatment (AOT) • Forensic Assertive Community Treatment (FACT) • Full-Service Partnerships (FSP) • Regional community-based treatment and Diversion programs for individuals not tied to any one county • Crisis Residential • Substance abuse residential treatment • Psychiatric health facilities • Mental Health Rehabilitation Centers • Transitional residential treatment	Funding/ Policy	Increases access to community-based treatment alternatives for justice-involved individuals with serious mental illnesses and reduces the incarceration.	
M.3	Establish a new category of forensic Assisted Outpatient	Statutory	Increases access to community-based treatment	Establishing category would be a medium-term strategy. However, implementing programs would be a long-term strategy.

	Treatment commitment that includes: • Housing • Long-acting injectable psychiatric medication • Involuntary medication orders, when necessary, as ordered by the court, and appropriate due process procedures are followed. • FACT team • Intensive case management		alternatives for justice-involved individuals with serious mental illnesses and reduces the incarceration. A forensic AOT commitment would ensure access to, and engagement with an intensive level of outpatient services designed to interrupt the cycle of criminalization in lieu of inpatient restoration commitment.	
M.4	Establishing statewide pool of court-appointed evaluators and increase the number of qualified evaluators: • Request counties to share their lists of court-appointed evaluators. • Identify demographics and cultural and linguistic competence of evaluators.	Funding/ Operations	Assists courts in access to expanded statewide pool of court-appointed evaluators and potentially reduces the amount of time individuals wait in jail for a court-appointed evaluation. Establishing a diverse pool of court appointed	

	• Increase court funding for court appointed evaluator pay.		evaluators reduces the risk that individuals are determined to be incompetent to stand trial due to cultural and linguistic differences.	
M.5	Improve statutory process leading to finding of incompetence or restoration to competence: • Set time frames for appointments of court appointed evaluators and receipt of reports. • Set statewide standards for court evaluations and reports. • Expand list of individuals who can recommend to the court a need for re-evaluation if someone may have been restored – noted already authorized for those over 60 days.	Statutory	Reduces time in jail for individuals awaiting competency assessments and increases quality of court-appointed evaluator reports. Allows an individual to be reevaluated for competency after the initial finding and before transfer to a treatment program.	Penal Code 1370 in 2019 was amended to allow jail providers and public defenders to request the court to appoint an evaluator to reevaluate a person's competency. Welfare and Institutions Code 4335.2 was added in 2021 to allow DSH evaluators to reevaluate an individual for competency after they have been on the waitlist for 60 days. Implementation of statutory changes may require funding or other support. Establishing timeline for court-appointed evaluators would be dependent upon increasing the pool of evaluators.

M.6	Revise items court-appointed evaluators must consider when assessing competence to include: • Eligibility for Diversion • Likelihood for restoration • Medical needs • Capacity to consent to medications • Consideration of malingering	Statutory	Assists the court in determining an individual's potential eligibility for Diversion or whether another treatment pathway to competency restoration is more appropriate.	Important to ensure appropriate training, technical assistance, and quality assurance measures for court-appointed evaluators are also implemented in conjunction with this recommendation, otherwise individuals may unnecessarily be excluded from Diversion opportunities. May also consider whether the court-appointed evaluator competency assessment could also include placement recommendations rather than having a separate placement performed by the CONREP Community Program Director. Would require significant training and technical assistance on increasing knowledge of the statewide continuum of placement options.
M.7	Revise/improve involuntary medication order statutory process: • Involuntary medication orders follow the person and are not specific to the placement locations. • Court-appointed psychologists may opine on consent capacity and potential need for involuntary medications when	Statutory	Provides treatment access and stabilization for individuals who do not have the capacity to consent to treatment due to the current severity of the symptoms of their mental illness. Facilitates improved care coordination and rapid re-stabilization to prevent	

	providing reports to the court on incompetence to stand trial. • Remove special designation requirements in Penal code 1369.1 requiring jails to be designated to provide involuntary medications for felony ISTs and allow jails to provide involuntary medications, when necessary, ordered by the court, and appropriate due process procedures have been followed.		rehospitalization in locked settings when a justice-involved individual decompensates.	
M.8	Provide access to community-based inpatient treatment, when needed, for stabilization of acute mental health symptoms prior to placement in Diversion programs.	Funding/ Capacity	Provides increased mental health stabilization services to reduce barriers to Diversion eligibility and increase access to Diversion for felony ISTs.	The 2021Budget Act includes $250M for DSH to increase IMD and sub-acute capacity in the community for felony ISTs, which can be utilized to provide stabilization services.
M.9	Provide funding to expand support services to increasing utilization of Diversion and community-	Funding/ Operations	Supports providers in treatment and support plan development for	Could pilot these support services in counties with the greatest number of ISTs to facilitate greater number of individuals placed in Diversion.

	based restoration for felony ISTs and enhance services for existing jail-based competency treatment programs including: • Diversion Program Provider Support/Technical Assistance - develop Diversion technical assistance/support teams consisting of psychiatrists and criminal justice experts to provide 24 hours a day 7 days a week non-urgent and emergency technical assistance and support. • Forensic Peer Support Specialists (or General Peer Support Specialists) – Provide funding to support utilization of peer support specialists in the courts, jails, Diversion, and treatment programs.		difficult cases and responding to emergent/urgent Diversion program and treatment challenges. Increases treatment engagement and success in Diversion/community-based treatment for felony ISTs. Assists court and jails with navigation, identification, and connection to system partners to facilitate dismissal/Diversion, case planning, and effective reentry to the community. Expands opportunities for higher-risk individuals to be served in community programs.	The 2021 Enacted Budget includes funding to support probation services for a subset of IST defendants served in the Los Angeles community-based restoration program. In addition, a portion of funding is available to expand community-based restoration programs to other counties and can be used to support probation services.

	• Probation Partnerships - Leverage potential opportunity for probation partnerships to provide community Diversion supervision and rapport building and increasing client engagement in treatment for higher-risk individuals. Integration of the SSI/SSDI Outreach Access, and Recovery (SOAR specialists in Diversion programs to increase SSI/SSDI application success rates and increase individual funding for community-based housing. Forensic navigators – provide funding to support utilization of liaisons or navigators in courts/jails to identify those who may need		Increases funding for community-based housing.	

	community-based treatment and supports and make appropriate connections with system partners to facilitate dismissal/Diversion, case planning, and effective reentry to the community.			
M.10	Support individuals with serious mental illness remaining stable in the community by: • Implementing Psychiatric Advance Directives (PADs) - peers would assist with the completion of the PADs (see above for peer costs). • Enhance funding to the public guardians to ensure people with serious mental illness are appropriately placed in the continuum of care.	Policy/ Funding	Reduces homelessness and the cycle of criminalization of individuals with serious mental illness.	Disability Rights California is in the process of updating their PAD resources and can be a resource for guidance, forms, etc.

M.11	Explore alternative jail-based competency and community-based restoration contract models to maximize utilization of community facilities for treatment rather than providing in-jail competency treatment.	Policy	Increases community-based treatment options and reduces reliance on jail-based treatment to serve felony ISTs.	Existing authority to expand community-based restoration programs may be used to support this contract model.
M.12	Expediting assessment and treatment immediately upon booking of defendants with serious mental illness, including: • Completing universal behavioral health and suicide risk assessments, substance abuse screenings, and review of records and behavioral health history by jail providers. • Performing a housing and service needs assessment to inform early consideration of housing and service needs for treatment of ISTs in the community.	Policy/ Funding	Increases early access to treatment and opportunities for community-based treatment options.	Additional funding/resources may be needed by jails, district attorneys, and public defenders to increase early access to treatment and increase the number of behavioral health providers qualified to perform the assessments and provide immediate treatment.

	• Implementing consideration of the family perspective and documentation of the mental health history and treatment of a loved one and including co-occurring substance use disorder challenges. • Determine a course of treatment that may begin in the jail, including medications, and discharge planning should start at the time of booking. • Early review of cases at booking or as soon as possible by District Attorney and Public Defender, in partnership with county behavioral health and jail treatment providers, for each defendant screened as mentally-ill to			

	eliminate those cases that will not be filed (defendant to be released), or for those defendants in situations where a complaint is likely to be filed, determine if there are opportunities for pre-trial release into treatment and services to provide a recommendation to the Judge at or before the time of arraignment.			
M.13	Establish requirements and/or provide incentives/enhanced rates to support increased community-based treatment and housing for justice-involved individuals with SMI, including: • Increase community providers, facilities willing to serve, and landlords willing to provide housing for this population.	Funding/ Statutory	Eliminates barriers and discriminatory practices in access to community-based treatment for justice-involved individuals.	Consider utilizing pay for success models.

	• Increase access to acute inpatient services for inmates under 5150s.			
M.14	Provide flexibilities, and expedited licensing to increase access to inpatient beds and housing, including: • Expedited licensing of Psychiatric Health Facilities (PHFs) and Mental Health Rehabilitation Centers (MHRCs). • Streamlining/coordination of licensing bodies when trying to establish new adult residential facilities and other treatment facilities.	Policy	Facilitates faster expansion of community treatment and housing resources. Eliminates perceived licensing barriers to quick expansion of treatment/housing resources.	
M.15	Revise DSH's CONREP Community Program Director Role, placement criteria, and assessment process to facilitate increased felony IST placement to CONREP, community-based restoration and Diversion programs and increased transitions from state	Statutory	Increases access to Diversion and community-based restoration programs for felony ISTs. Increases state hospital capacity for ISTs with highest level of treatment	

	hospitals to the CONREP community treatment continuum for individuals committed to DSH as Not Guilty by Reason of Insanity or Offenders with Mental Health Disorders.		needs by stepping down individuals from state hospitals to CONREP continuum.	
M.16	Allow access to and regularly assess eligibility for transition to DSH funded Diversion opportunities for individuals who are treated at DSH hospitals and jail-based competency treatment programs.	Policy/ Funding	Provides pathway to community treatment and supports reduction in recidivism for individuals who have received restoration of competency treatment in a DSH hospital or JBCT program.	
M.17	Provide increased and ongoing funding to support expansion of DSH Diversion and community-based restoration programs.	Funding	Provides increased access to community-based treatment options.	Existing funding and expansion funding contained in the 2021-22 Budget Act for DSH Diversion programs is one-time funding. Currently community-based restoration programs are only operated in partnership with Los Angeles County. The 2021-22 Budget Act provides funding for 552 additional beds to expand the existing program and develop new community-based restoration programs in other counties across three fiscal years.

				Support for housing and infrastructure needs when establishing new programs should be considered.

Long-Term Strategies: Solutions that can begin implementation by January 10, 2024 and January 10, 2025

Goals:

a. Break the cycle of criminalization.
b. Reduce the number of individuals found incompetent to stand trial on felony charges.
c. Provide bridge funding or strategies until broader behavioral health transformation initiatives are fully implemented including CalAIM, Behavioral Health Care Continuum Expansion, and Community Care Expansions.

#	Strategy	Type	Potential Impact	Other Considerations
L.1	Partner with the Homeless Coordinating and Financing Council (now the California Interagency Council on Homelessness) to: • Advocate to HUD to include the definition of at-risk of homelessness as and eligible population for resources. • Advocate with HUD to leverage existing allocations from federal government to local Continuums of Care (CoCs). • Consider flexibilities around housing first approaches and ensure definition of homelessness	Policy	Increased coordination and access to housing resources for individuals with serious mental illness to eliminate cycling in and out of homelessness.	

	includes at-risk of homelessness populations. • Provide training and technical assistance to CoCs, Criminal Justice, and Behavioral Health partners on how to provide effective housing services to this population. • Explore and support strategies to exchange data to ensure that the Behavioral Health/Criminal Justice population is included in CoC resourced efforts. The Criminal Justice system needs to be connected to the homeless crisis response system. • Encourage local housing system leaders to participate in existing interdisciplinary meetings focused on			

	justice-involved populations. • Support inclusion of individuals with serious mental illness and justice involvement in housing priorities/ preferences for housing funding.			
L.2	Support effective implementation of the proposed Cal-AIM (California Advancing & Innovating Medi-Cal) components that impact the justice involved, including: • Enrollment in Medi-Cal prior to release. • 90-day in-reach to stabilize health and wellness, provide warm hand-offs and prepare for community reintegration. • Intensive community-based care and coordination – enhanced care management (ECM). • Access to community support (food and	Funding/ Policy	Provides coordination of medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails. Access to services upon release from jail can help reduce the cycle of criminalization for individuals with serious mental illness.	Department of Health Care Services (DHCS) has submitted application for Medi-Cal waiver to the Centers for Medicare and Medicaid Services for approval. While overall implementation is a longer-term strategy, planning for implementation is occurring with stakeholders in the short and medium-term.

	housing) post release. • Capacity building for workforce, IT/data systems, infrastructure. • Seek the IMD exclusion waiver.			
L.3	Develop quality improvement oversight/peer review of court-appointed evaluators and their reports, which may include: • Developing a certification program. • Implementing pay for performance strategies to tie funding to quality. • Requiring standardized training. • Implementing a peer review process to improve quality of reports.	Funding/ Statutory	Increased quality and timing of court-appointed evaluator reports. Reduced time in jail for individuals pending competency assessments. May reduce the number of individuals found incompetent to stand trial due to poor quality reports.	Consideration should be given to whether a certification, quality improvement, and oversight program should be implemented at the state level, by the Judicial Council or by a private/other certification program provider. Increased funding for court-appointed evaluator pay (strategy M.4) could be linked to quality improvement strategies. Individuals participating in quality improvement efforts/training or who are certified are eligible to receive higher pay for evaluations.
L.4	Increase opportunities for alternatives to arrest and pre-booking Diversion, including: • Mobile/non-police crisis response teams.	Funding	Reduces incarceration and increases access to community-based treatment for individuals with serious mental illnesses.	There may be opportunities to leverage resources with court pre-trial programs. While overall implementation is a longer-term strategy, planning for implementation with stakeholders would be in the short and medium-term.

	• Sobering or triage centers. • Diversion centers including Federally Qualified Health Center models.			
L.5	Expand community treatment and housing options for individuals living with serious mental illness and who are justice-involved, including: • Provide dedicated funding to develop housing to support Diversion and community-based restoration. • Provide funding to incentivize the development and expansion of community-based restoration programs across the state. • Provide incentives or flexible housing pool models for housing developers, providers of supportive housing (including peer-run organizations), and owners of rental units	Funding/ Policy	Increases access to Diversion and community-based treatment for felony ISTs. Provides treatment and housing options to provide community-based treatment and Diversion. Supports infrastructure development and prioritization for justice-involved individuals including felony ISTs.	

	to create additional housing resources or provide operating subsidies or supports for justice-involved individuals with serious mental illnesses. • Include justice-involved individuals with serious mental illness as priorities in homelessness, behavioral health, and community care infrastructure expansion funding. • Provide landlord incentives. • Expand Social Rehabilitation facilities. • Develop unlocked residential housing with treatment and supports. • Support regional programs and approaches for behavioral health and housing strategies, especially in less			

	densely populated regions. • Increase permanent supportive housing opportunities for justice-involved individuals with serious mental illnesses. • Consider funding support for Accessory Dwelling Units (ADU) development to support families' ability to provide independent housing for loved ones with SMI on their properties.			
L.6	Develop new licensing category for enriched and intensive community treatment options for individuals living with Serious Mental Illness including individuals who are justice-involved which may include provisions of mental health, health care, and intensive support services in a home-like setting:	Statutory	Increases intensive community-based treatment options for individuals with serious mental illnesses to prevent homelessness and criminalization.	

	• Explore similar model to the Short-term Residential Therapeutic Programs models that serve children and youth whose needs create barriers to placement in family-based care. • Explore similar licensing categories to those that support adults with developmental disabilities.			
L.7	Facilitate appropriate information sharing and support cross-system data initiatives across State, courts, and local entities that serve ISTs. • Develop State Health Information Guidance on sharing health and housing information in the context of serving people involved in the criminal justice systems, including the development of standard	Policy	Facilitates improved treatment/coordination. Supports research, evaluation, and policy development to inform ongoing strategies and investments.	

	authorizations for release of information and MOU's and provide training and technical assistance on guidance implementation. • Provide funding to support counties to undertake analyses of their criminal justice populations, including those with behavioral health needs to understand trends and identify data-driven strategies to reduce the number of ISTs. • Provide funding to develop a state approach to monitor key data at the intersection of criminal justice, behavioral health, and homelessness.			
L.8	Support the development and expansion of a culturally and linguistically competent workforce to meet an individual's forensic	Funding/ Policy	Provides a diverse workforce trained to provide services and support to justice-involved individuals	

	and behavioral health needs, including: • Funding for forensic fellowships. • Utilizing 4th year residents and psychology students to provide court-appointed evaluations. • Support increased psychologist education and training and psychiatric residency programs with rotation requirements to serve justice-involved individuals. • Explore expansion of mental health and other professionals to serve justice-involved individuals. • Expand the use of peer support specialists and family members. • Support care team models so individuals are working at the top of their licensure.		with serious mental illness.	

	• Provide recruitment and retention incentives. • Identify funding streams that could be braided (and augmented) to address workforce shortages. • Educate workforce on serving in the role of the housing advocate, collaborative justice principles, motivational interviewing, assessing and mitigating dangerousness, implicit bias, and other culturally relevant competencies.			
L.9	Phase out the reliance and utilization of jail-based competency treatment programs as community-based treatment and Diversion program options for felony ISTs are expanded.	Policy	Prioritizes community-based treatment options for individuals with serious mental illness to provide for improved outcomes and connection to long-term	

			community treatment and supports.	
L.10	Explore and, if needed, implement improvements to policies and practices governed by the Mental Health Services Act and the Lanterman-Petris-Short Act to facilitate access to care and treatment for individuals who are experiencing severe and disabling mental health crisis.	Statutory	Increased access to treatment and reduced criminal-justice involvement for individuals with serious mental illness.	
L.11	Provide funding support to counties to expand access to AB1810 Mental Health Diversion (Penal Code 1001.36), including for misdemeanors.	Funding/ Policy	Increasing access to mental health Diversion opportunities for misdemeanors can reduce the cycle of incarceration at an earlier stage reducing the potential for future felony arrest and IST determination.	Consider eliminating county matching requirements which can create barriers to MH Diversion expansion. Include funding for housing individuals participating in Mental Health Diversion
L.12	Provide increased access to permanent supportive housing for individuals with serious mental illness who are justice-involved.	Funding/ Policy	Individuals found incompetent to stand trial on Felony charges and referred to DSH are often unsheltered	

			homeless at the time of arrest and have had multiple prior criminal justice encounters. Providing permanent supportive housing will help reduce the cycle of criminalization for individuals with serious mental illness.	
L.13	Revise incompetent to stand trial statutes to require the prosecution to establish competency, rather than current requirement of the defense to establish incompetency.	Statutory	Streamlines pathway to treatment for individuals with serious mental illness where there is clear evidence of incompetence.	

[1] Incompetent to Stand Trial Solutions Workgroup Website: https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/

Appendix A: IST Solutions Working Group Membership and Affiliations

Working Group 1: Early Access to Treatment and Stabilization for Individuals Found Felony IST

- **Co-Chair: Melanie Scott**, PsyD, Assistant Chief Psychologist, California Department of State Hospitals
- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Deanna Adams**, Senior Analyst, Judicial Council of California
- **Kirsten Barlow**, National Alliance of Mental Illness (NAMI) – California
- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Elise Devecchio-Cavagnaro**, Ph.D., Consulting Psychologist, Department of Health Care Services
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR) Office of the Secretary
- **Paige Hoffman**, Staff Services Analyst, Council on Criminal Justice and Behavioral Health, California Department of Corrections and Rehabilitation
- **Karen Larsen**, Health & Human Services Agency Director, Yolo County & County Behavioral Health Directors Association (CBHDA)
- **Kristopher Kent**, Attorney, California Department of State Hospitals
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Stephen Manley**, Superior Court Judge, Santa Clara County
- **Christy Mulkerin**, MD, Chief Medical Officer, San Luis Obispo County Jail
- **Kim Pederson**, Senior Attorney, Disability Rights California
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association (CPDA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Cory Salzillo**, Legislative Director, California State Sherrif's Association

Working Group 2: Diversion and Community-Based Restoration for Felony ISTs

- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Co-Chair: Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency

- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Jessica Cruz**, MPA/HS, CEO, National Alliance of Mental Illness (NAMI) – California
- **Steven Kite**, COO, National Alliance of Mental Illness (NAMI) – California
- **Sarah Desmarais**, PhD, Senior Vice President, Policy Research Associates, Inc.
- **Elise Devecchio-Cavagnaro**, Ph.D., Consulting Psychologist, Department of Health Care Services
- **Anita Fisher**, Council on Criminal Justice and Behavioral Health / Family Member
- **Neil Gowensmith**, Ph.D. Assistant Professor, University of Denver, Licensed Clinical & Forensic Psychologist
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR) Office of the Secretary
- **Cathy Hickenbotham**, Council on Criminal Justice and Behavioral Health (CCJBH), California Department of Corrections and Rehabilitation (CDCR)
- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC)
- **Tony Hobson**, PhD, Behavioral Health Director, Plumas County
- **John Keene**, Chief Probation Officer, San Mateo County & President-Elect, Chief Probation Officers of California CPOC)
- **Veronica Kelley**, Director, San Bernardino County Department of Behavioral Health & Board President, California Behavioral Health Directors Association (CBHDA)
- **Michelle Cabrera**, Executive Director, California Behavioral Health Directors Association (CBHDA)
- **Kristopher Kent**, Attorney, California Department of State Hospitals
- **Pamila Lew**, Senior Attorney, Disability Rights California (DRC)
- **LD Louis**, Assistant District Attorney, Alameda County District Attorneys Office & California District Attorneys Association (CDAA)
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Gilda Valeros**, Supervising Attorney for Santa Clara County's Public Defender's Office
- **Stephen Manley**, Superior Court Judge, Santa Clara County

Working Group 3: Initial County Competency Evaluations

- **Co-Chair: Charles Scott**, MD, Chief, Division of Psychiatry and the Law, Forensic Psychiatry Training Director, and Professor of Clinical Psychiatry at the University of California, Davis Medical Center
- **Co-Chair: Katherine Warburton**, DO, Medical Director, Deputy Director of Clinical Operations, California Department of State Hospitals
- **Deanna Adams**, Senior Analyst, Judicial Council of California
- **Francine Byrne**, Principal Manager, Criminal Justice Services, Operations & Programs Division, Judicial Council of California
- **Katherine Clark**, Assistant Program Budget Manager, California Department of Finance
- **Matthew Greco**, Deputy District Attorney, San Diego County District Attorney's Office
- **Scarlet Hughes**, Executive Director, California Association of Public Administrators, Public Guardians and Public Conservators (CAPAPGPC)
- **Stephen Manley**, Superior Court Judge, Santa Clara County
- **Farrah McDaid Ting**, Senior Legislative Representative, Administration of Justice, California State Association of Counties (CSAC)
- **Danny Offer**, National Alliance of Mental Illness (NAMI) – California
- **Ira Packer**, PhD, Clinical Professor of Psychiatry & Director, Forensic Psychology Residency, University of Massachusetts Medical School
- **Neil Gowensmith**, Ph.D. Assistant Professor, University of Denver, Licensed Clinical & Forensic Psychologist
- **Dawn Percy**, Deputy Director, Department of Developmental Services
- **Jonathan Raven**, Chief Deputy District Attorney, Yolo County (CDAA)
- **Stephanie Regular**, Assistant Public Defender, Contra Costa County Public Defender Office & Co-Chair of the Mental Health Committee of the California Public Defender Association (CPDA)
- **Marni Sager**, Manager, Department of Developmental Services
- **Todd Schirmer**, PhD, CCHP, Forensic Division Director, Marin County Behavioral Health & Recovery Services & County Behavioral Health Directors Association (CBHDA)

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) The COVID-19 public health emergency has impacted every aspect of life as social distancing became a necessity, businesses closed, schools transitioned to remote education, and millions of Americans lost their jobs. The pandemic's impacts on behavioral health, including the toll of pandemic-related stress, have increased the need for community behavioral health resources.

(b) In particular, the pandemic has exacerbated the need to build new capacity or expand existing capacity for the continuum of behavioral health treatment resources in less restrictive, community-based, residential settings of care.

(c) It is the intent of the Legislature to provide competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to support the community continuum of behavioral health treatment resource needs due to the pandemic.

SECTION 2. Part 7 (commencing with Section 5960) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 7. BEHAVIORAL HEALTH SERVICES AND SUPPORTS

Chapter 1. Behavioral Health Continuum Infrastructure Program

5960. The department may establish the Behavioral Health Continuum Infrastructure Program pursuant to this chapter if the Legislature appropriates funds for this purpose.

5960.5. If the department establishes the program pursuant to this chapter, the department may do to as follows:

(a) Award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build new capacity or expand existing capacity for short-term crisis stabilization, acute and subacute care, crisis residential, community-based mental health residential, substance use disorder residential, peerrespite, mobile crisis, community and outpatient behavioral health services, and other clinically enriched longer term treatment and rehabilitationoptions for persons with behavioral health disorders in the least restrictive and leastcostly setting.

(b) Contract with the Department of State Hospitals pursuant to Chapter 6.7 (commencing with Section 4361.5 of Division 4 of the Welfare and Institutions Code for the following purposes:

(1) To subcontract with private or public entities for sub-acute bed capacity such as Institutions for Mental Disease, Mental Health Rehabilitation Centers, Skilled Nursing Facilities, or any other treatment options, including Community Based Restoration programs, to address the increasing number of patient referrals to the Department of State Hospitals.

(2) To subcontract with private or public entities to house and treat individuals committed to the California State Department of State Hospitals pursuant to Welfare and Institutions Code section 5358 or Penal Code sections 1026, 1370, and 2972. Subcontracted funds may include:

i. Program implementation costs, including funds for projects to modify, expand

or retrofit a space,

ii. One-time purchases of patient and staff furnishings and minor equipment,

iii. Activities related to recruitment and training of staff prior to program activation,

iv. Operating expenses.

(c)Section 5960.30 shall also apply to the Department of State Hospitals subcontractors.

5960.10. Except as provided in Section 5960.15, the department shall determine the methodology and distribution of the grant funds appropriated for the program pursuant to Section 5960.5(a) to those entities it deems qualified.

5960.15. An entity shall meet all of the following conditions in order to receive grant funds pursuant to Section 5960.5(a), to the extent applicable and as required by the department:

(a) Provide matching funds or real property.

(b) Expend funds to supplement and not supplant existing funds to construct, acquire, and rehabilitate real estate assets.

(c) Report data to the department within 90 days of the end of each quarter for the first five years.

(d) Operate services in the financed facility for the intended purpose for a minimum of 30 years.

5960.20. (a) This chapter shall be implemented only if, and to the extent that, the department determines that federal financial participation under the Medi-Cal program, including but not limited to the increased federal funding available pursuant to Section 9813 of the federal American Rescue Plan Act of 2021 (Pub. Law 117-2), is not jeopardized.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this chapter, in whole or in part, by means of information notices or other similar instructions, without taking any further regulatory action.

5960.25. For purposes of implementing this chapter, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

5960.30. (a) Notwithstanding any other law, a facility project funded by a grant pursuant to this chapter shall be deemed consistent and in conformity with any applicable local plan, standard, or requirement, and allowed as a permitted use, within the zone in which the structure is located, and shall not be subject to a conditional use permit, discretionary permit, or to any other discretionary reviews or approvals.

(b) Notwithstanding any other law, the California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code) shall not apply to any facility project, including a phased project, funded by a grant pursuant to this chapter if all of the following requirements, if applicable, are satisfied:

(1) No facility is acquired by eminent domain.

(2) The grantee shall ensure a facility is licensed by and in good standing with the department or other state licensing entity, as applicable, at the time of occupancy. The facility shall be in decent, safe, and sanitary condition at the time of occupancy.

(3) The grantee shall require all contractors and subcontractors performing work on the facility project to pay prevailing wages for any proposed rehabilitation, construction, or major alterations in accordance with Chapter 1 (commencing with

Section 1720) of Part 7 of Division 2 of the Labor Code.

(4) The grantee obtains an enforceable commitment that all contractors and subcontractors performing work on the facility project will use a skilled and trained workforce for any proposed rehabilitation, construction, or major alterations in accordance with Chapter 2.9 (commencing with Section 2600) of Part 1 of Division 2 of the Public Contract Code.

(5) The project proponent submits to the lead agency a letter of support from a county, city, or other local public entity for any new proposed construction, major alteration work, or rehabilitation.

(6) Any new construction, facility acquisition, or rehabilitation is paid for, in whole or part, with public funds.

(7) The facility project expands the availability of behavioral health treatment services in the subject jurisdiction.

(8) Long-term covenants and restrictions require the facility to be used to provide behavioral health treatment for no fewer than 30 years.

(9) The facility project does not result in an increase in the existing onsite development footprint of structure, structures, or improvements by more than 10 percent. Any increase to the existing onsite development footprint shall be exclusively to support the provision of behavioral health treatment in the subject jurisdiction, including, but not limited to, all of the following:

(A) Achieving compliance with local, state, and federal requirements.

(B) Providing sufficient space for the provision of services and amenities.

(C) If determined that a grantee's facility project is not subject to the California Environmental Quality Act pursuant to this section, the grantee shall file a notice of exemption with the Office of Planning and Research and the county clerk of the county in which the project is located in the manner specified in subdivisions (b) and (c) of Section 21152 of the Public Resources Code.

5960.35. (a) The following definitions shall apply to this chapter:

(1) "Department" means the State Department of Health Care Services.

(2) "Program" means the Behavioral Health Continuum Infrastructure Program authorized by this chapter.

(b) The following definitions shall apply to the implementation of this chapter:

(1) "Low-rent housing project," as defined in Section 1 of Article XXXIV of the California Constitution, does not apply to any facility project pursuant to this section that meets any one of the following criteria:

(A) The development is privately owned housing, receiving no ad valorem property tax exemption, other than exemptions granted pursuant to subdivision (f) or (g) of Section 214 of the Revenue and Taxation Code, not fully reimbursed to all taxing entities, and not more than 49 percent of the dwellings, apartments, or other living accommodations of the development may be occupied by persons of low income.

(B) The development is privately owned housing, is not exempt from ad valorem taxation by reason of any public ownership, and is not financed with direct long-term financing from a public body.

(C) The development is intended for owner-occupancy, which may include a limited-equity housing cooperative as defined in Section 50076.5 of the Health and Safety Code, or cooperative or condominium ownership, rather than for rental-occupancy.

(D) The development consists of newly constructed, privately owned, one-to-four family dwellings not located on adjoining sites.

(E) The development consists of existing dwelling units leased by the state public body from the private owner of these dwelling units.

(F) The development consists of the rehabilitation, reconstruction, improvement or addition to, or replacement of, dwelling units of a previously existing low-rent

housing project, or a project previously or currently occupied by lower income households, as defined in Section 50079.5 of the Health and Safety Code.

(G) The development consists of the acquisition, rehabilitation, reconstruction, improvement, or any combination thereof, of a development which, prior to the date of the transaction to acquire, rehabilitate, reconstruct, improve, or any combination thereof, was subject to a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households and maintains, or enters into, a contract for federal or state public body assistance for the purpose of providing affordable housing for low-income households.

(2) "Tribal entity" shall mean a federally recognized Indian tribe, tribal organization, or urban Indian organization, as defined in Section 1603 of Title 25 of the United States Code.

5960.40. The provisions of this chapter are severable. If any provision of this chapter or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

5960.45. This chapter shall remain in effect only until January, 1, 2027, and as of that date is repealed.

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 10/20)

Fiscal Year	Business Unit	Department	Priority No.
FY 2021-22	4260	Health Care Services	

Budget Request Name	Program	Subprogram
4260-314-BCP-2021-MR	3960	3960010

Budget Request Description
Behavioral Health Continuum Infrastructure Program

Budget Request Summary
The Department of Health Care Services (DHCS) requests $22,500,000 total funds ($12,500,000 General Fund and $10,000,000 Coronavirus Fiscal Recovery Fund of 2021 [CFRF]) in fiscal year (FY) 2021-22, and $62,750,000 total funds ($61,250,000 General Fund and $1,500,000 CFRF) in FY 2022-23 to administer the Behavioral Health Continuum Infrastructure Program.

DHCS also requests corresponding provisional language and statutory changes.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed	
☒ Yes ☐ No		
Does this BCP contain information technology (IT) components? ☐ Yes ☒ No	Department CIO N/A	Date

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. N/A Project Approval Document: N/A

Approval Date:

If proposal affects another department, does other department concur with proposal? ☐ Yes ☒ No

Prepared By	Date	Reviewed By	Date
Jessica Bogard	5/14/2021	Erika Sperbeck	5/14/2021
Department Director	Date	Agency Secretary	Date
Will Lightbourne	5/14/2021	Brendan McCarthy	5/14/2021

Department of Finance Use Only

Additional Review: ☐ Capital Outlay ☐ ITCU ☐ FSCU ☐ OSAE ☐ Dept. of Technology

PPBA	Date submitted to the Legislature
Iliana Ramos	5/14/2021

A. Budget Request Summary

The Department of Health Care Services requests $22,500,000 total funds ($12,500,000 General Fund (GF), and $10,000,000 Coronavirus Fiscal Recovery Fund of 2021(CFRF) in fiscal year (FY) 2021-22, and $62,750,000 total funds ($61,250,000 GF, and $1,500,000 CFRF) in FY 2022-23 to administer the Behavioral Health Continuum Infrastructure Program(BH-CIP). DHCS also requests corresponding provisional language and statutory changes.

The BH-CIP is a grant program that authorizes DHCS to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources.

B. Background/History

Background on the Behavioral Health Continuum Infrastructure

Prior to the COVID-19 pandemic, California's rates of overdose deaths, suicides, mental illness, and substance use disorder were steadily increasing. The majority of Californians with behavioral health conditions self-reported they were not receiving treatment.[1] The COVID-19 pandemic further accelerated these trends: social isolation, financial insecurity, housing insecurity, systemic discrimination, and inequitable losses increased the severity and frequency of mental health crises and risky substance use.

The problem is not unique to California.[2] Many states face similar challenges and are working to divert response to mental health crises from law enforcement to behavioral health treatment. Expanding the availability of behavioral health resources is an investment in equity, because lack of available treatment beds disproportionately results in people of color receiving jail sentences instead of treatment. The likelihood of incarceration over treatment is closely correlated with the availability of treatment resources.[3]

California counties face a behavioral health continuum infrastructure deficit. For example, inpatient psychiatric bed capacity in California is 21 beds/100,000 people whereas experts estimate 50 beds/100,000 people is needed to meet the need across the state.[4] In a 2017 study (using 2014 data that has not yet been updated[5]), California had among the lowest inpatient psychiatric bed capacity in the country. Only about 2,600 subacute mental health treatment beds are licensed in California[6] and the number of Substance Use Disorder (SUD) treatment facilities has decreased by 13 percent over the last three years (down to 874 licensed facilities in 2020 compared to 1,009 in 2018). In addition, although social model residential services in home-like environments have been proven an effective mechanism to support recovery, build resilience and independence, and avoid the trauma of institutionalization, many California counties lack alternatives to institutional care for people whose mental health disabilities make it difficult to living independently.

Several drivers contribute to this mismatch of supply and demand: high California real estate costs; "not in my backyard" mentality and zoning restrictions; and difficulty accessing low-

[1] California Health Care Foundation Mental Health Almanac 2018 and SUD Almanac 2018.
[2] https://crisisnow.com/wp-content/uploads/2020/07/IIMHL-DC-Crisis-Declaration-FINAL-1-4.pdf
[3] Green TM. Police as frontline mental health workers. The decision to arrest or refer to mental health agencies. Int J Law Psychiatry. 1997; 20(4):469–486.
[4] Based on expert consensus panel, Treatment Advocacy Center; median for counties in the Organisation for Economic Cooperation and Development is 68 beds/100k
[5] https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf
[6] Psychiatric Health Facilities and Mental Health Rehabilitation Centers.

income housing, resulting in growing homelessness which in turn can lead to increasing numbers of people with severe mental illness requiring residential care. Additionally, the restrictive federal interpretation of limitations of federal funding for patient care provided in Institutions for Mental Disease (IMDs) results in the denial of federal Medicaid funding for many treatment facilities. This results in increased costs to county behavioral health programs to pay for such placements when needed, preventing county behavioral health departments and county-contracted providers from building financial reserves that could otherwise allow for significant infrastructure investments.

2021-22 Governor's Budget BH-CIP Proposal

To support counties and tribal entities with one-time investments in behavioral health infrastructure, the 2021-22 Governor's Budget included the BH-CIP that provides $750 million in local assistance grants to qualified entities to efficiently and cost-effectively construct, acquire, and rehabilitate real estate assets. This proposal builds upon the Governor's Budget proposal and will allow California to expand the community continuum of behavioral health treatment facilities, allowing individuals to live and be treated in a stable environment which leads to better health and behavioral health outcomes. This will include the addition of approximately 15,000 beds, units, or rooms to expand such capacity.

BH-CIP funding may be used to expand capacity for the following types of facilities, including but not limited to:

- Crisis Intervention, Stabilization and Crisis Residential.
- Residential Treatment.
- Day Rehabilitation.
- Day Treatment Intensive or Partial Hospitalization with Housing Supports.
- Adult Residential Care Facilities/Board and Care Facilities.
- Room and Board with Intensive Outpatient Services.
- Peer Respite and Shared Housing.
- Locked and Unlocked Forensic Facilities.
- Community-Based Outpatient and Behavioral Health Wellness Services.
- Full Continuum of Care Focused on Individuals 25 Years and Younger.

Resource History
(Dollars in thousands)

Community Services Division

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20
Authorized Expenditures	N/A	N/A	N/A	N/A	$129,863
Actual Expenditures	N/A	N/A	N/A	N/A	$39,287
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	132.5
Filled Positions	N/A	N/A	N/A	N/A	108.4
Vacancies	N/A	N/A	N/A	N/A	24.1

*Effective FY 2019-20 CSD split from Substance Use Disorder Program Policy and Fiscal Division (SUDPPFD)

C. State Level Consideration

The BH-CIP aligns with other Administration initiatives, including, but not limited to:

- The Administration's efforts to build out the full continuum of care for justice-involved individuals;
- Appropriate diversion and restoration treatment for those found Incompetent to Stand Trial (IST);
- The Children and Youth Behavioral Health Initiative, which would transform the system of care for individuals 25 years and younger.
- The CalAIM behavioral health payment reform, Serious Mental Illness/Serious Emotional Disturbance Demonstration Waiver opportunity, and the Enhanced Care Management and In Lieu of Services proposals.

The BH-CIP also aligns with existing programs that address housing with behavioral health supportive services, such as: the Department of Housing and Community Development (HCD)'s Project Homekey; Mental Health Services Act local funding, including support of permanent supportive housing; HCD's No Place Like Home Program; HCD's California Emergency Solutions and Housing; and HCD's Housing for Healthy California Program.

Existing programs and proposed Administration proposals complement one another in that they reach a broad spectrum of populations with needs, such as:

- Homeless/at risk of homelessness persons who can live independently and who do not require services or care
- Homeless/at risk of homelessness persons who have behavioral health needs or who need around-the-clock care

- Persons who are not homeless but who have behavioral health needs or who require around-the-clock care

The BH-CIP may also help address the below key challenges faced by California:

- Insufficient capacity to decompress acute care hospitals, especially during public health emergencies
- Inappropriately long length of stays in acute care and psychiatric hospitals, due to lack of options for step-down to community-based treatment
- Excessive criminal justice involvement for people with mental illness and/or substance use disorder, due to lack of bed capacity at time of crisis, and lack of housing on release from jail or prison (often leading to re-arrest)
- Lack of options for older adults with behavioral health disorders and/or developmental disorders, which typically require more intensive staffing, which is often not covered by the financial model of the facilities, leading to frequent displacements.

D. Justification

DHCS requests resources to manage the complexities of working with a variety of eligible entities, including, but not limited to, up to 58 counties and 109 diverse federally-recognized Tribes in California, to equitably distribute resources, and to provide oversight to document that resources result in a measurable expansions of behavioral health capacity.

Specifically, DHCS requests resources to administer the additional local assistance funding of $237,500,000 in FY 2021-22 and $1.38 billion in FY 2022-23 for the Behavioral Health Continuum Infrastructure Program proposed in the May Revision.

As part of the CalAIM initiative, DHCS intends to pursue the SMI/SED Demonstration Waiver and will perform a statewide gap analysis to assist the department in identifying the areas of most need across the state. Although each county is responsible for assessing its needs and enhancing its behavioral health infrastructure, as the statewide Medicaid entity, it is reasonable for DHCS to assess need across the state in order to allocate appropriate levels of funding based on need and gaps in the behavioral health continuum.

DHCS will need to coordinate with contractors to ensure efficient and accountable grants management, to leverage needed expertise and experience in designing and implementing real estate acquisition and capital improvement projects, and to deploy technical experts to help grantees move through predictable political, legal, operational and technical challenges that reduce or delay success of the program. Success will depend on collaborating with resource developers and contractors with real estate acumen. Grantees will require comprehensive technical assistance and training regarding real estate and infrastructure implementation. In addition, contracting with a variety of entity types will require substantial legal expertise to ensure the DHCS investment is protected in the long-term. DHCS currently does not have the capacity, aptitude or staff to engage in effective real estate acquisition with a sustainable impact on treatment access.

DHCS anticipates the first round of BH-CIP competitive grant funding will be released to through a Request for Application (RFA) by January 2022. Additional rounds of RFAs would be released in order to utilize all of the grant funding and estimates anywhere from 300-600 participating grantees over the period of the grant.

Community Services Division

CSD is responsible for various behavioral health programs and services for adults, youth, and children. The CSD is charged with policy development, oversight, and compliance and monitoring of the Mental Health Services Act, Short-Term Residential Therapeutic Programs and Children's Therapeutic Care Programs. Additionally, CSD administers several grants through the Substance Abuse Mental Health Services Administration. CSD is also responsible for the State Targeted Response to the Opioid Crisis Grants and has funded the Medication Assisted Treatment Expansion Project. As part of grant oversight, CSD administers multiple contracts with counties and providers. CSD also oversees other programs including behavioral health prevention and family services and Proposition 64 youth SUD prevention funding. The CSD is also responsible for conducting data analysis and research activities to various programs that provide behavioral health services to individuals throughout California.

CSD consists of three branches: Community Support Branch, Operations Branch, and Behavioral Health Analytics and Research Branch.

Limited-term Contract Resources

DHCS requests resources to support administrative consultant organizations that will address vastly different programmatic and administrative areas of the BH-CIP. The BH-CIP during May Revision has expanded to encompass three targets within the continuum:

- Broad behavioral health across the continuum
- Dedicated behavioral health for children and youth age 25 or younger
- Increase county capacity to treat individuals found incompetent to stand trial (IST)

DHCS resources, in collaboration with the administrative consultants, will implement the BH-CIP and develop training and educational materials for grantees to address key components of BH-CIP activities. Additionally, the administrative consultants will provide subject matter expertise on capital infrastructure projects, and support DHCS with BH-CIP administrative functions. Furthermore, administrative consultants are necessary to provide expert training and technical assistance to awardees on land use zoning, permitting, rehabilitation, managing local political opposition, and/or new construction costs and real estate acquisition. Documents submitted in the country and tribal grant applications, and during the course of implementing projects, is likely to require expertise that DHCS staff classifications do not possess.

The following administrative consultant distribution of workload would be as follows:

Administrative Consultant 1: To Be Determined by RFA

- Assist DHCS in the review of applications.
- Provide comprehensive technical assistance and training, regarding real estate and infrastructure implementation.
- Develop/execute contracts and award grant monies.
- Provide payment to grantees for completed milestones.

- Provide oversight to ensure all land acquisition and real estate documents are secured and provided.

- In collaboration with DHCS, provide annual quality assurance review of awardees.

- In collaboration with DHCS, develop and implement BH-CIP Training and Educational Materials, including protocols and guidelines, for Grantees.

Administrative Consultant 2: To Be Determined by RFA

- Perform outreach, which will include disseminating funding opportunities to eligible organizations; facilitating meetings, webinars, and coaching calls with local governmental entities, providers, and other stakeholders; and developing and publishing content to promote the project.

- Assist qualifying entities in preparing and completing the RFA; especially for small and rural counties and tribal entities.

- Once grantee applications are submitted, assist grantees with challenges to land acquisition, NIMBY issues, and any other project issues.

- Subcontract with a tribal entity or subject matter experts with tribal experience. Subcontractor will provide tribal insight for grantees, land acquisition, tribal needs and board approval and would also assist DHCS on any tribal inquiries. In addition, tribal training and technical assistance will require approaches and materials that are reflective of the distinct cultural needs of American Indian and Alaska Native populations.

- Develop and deliver training and technical assistance on topics, including but not limited to: land use, zoning, permitting, rehabilitation, and/or new construction costs and real estate acquisition, as well as navigating California environmental regulations.

- Collect and aggregate all submitted quarterly reports into a concise single quarterly report that details quantitative and qualitative activities, such as project progress, successes, and challenges. The Administrative Consultant will also submit a final report that includes comprehensive, aggregated quantitative and qualitative grantee performance data; templates, documents, and materials developed for services performed as part of the contract; general data or auditing information collected during the contract; a summary of challenges encountered in implementing services during the contract; and a summary of successful strategies encountered in implementing services during the contract.

E. Outcomes and Accountability

If approved, the additional requested resources will allow DHCS to support the expansion of the community behavioral health facility capacity by approximately 15,000 beds statewide; increase access to behavioral health services for some of California's most vulnerable populations; develop the competitive grant process expediently; execute awardee contracts expediently in order to efficiently utilize the grant funds and matching funds; process contractor payments timely; deliver needed training and technical assistance to grantees; verify data is collected and aggregated appropriately, so that project outcomes are clearly defined and understood; and confirm that funds obligated for this effort are used appropriately and effectively.

F. Analysis of All Feasible Alternatives

Alternative 1:

Approve the request for $22,500,000 total funds ($12,500,000 General Fund and $10,000,000 CFRF in FY 2021-22, and $62,750,000 total funds ($61,250,000 General Fund and $1,500,000 CFRF) in FY 2022-23 Also approve the requested corresponding provision language and statutory changes.

Pros:
- Aligns with the requirements of the FY 2021-22 Governor's Budget;
- Expands behavioral health facility capacity by approximately 15,000 beds statewide;
- Expands behavioral health infrastructure and outpatient and residential treatment;
- Augments the service spectrum through approaches such as CalAIM to ultimately reduce homelessness, incarceration, and unnecessary hospitalizations and inpatient days by appropriately utilizing community-based models of care;
- Processes project invoices are processed timely and efficiently; and
- Executes grantee contracts expediently in order to effectively utilize the grant funds and matching funds.

Cons:
- Requires General Fund resources to fund salary and associated costs.

Alternative 2:

Do not approve this request

Pros:
- No General Fund impact. No increase in workspace or equipment purchases to accommodate contractors

Cons:
- Very likely to result in delays in developing the competitive grant process as no other staff resources are available to implement the grant;
- May result in improper awarding of grants and insufficient grantee oversight, due to lack of technical land use expertise to determine if applicants have appropriate and viable project plans for rehabilitation or acquisition of new properties;
- Potential for lack of utilization of grant funds due to insufficient resources to implement program.
- Difficult to assess progress in expanding the behavioral health continuum
- Overextended staff; and
- Loss of staff due to overwhelming workload.

G. Implementation Plan

Upon approval, DHCS will recruit resources to initiate project development and implementation, including key administrative processes, such as fiscal, contracting, data collection and reporting, and oversight and monitoring. Additionally, DHCS will need to move efficiently to design and develop consultant contractor RFAs and SOWs, so that grantees working to expand behavioral health capacity are awarded and funded in FY 2021-22.

H. Supplemental Information

Attachment A: Fiscal Detail Sheets
Attachment B: Proposed Provisional Language
Attachment C: Funding Summary

I. Recommendation

Alternative 1:
Approve the request for $22,500,000 total funds ($12,500,000 General Fund and $10,000,000 CFRF in FY 2021-22, and $62,750,000 total funds ($61,250,000 General Fund and $1,500,000 CFRF) in FY 2022-23. Also approve the requested corresponding provision language. The requested resources are needed to:

- Expand behavioral health facility capacity by approximately 15,000 beds statewide;
- Expand the community continuum of behavioral health treatment resources;
- Assess augmentation of the service spectrum through approaches such as CalAIM to ultimately reduce homelessness, incarceration, and unnecessary hospitalizations and inpatient days by appropriately utilizing community-based models of care;
- Process project invoices timely and efficiently; and
- Execute awardee contracts expediently in order to effectively utilize the grant funds and matching funds.

BCP Fiscal Detail Sheet

BCP Title: Behavioral Health Continuum Infrastructure Program

BR Name: 4260-314-BCP-2021-MR

Budget Request Summary

Operating Expenses and Equipment

Operating Expenses and Equipment	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
5301 - General Expense	0	2,500	61,250	0	0	0
5340 - Consulting and Professional Services - External	0	20,000	1,500	0	0	0
Total Operating Expenses and Equipment	**$0**	**$22,500**	**$62,750**	**$0**	**$0**	**$0**

Total Budget Request

Total Budget Request	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
Total Budget Request	**$0**	**$22,500**	**$62,750**	**$0**	**$0**	**$0**

Fund Summary

Fund Source

Fund Source	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
State Operations - 0001 - General Fund	0	12,500	61,250	0	0	0
State Operations - 8506 - Coronavirus Fiscal Recovery Fund of 2021	0	10,000	1,500	0	0	0
Total State Operations Expenditures	**$0**	**$22,500**	**$62,750**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$22,500**	**$62,750**	**$0**	**$0**	**$0**

Program Summary

Program Funding

Program Funding	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
3960010 - Medical Care Services (Medi-Cal)	0	12,500	61,250	0	0	0

Program Funding	FY21 Current Year	FY21 Budget Year	FY21 BY+1	FY21 BY+2	FY21 BY+3	FY21 BY+4
3960050 - Other Care Services	0	10,000	1,500	0	0	0
Total All Programs	**$0**	**$22,500**	**$62,750**	**$0**	**$0**	**$0**

Proposed provisional language

Add the following Provision to Item 4260-001-0001:

7. (a) Notwithstanding any other law, of the funds appropriated in Schedule (1) of this item, $12,500,000 is available for encumbrance or expenditure until June 30, 2024, for the State Department of Health Care Services to implement the Behavioral Health Continuum Infrastructure Program pursuant to Chapter 1 (commencing with Section 5960) of Part 7 of Division 5 of the Welfare and Institutions Code.

Behavioral Health Continuum Infrastructure Program

The Governor's Budget proposed $750 million one-time General Fund for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. An April 1 Finance Letter shifted $6.5 million one-time General Fund from local assistance to state operations, available over a three-year period. The May Revision shifts $300 million General Fund to CFRF in 2021-22, adds $250 million one-time General Fund in 2021-22 targeted to individuals with a serious mental illness who are deemed Incompetent to Stand Trial (IST), adds $1.2 billion one-time General Fund in 2022-23, and adds $225 million total funds over three years targeted to individuals aged 25 and younger.

	BY 2021-22		BY+1 2022-23		BY+2 2023-24		Total Over 3 Years	
Target Population[1/]	GF	CFRF	GF	CFRF	GF	CFRF	GF	CFRF
Minimum funding for the CYBH Initiative (individuals age 25 and younger)		$ 10.0	$ 25.0	$ 220.0			$ 25.0	$ 230.0
Minimum funding for ISTs	250.0						250.0	
Remaining funding for broad use	445.7	300.0	1,202.2		2.1		1,650.0	300.0
Total	$ 695.7	$ 310.0	$1,227.2	$ 220.0	$ 2.1		$1,925.0	$ 530.0

[1/] Of the $2.455 billion total funds over three years for the program, there are minimum amounts targeted to individuals age 25 and younger and ISTs. The remaining funds may also be targeted for these populations.

State of California

Department of Health Care Services

Assessing the Continuum of Care for Behavioral Health Services in California

Data, Stakeholder Perspectives, and Implications

January 10th, 2022

This report was prepared for DHCS by Manatt Health with support from Dr. Anton Nigusse Bland

Assessing the Continuum of Care for Behavioral Health Services in California

Data, Stakeholder Perspectives, and Implications

I. Executive Summary

About the Assessment

The COVID-19 pandemic has exacerbated behavioral health challenges—both mental health and substance use disorder—and placed significant demands on the existing system of care and workforce capacity. With behavioral health a top priority of the Newsom administration and the inequities across the health care system further exacerbated by the COVID-10 pandemic, it is the optimal time for the Department of Health Care Services (DHCS) to produce an updated assessment of California's behavioral health system. While DHCS will use the assessment to inform its work on initiatives such as the BHCIP and the SMI/SED 1115 waiver application, it is not the single source of information that will be used nor is it a description of the Administration's specific positions and plans. DHCS is committed to continuing to work closely with stakeholders to implement critical initiatives underway and develop future policy as behavioral health initiatives evolve.

The assessment will provide data and stakeholder perspectives for DHCS as it implements major behavioral health initiatives, responds to new federal funding opportunities, and prepares to submit a Section 1115 Medicaid demonstration waiver in 2022 to strengthen mental health services for people living with serious mental illness (SMI) and children and youth living with serious emotional disturbance (SED).[1]

Specifically, this assessment aims to do the following:

- **Provide a framework** to describe the core continuum of behavioral health care services, making it possible to compare "what is" in California to "what should be."
- **Review the available data and gather insights from stakeholders and experts** on the need for and supply of key behavioral health services in California.
- **Support design and implementation of various behavioral health initiatives,** including the application to the Centers for Medicare and Medicaid Services (CMS) for an SMI/SED 1115 waiver and the Behavioral Health Continuum Infrastructure Program (BHCIP)
- **Explore issues and opportunities for specific populations** – children, adolescents, and youth; American Indian/Alaska Native (AI/AN) individuals; and individuals who are justice-involved. These populations were identified by focus group participants in the early stages of the assessment as critical to address through an equity lens, but they should not be viewed as the only groups that warrant close attention.
- **Discuss the implications for DHCS' work** and for California's broader efforts to strengthen the behavioral health system.

The assessment was prepared between July and November 2021 using data from existing California reports and surveys as well as California-specific information from national databases and a review of Medi-Cal (the state's Medicaid program)

[1] This waiver is referred to as the SMI/SED 1115 waiver throughout the remainder of this report.

administrative claims. To integrate the perspectives of key stakeholders, the assessment also draws from a survey of counties' behavioral health directors conducted in partnership with the County Behavioral Health Directors Association of California (CBHDA) as well as stakeholder interviews and focus groups. The assessment provides some data and information on the broader behavioral health system in California, but focuses most heavily on the services available to Medi-Cal enrollees living with serious mental illness and substance use disorders. This reflects the prominent role of Medi-Cal in serving Californians experiencing these conditions, as well as DHCS's role as the steward of the Medi-Cal program. It is important to note that this data was collected at a time when the state is implementing numerous large scale programs that seek to address many of the problems detailed in this report, and thus, the data does not reflect the impacts of these recent significant investments (see "Major New and Planned Behavioral Health Initiatives" table).

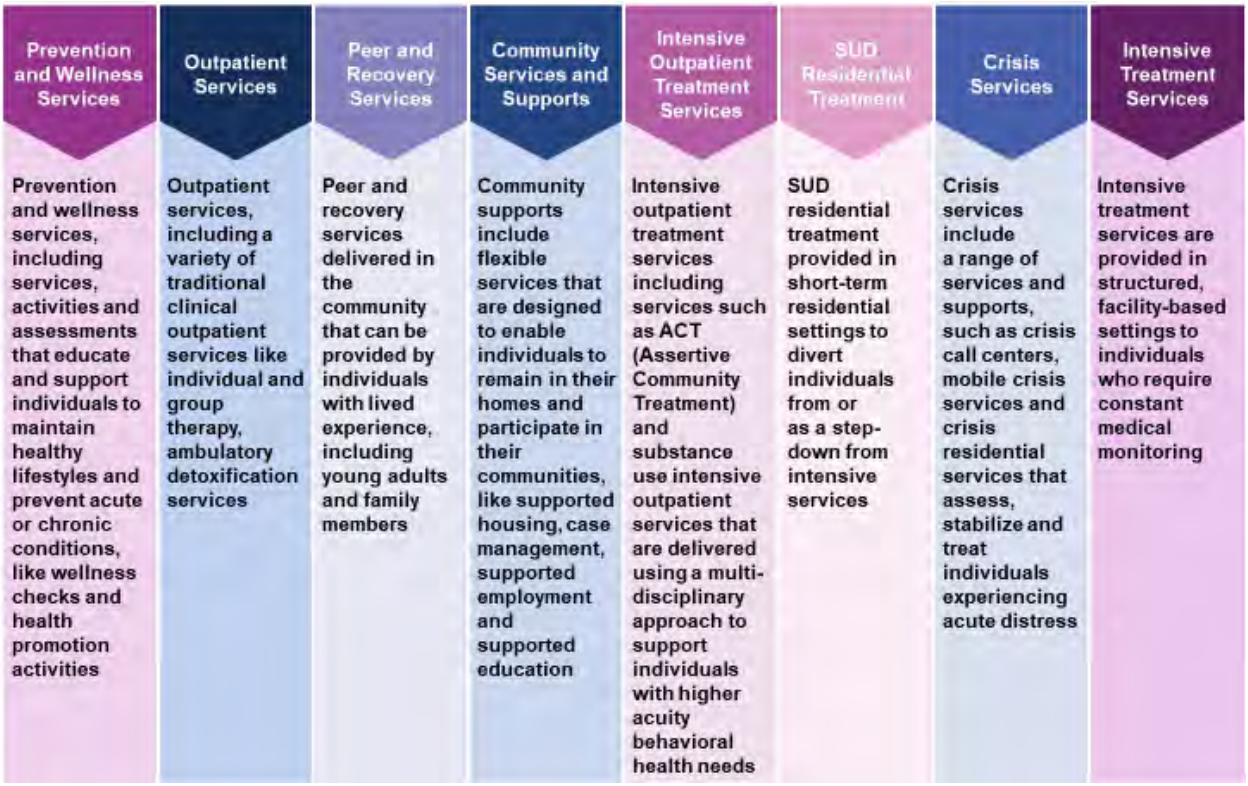
Envisioning a Core Continuum of Care

The assessment defines a core continuum of behavioral health services, identifying the elements of a strong and effective behavioral health system. Drawn from the literature and expert opinion, it is grounded in a set of key principles. These include that the behavioral health system should:

- Be person-centered and culturally responsive;
- Offer a full array of services with an emphasis on upstream prevention and a wide range of community-based care;
- Focus on achieving equity; and
- Reflect evidence-based and community-defined best practices.

While the continuum describes eight different major categories of services, it is important to highlight that they are not always distinct from one another. In practice, a person might require and receive services from more than one category at any given moment in time. For example, a person enrolled in an intensive outpatient program might also receive support from a peer recovery specialist. Moreover, people routinely move in and out of care, requiring services from different categories, sometimes in a matter of hours or days.

Figure 1. **Core Continuum of Care**



The State of Behavioral Health in California

Close to one in ten California adults (9.2 percent) has a substance use disorder (SUD), and nearly one in 20 (4.5 percent) has a serious mental illness (SMI).[2] Many of these adults living with SMI or SUD are among the 14 million Californians[3] enrolled in Medi-Cal. Medi-Cal plays a particularly important role for people living with SMI and SUD. Many others receive services through county and tribal-led entities. Private insurers cover over 21 million Californians, and also play a key role.[4] However, a number of stakeholders reported that people living with the most serious behavioral health conditions – severe mental illness, serious emotional disturbance (SED) among children and youth, life-threatening eating disorders – often end up served through the public

---

[2] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[3] Medi-Cal Enrollment, Monthly Statewide Medi-Cal Enrollment, California Department of Health Care Services, June 2021. Available at https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx.

[4] Kaiser Family Foundation. Health Insurance Coverage of the Total Population: https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

behavioral health system. This can be because they do not have private insurance, but, a number of provider stakeholders also shared anecdotal reports of private insurers failing to provide the appropriate level of resources necessary to serve more severely affected individuals, leaving patients to move into the public system. A recent national consumer study found that patients with private insurance were more likely to rate their mental health provider network ("provider network" includes physicians, clinicians, other health care professionals and their institutions that comprise the network), as inadequate compared with their medical provider network.[5] These findings coupled with the high rate of denials of claims for mental health treatment under private insurance suggests that more individuals with serious behavioral health conditions may eventually rely on the public behavioral health system for their services.[6]

An analysis of the prevalence of behavioral health conditions in California and the extent to which people are receiving services for such conditions indicated:

- **A significant and increasing number of California residents are living with a mental health condition or substance use disorder.** Relative to the country as a whole, California adults are somewhat more likely to have a substance use disorder and less likely to have a serious mental illness. However, the rate of serious mental illness in California as reported in survey data has increased by more than 50 percent from 2008 - 2019.[7] A larger and growing number of California residents experience a mental, behavioral or emotional disorder (any mental illness) that does not meet the clinical threshold for SMI, which leads to functional impairment that substantially interferes with or limits one or more major life activities.[8,9] These individuals may experience mood disorders, including mild depression and anxiety, that can be treated effectively with different forms of evidence-based psychotherapy, such as cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) which are structured treatment modalities.

- **Many children in California are living with a serious emotional disturbance, and behavioral health conditions and suicide rates are rising.** One in 13 children in California has a SED, with rates higher for low-income children and those

---

[5] Busch SH, Kyanko K. Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults With Private Insurance. *JAMA Netw Open.* 2021;4(10):e2130770. doi:10.1001/jamanetworkopen.2021.30770.

[6] N.D. Cal., No. 3:14-cv-02346-JCS, 3/5/19.

[7] SAMHSA. California Behavioral Health Barometer Volume 6. https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.

[8] SAMHSA. 2018-2019 NSDUH State Specific Tables. January 28, 2021. Available at https://www.samhsa.gov/data/report/2018-2019-nsduh-state-specific-tables.

[9] SAMHSA. 2017-2018 NSDUH Model-Based Prevalence Estimates (50 States and the District of Columbia). December 18, 2019. Available at https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates.

who are Black or Latino, relative to other racial and ethnic groups.[10] In recent years, the suicide rate among youth in California has been rising, and the pandemic appears to have worsened the situation.[11] Nationwide, visits to emergency departments (EDs) due to a mental health crisis have climbed by 24 percent for children between the ages of 5 and 11 and 31 percent for those ages 12 to 17. (California-specific data on ED use due to mental health crises for children and youth were not available for this report.)[12]

Figure 2. **Number of Suicides in California per 100,000 Youth Ages 15-24[13]**

Period	2012 - 2014	2013 – 2015	2014 - 2016	2015 - 2017	2016 - 2018	2017 - 2019
Suicide rate per 100,000	7.3	7.6	7.7	8.3	8.6	8.9

- **Marginalized groups experience higher rates of behavioral health conditions and more barriers to care.** As in the rest of the country, marginalized groups in California often are at higher risk for behavioral health issues, but also are less likely to be able to access services. For example, , American Indian/Alaska Native (AI/AN) populations nationally report higher rates of post-traumatic stress disorder and alcohol dependence than any other ethnic/racial group (recent California-specific data are not available), while Black and Latino children in California face relatively higher rates of SED. At the same time, marginalized groups face additional barriers to care. Black Californians, for example, are far less likely to report receiving mental health services for themselves or a family member than other racial and ethnic

[10] Holzer C and Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

[11] California Dept. of Public Health, Death Statistical Master Files (Jun. 2021); CDC WONDER Online Database, Underlying Cause of Death (Jun. 2021); California Dept. of Finance, Population Estimates and Projections (Jul. 2021). Data downloaded from KidsData.org: https://www.kidsdata.org/topic/213/suicide-rate/table#fmt=2772&loc=2&tf=134,125,122,120,93,86&sortColumnId=0&sortType=asc.

[12] RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3.

[13] Source: California Dept. of Public Health, Death Statistical Master Files (Jun. 2021); CDC WONDER Online Database, Underlying Cause of Death (Jun. 2021); California Dept. of Finance, Population Estimates and Projections (Jul. 2021). Data downloaded from KidsData.org: https://www.kidsdata.org/topic/213/suicide-rate/table#fmt=2772&loc=2&tf=134,125,122,120,93,86&sortColumnId=0&sortType=asc.

groups (16.1 percent of Black Californians versus 23.1 percent of white, 23 percent of Asian and 29 percent of Latino Californians).[14]

- **Individuals who are justice-involved experience substantially higher rates of mental health conditions and substance use disorders, and often end up incarcerated because of those conditions.** In California, close to one in three adults in prison (30 percent) received mental health services in 2017, more than doubling the rate since 2000. Jails typically have even higher rates of individuals living with mental health and substance use disorders, largely because people may have been arrested and incarcerated for nuisance crimes associated with their conditions (e.g., erratic behavior due to psychosis, possession of illicit drugs). While rates vary by jail and over time, a conservative estimate is that more than 60 percent of adults in jail have a substance use disorder and a quarter to a third have a serious mental illness. Further, data suggest that over half of all youth in the county-based juvenile justice system in California have an open mental health case.[15]

- **Many California residents with a behavioral health condition experience challenges in obtaining get treatment.** Among Californians seeking mental health services, more than four in ten (43 percent) reported that it was somewhat or very difficult to secure an appointment with a provider who accepts their insurance. By contrast, 15 percent of Californians seeking physical health services reported that it was somewhat or very difficult to find a provider who accepted their insurance.[16] As much as one third or more of individuals with serious mental illness who are enrolled in Medi-Cal do not receive any Medi-Cal specialty mental health services.[17] Similar issues arise with respect to those with substance use disorders; nationally, nearly 90 percent of people living with a substance use disorder do not receive treatment, and, in California, the rate at which residents accessed treatment for a substance use disorder declined during the pandemic.[18] In some instances, people with significant

---

[14] The 2021 CHCF California Health Policy Survey." California Health Care Foundation. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

[15] "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," California Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/wp-content/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[16] "The 2021 CHCF California Health Policy Survey," California Health Care Foundation, January 2021. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

[17] Less than 4 percent of adult Medi-Cal beneficiaries in California received a specialty mental health service in 2019. Analysis of Medi-Cal claims data suggests that some 6.3 percent of Medicaid beneficiaries had SMI in 2019, implying that many adult Medi-Cal beneficiaries with SMI fail to receive treatment.

[18] Henretty, Kirsten et al. "Impact of the Coronavirus Pandemic on Substance Use Disorder Treatment: Findings from a Survey of Specialty Providers in California." Substance Abuse: Research and Treatment. January 2021. doi:10.1177/11782218211028655.

behavioral health needs who seek care may be rejected because their needs are deemed to be "too severe," or because they have a history of incarceration or behaviors that providers decide make them ineligible for their programs and treatment initiatives.

- **Medi-Cal plays a significant role in covering individuals living with serious mental illness and substance use disorders.** The rate of serious mental illness among Medicaid enrollees nationally is nearly double the rate among individuals with other sources of insurance and is also higher than the rate among individuals who are uninsured.[19] Medi-Cal claims data suggest that this trend holds in California as well. For close to half of California residents with a substance use disorder, Medi-Cal is the primary source of coverage.[20]

- **County-level variation in the prevalence of behavioral health conditions is marked.** Given the vast differences across California in the economic and demographic characteristics of county residents, there are sizable differences in the county-level rate of behavioral health conditions. Among Medi-Cal enrollees, the rate (as reflected in claims data) of serious mental illness by county ranges from a low of 4.1 percent to a high of 12.1 percent; substance use disorder ranges from 2.1 percent to 8 percent; and SED ranges from less than 1 percent to 7.8 percent.[21] Higher rates of SUD among Medi-Cal enrollees in some counties are correlated with greater loss of life—five of the 10 counties with the highest rates of substance use disorder among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall drug-overdose death rates in 2020.[22]

Key Issues and Opportunities

The assessment describes existing challenges and key opportunities across the state to improve prevention services and treatment options. The key issues and opportunities that emerged from the assessment are described below. Many of them already are a focus of DHCS' behavioral health agenda, offering an important and timely opportunity to continue to address these challenges.

---

[19] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[20] National Health Law Program. Substance use Disorders in Medi-Cal: An Overview. https://healthlaw.org/resource/substance-use-disorders-in-medi-cal-an-overview/#_ftn1.

[21] While there are limitations on how claims-based data can be used, they likely serve as a relatively reliable proxy of county-level variation. See appendix C for additional information regarding the limitations of these claims-based measures.

[22] Data on drug overdose death rates from California Overdose Surveillance Dashboard: https://skylab.cdph.ca.gov/ODdash/

It is critical to have a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

The assessment highlights the importance of a comprehensive effort to develop a continuum of prevention and crisis services, building on the many existing initiatives that already are underway. Crisis services are a critical part of the broader behavioral health care continuum. If working as intended, they can offer timely help to people in crisis, contribute to people receiving services in the least restrictive setting, minimize strain on EDs and hospitals, and reduce and change the role of law enforcement in responding to mental health and substance use crises.

The majority of California's county behavioral health agencies consider it a high priority to build out crisis services. In most instances, they are looking to establish models that offer 24/7 services, 365 days a year, and connect to the new 988 line for suicide prevention and mental health crises slated to go into effect on July 1, 2022. Notably, there is strong interest using crisis services to prevent a deterioration in people's conditions and to connect people to long-term resources, not simply to stabilize people in the current moment.

Community-based living options are essential for people living with serious mental illness and/or a substance use disorder.

Community treatment capacity, stories of long waits in the ED and people staying in inpatient psychiatric hospitals for lengthy periods are some of the most apparent challenges in California's behavioral health system. Tthe assessment highlights the importance of responding to these urgent needs and developing a strategy for finding ways to help people to live independent and meaningful lives in their communities. In line with DHCS's broader vision for the California Advancing and Innovating Medi-Cal (CalAIM) initiative, this requires a fundamental shift toward whole-person care that is rooted in the priorities of the people served by the behavioral health system. For many people experiencing significant behavioral health issues, this means determining where they want to live, finding ways to connect with others, becoming employed and participating in meaningful activities that facilitate community integration.

Central to this issue is the statewide housing shortage, especially affordable housing accompanied by supports for people living with significant mental illness or substance use disorders (i.e., supportive housing). Nearly all counties reported acute needs for housing and housing support services across the board, ranging from affordable units to permanent supportive housing options that provide wraparound behavioral health services. According to a number of focus group participants, the lack of a range of housing options and supports for individuals and families with behavioral health needs perpetuates a costly cycle of avoidable ED visits, inpatient stays, long-term residential placements or incarceration. Focus group participants also flagged the need for supported employment services to help individuals obtain and maintain jobs in their communities. It is important to note that California has made significant investments in recent years to bolster the state's supply of affordable housing and key DHCS initiatives

that are underway – such as CalAIM and the Home and Community-Based Services Plan – aim to strengthen support services.

More treatment options are vital for children and youth living with significant mental health and substance use disorders.

The assessment highlights the importance of efforts already underway to improve treatment services for children and youth, including California's new Children and Youth Behavioral Health Initiative and DHCS's work in collaboration with the Department of Social Services to support children and youth at risk of entering or already enrolled or graduated from the foster system.

With the COVID-19 pandemic illustrating the critical role of school and community for children and youth, stakeholders repeatedly raised the need for outpatient and intensive outpatient services that can be delivered in and linked to schools, via telehealth or through intensive in-home services that allow children to remain with their families. When residential treatment is required, there currently is a dearth of options, especially for youth living with a substance use disorder, which often results in them being sent far away from their families to other counties or even other states. SB 855, California's relatively new law requiring state-regulated insurance plans to offer medically necessary mental health and substance use disorder services, is expected to improve the availability of necessary care for children and youth with private coverage, as are the investments within the Children and Youth Behavioral Health Initiative.

Prevention and early intervention are critical for children and youth, especially those who are at high risk.

With rising stress on families, devastating trends in youth suicide rates, and reports of increasing hospitalizations of children and adolescents for mental health conditions, stakeholders also raised the importance of prevention and "upstream" efforts, beginning with infants and young children. California has a number of efforts underway in this arena on which to build, including new Medi-Cal coverage of dyadic therapy for families with children; a first-in-the-nation initiative to promote screening for Adverse Childhood Experiences (ACEs); and, via the Children and Youth Behavioral Health Initiative, a virtual platform and other preventive resources available to all children and youth regardless of their source of insurance. Schools were identified as a vital resource for preventive and early intervention activities. Currently, just slightly over half of counties have at least one school-based health center that offers mental health services;[23] however, most counties are providing some form of mental health services in schools. These centers and additional school-linked services can provide support to children and youth living with anxiety, depression and other conditions, as well as offer support groups and other resources to a much broader group of students who are experiencing

[23] Data provided by the California School-Based Health Alliance via personal correspondence in July 2021.

grief, loss or stressful events such as discrimination or family stress and do not have a diagnosed condition.

Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.

A consistent theme in the assessment is the importance of culturally responsive services across the continuum of care that meets the needs of people of varied genders, sexual orientations, races, and ethnicities. This requires using California's workforce initiatives to ensure that there is a strong focus on recruiting and retaining a diverse set of providers , such as is the focus with many of the workforce programs through the Department of Health Care Access and Information. Many stakeholders also noted that California's new option for counties to offer peer support services in Medi-Cal may make it more likely that enrollees will be able to see providers who share some of their life experiences, such as language and cultural background. Along with a focus on addressing racial and ethnic disparities in all initiatives and policymaking, targeted initiatives are needed for marginalized populations akin to the work already underway in AI/AN communities to expand medications for addiction treatment (also known as medication-assisted treatment, or MAT) through the Tribal MAT project.

More broadly, the importance of addressing disparities in behavioral health and strategies for doing so have been elevated by the California Reducing Disparities Project (CRDP). CRDP is a statewide policy initiative to reduce mental health disparities among historically unserved and underserved communities. Phase I of the project focused on development of a strategic plan for addressing mental health disparities along with population-specific assessments and recommendation reports for five priority populations -- Black, Asian and Pacific Islander, Latino, American Indian/Alaska Native and LGBTQ+. Now in Phase II, CRDP is in the process of implementing and evaluating 35 community-defined evidence practices (CDEPs) delivered by community-based organizations (CBOs) that provide culturally and linguistically competent prevention and early intervention mental health services to priority populations.

More can be done to encourage evidence-based and community-defined practices are used consistently and with fidelity throughout California's behavioral health system.

The assessment highlights the importance of embracing and making full use of evidence-based treatments that can greatly improve lives when implemented broadly and with fidelity. Options for consideration include contingency management for stimulant use disorders; supported employment; supportive housing; Assertive Community Treatment (ACT) teams and Forensic Assertive Community Treatment (FACT) teams; first-episode psychosis initiatives; specialized eating disorder protocols; and MAT. A number of individual California counties and providers offer one or more of these services, but they are not yet available with fidelity on the scale required to support optimal care for Californians.

DHCS has focused on spreading many of these practices in recent years, such as via the California MAT Expansion Project, but more can be done. Currently, for example, many counties still lack sufficient providers with waivers to prescribe MAT. Multi-disciplinary teams that provide ACT are not a covered benefit in Medi-Cal despite their established effectiveness in helping people living with serious mental illness remain in the community. Many other evidence-based approaches such as First Episode Psychosis (FEP) programs are offered in some regions of the state or in highly specialized programs but would be more impactful if more broadly available. DHCS is proposing a pilot program to offer contingency management to Medi-Cal enrollees with a stimulant use disorder beginning July 1, 2022, which is expected to propel broader dissemination of this key practice. Beyond specific models of care, there is significant interest in expanding the use of evidence-based approaches to therapy, including CBT and DBT. These modalities have a strong evidence base and can be effective for individuals with mild to moderate conditions, as well as for those with more serious mental illness and substance use disorders.

In addition to expanding coverage and access to EBPs across the state, DHCS also recognizes the importance of sustaining community-defined practices that reflect a "bottom up" locally-grown approach for behavioral health interventions. Under this model, community-based practitioners develop interventions that are geared toward a specific community or population and are often culturally grounded. Examples of community-defined practices include Sister Circles – offering social support that creates a safe and encouraging space for Black women to engage in collective healing.

More effectively addressing the behavioral health issues—and related housing, economic and physical health issues—of individuals who are justice-involved is critical.

Stakeholders repeatedly underscored the importance of finding more effective ways to avert the unnecessary incarceration of individuals for mental health and substance use disorders—such as through changes to the crisis system noted above—as well as to ensure that when these individuals are released, they are connected to services and supports. Cal-AIM advances this goal by requesting federal approval to expand coverage for certain Medi-Cal services in the 90 days prior to release from jail or prison or a juvenile justice facility, and provide a 30-day supply of medication as well as durable medical equipment needed post-release. There is deep interest in DHCS' initiative to secure federal approval to offer services to individuals who are justice-involved. A number of counties already have such efforts underway. Beyond reimbursement for services provided to individuals while incarcerated and ensuring a supported reentry, counties and other stakeholders highlighted the importance of building out the network of providers who are trained and equipped to work with these individuals.

******

Many more findings and data are included in the full report, as well as a discussion of the implications of the data and recommendations made by various stakeholders for how DHCS and other state agencies can respond. In the months and years ahead,

DHCS will continue to review and update these findings to inform its process for implementing existing initiatives and in developing new ones. DHCS will continue to work with a wide array of stakeholders – consumers, families, providers, payers and more – that share the strong interest in improving California's behavioral health system for all.

II. Introduction

Over the past several years, the State of California has made significant investments to strengthen its behavioral health system (inclusive of mental health and substance use disorder (SUD)) (see description of investments in callout box later in this section) through implementation and planning several major initiatives for all Californians regardless of their insurance status. These include:

- Investing over $2 billion for competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources (BHCIP).
- Dedicating over $4 billion to behavioral health care for California's children and youth (the Children and Youth Behavioral Health Initiative), including: building a virtual care services platform; making historic investments in school behavioral health services; expanding the behavioral health workforce; launching a public education campaign; scaling evidence-based behavioral health services across the state; empowering youth and incorporating youth voice; and other significant investments in children and youth well-being.
- Expanding crisis services, including new mobile crisis infrastructure grants, and supporting the statewide suicide and mental health crisis response line network
- Funding housing for people who are experiencing homelessness or at risk of homelessness due to behavioral health issues, age, or disability.
- Making significant investments – hundreds of millions of dollars – into the foster care system since the inception of Continuum of Care Reforms, of which a portion is to support behavioral and mental health initiatives.
- Investing across several years, through the Department of Health Care Access and Information, in health and behavioral health workforce, including increasing the number of behavioral health providers in the state, expanding the diversity of providers, and targeting providers to the most underserved communities.

For the 14 million people in California enrolled in Medi-Cal (the state's Medicaid program),[24] DHCS is simplifying and strengthening behavioral health services as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, a multiyear effort to support integrated, whole-person care.

The State's sharp focus on behavioral health and its recent investments reflect the urgent and growing need for the prevention and treatment of behavioral health

[24] Medi-Cal Enrollment, Monthly Statewide Medi-Cal Enrollment, California Department of Health Care Services, June 2021. Available at https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx.

conditions among California's residents. The challenges existed before COVID-19, and the pandemic has further increased the importance of addressing them. It has exposed areas for improvement in the behavioral health care continuum, expanded the need for services due to isolation and stress, exacerbated workforce shortages, and shone a spotlight on inequities in the need for and access to all forms of health care. Between April and June 2020, nationally the rate of people reporting symptoms of anxiety and depression tripled compared with the previous year.[25] The impact of COVID-19 on Black, Indigenous and People of Color communities was even more stark, with Black and Latino adults experiencing significantly higher rates of anxiety and depression than white adults.[26] For children, the pandemic highlighted that their mental health and well-being are inextricably linked to their families, schools and communities, bringing renewed attention to the importance of family- and community-based behavioral health services.

With behavioral health a top priority of the Newsom administration, many major behavioral health initiatives underway, new federal funding opportunities, and escalating demand for more behavioral health services, it is the optimal time for DHCS to produce an updated assessment of California's behavioral health system. The assessment is designed to serve as a resource for DHCS and other stakeholders as the work continues to improve California's behavioral health system. It will inform various DHCS initiatives, including the BHCIP and plans to submit a Section 1115 Medicaid demonstration waiver in 2022 to strengthen mental health services for people living with serious mental illness and children and youth living with serious emotional disturbance (i.e., the SMI/SED 1115 waiver). The federal government requires states to provide data on the availability of mental health services across the continuum as part of the application process for an SMI/SED waiver.

Specifically, the assessment aims to do the following:

- **Provide a framework** to describe the core continuum of behavioral health care services, making it possible to compare "what is" in California to "what should be."
- **Review the available data and gather insights from stakeholders and experts** on the need for and supply of key behavioral health services in California.
- **Support design and implementation of various behavioral health initiatives,** including the application to the Centers for Medicare and Medicaid Services (CMS) for an SMI/SED 1115 waiver and the BHCIP
- **Explore issues and opportunities for specific populations** – children, adolescents, and youth; American Indian/Alaska Native (AI/AN) individuals; and individuals who are justice-involved. These populations were identified by focus

[25] National Center for Health Statistics: Household Pulse Survey, Centers for Disease Control and Prevention, October 2021. Available at https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.

[26] "The Implications of COVID-19 for Mental Health and Substance Use," Kaiser Family Foundation, February 2021. Available at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

group participants in the early stages of the assessment as critical to address through an equity lens, but they should not be viewed as the only groups who warrant close attention. Many other groups are a priority for DHCS and are being addressed through other focused initiatives and analyses.

- **Discuss the implications for DHCS' work** and for California's broader efforts to strengthen the behavioral health system.

The assessment was prepared between July and November 2021 using data from existing California reports and surveys as well as California-specific information from national databases and a review of Medi-Cal administrative claims. This includes information from the Drug Medi-Cal Organized Delivery System (DMC-ODS), which provides a continuum of SUD services through participating counties. To integrate the perspectives of key stakeholders, the assessment draws from a qualitative survey of county behavioral health agencies conducted in partnership with the County Behavioral Health Directors Association of California in September 2021, interviews with 12 experts, and a series of seven focus groups conducted between July and September 2021 with providers, health plans, consumer groups and others. See Appendix C for a detailed description of the methodology.

While preparing this report, DHCS was acutely aware that the behavioral health needs of residents vary dramatically across the state, as do the options and strategies to address them. California is the most populous state in the country and one of the most geographically diverse. The state's 58 counties range in population size from 1,200 to more than 10 million. More than 800,000 individuals live in rural areas.

Unpacking DMC, DMC-ODS, and SMHS in the Medi-Cal Delivery System

DMC. Drug Medi-Cal (DMC) is a treatment funding source for eligible Medi-Cal beneficiaries. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal beneficiaries must receive SUD services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, and these regulations govern DMC treatment.

DMC-ODS. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a voluntary pilot program that provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. DMC-ODS enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. DHCS received approval on August 13, 2015, from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS Waiver. Prior to the expiration date, DHCS received a one-year waiver extension on December 29, 2020, that extends DMC-ODS through December 31, 2021.

SMHS. The Medi-Cal Specialty Mental Health Services (SMHS) program is "carved-out" of the Medi-Cal managed care program and operates under the authority of a waiver approved by CMS under Section 1915(b) of the Social Security Act. The SMHS program is administered through county mental health plans (MHPs) which are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals.

Due to realignment, which has transferred responsibility and funding from the state to counties for the administration of behavioral health services, California's counties play a major role in financing and delivering mental health and SUD services. This community behavioral health structure allows Californians to leverage the specialty system of care built by counties to respond broadly to residents' unique needs. In light of the role of counties in California's behavioral health system, the assessment focuses on the county public behavioral health safety net, provides county-specific data whenever possible, and seeks to account for differences between counties when assessing challenges and identifying strategies for addressing them.

Addressing Fragmentation in California's Public Behavioral Health System

Even though this assessment addresses the entire behavioral health "system" in California, mental health and substance use disorder services funded by public payers are currently provided through a patchwork of systems and providers. This fragmentation poses challenges for everyone, but perhaps most acutely for individuals living with co-occurring disorders. If enrolled in Medi-Cal, individuals may be confronted with multiple systems for substance use disorder and mental health services. Each has its own financing mechanisms, charting requirements, electronic health records and privacy regulations.[27] At present, individuals who also have a physical health condition—a common occurrence for individuals living with mental health and substance use disorders—must seek care from yet another source (e.g., a managed care plan or Medi-Cal's fee-for-service system). The current system is siloed and confusing for enrollees, their families, and providers. Indeed, the National Alliance for the Mentally Ill (NAMI) in California reports that difficulty in understanding and navigating a fragmented,

[27] Anthony, Susan. "In Their Own Words: How Fragmented Care Harms People with Both Mental Illness and Substance Use Disorder." California Healthcare Foundation. August 2021. Available at https://www.chcf.org/wp-content/uploads/2021/08/InTheirOwnWordsFragmentedCareMentalIllnessSUD.pdf.

county-based mental health system is a major barrier faced by family members of people living with mental illness as they work to help their loved one's secure care. [28]

DHCS is taking steps to promote better integration of care for behavioral and physical health issues, as well as community supports. Through CalAIM, DHCS will support administrative integration of mental health and substance use disorder systems; offer enhanced care management for high-need individuals, including many of those with significant mental health and substance use disorders; adopt a "no wrong door" approach to help enrollees more quickly and easily access mental health and substance use disorder services through statewide screening and transition tools; implement modified criteria for accessing specialty mental health services (SMHS) and reform behavioral health payment methodologies. All of these steps will reduce fragmentation and other barriers to care.

DHCS also is keenly aware of the importance of the multiple, largely public funding streams that finance public behavioral health services and the need to braid funding for the best use of federal, state, and local funds and to avoid duplication. These multiple funding sources include, but are not limited to: Federal Medicaid funding, the Mental Health Services Act (MHSA), federal block grant funds from SAMHSA, funding allocations from 1991 and 2011 realignment, and one-time federal resources such as State Opioid Response and American Rescue Plan Act grant funding. Other funding streams include state general funds, local funding, grants, and payments from commercial insurers.

As DHCS and other stakeholders consider how best to continue to improve the behavioral health system in California, there is a strong foundation on which to build. California has a long and rich history as an innovator in behavioral health. Across the country, it is known for the Mental Health Services Act (MHSA), which effective in January of 2005 established a one percent income tax on personal income in excess of $1 million per year. The revenue is used to help expand and transform California's behavioral health system to better serve individuals living with, and at risk of, serious mental health issues, and their families. California was one of the first states to expand its Medicaid program under the Affordable Care Act, allowing the state to provide important behavioral health services and supports to more low-income adults. California has expanded state funding to cover Medi-Cal services for undocumented children and older adults. It also was the first state to secure a Medicaid 1115 Demonstration waiver to provide a comprehensive continuum of care for SUD treatment, including services in a broader array of residential settings. More recently, California has extended its reforms to the private market, recently adopting SB 855 (see box at right), which expands the role of private insurers in covering behavioral health services across the continuum of care. The Children and Youth Behavioral Health Initiative (CYBHI) similarly seeks to transform California's behavioral health system into a world-class, up-

[28] "The 2020-2021 Annual State of the Communities Report with Families," NAMI California. Available at https://namica.org/wp-content/uploads/2021/11/NAMI-2020-21-Families-report_F-web.pdf.

stream focused ecosystem where ALL children and youth are routinely screened, supported, and served for emerging and existing behavioral health needs.[29]

Finally, it is important to highlight some of the major limitations of this assessment, which are explored further in Appendix C. First, due in part to the condensed timeline on which it was produced, the assessment simply could not address all the pressing behavioral health issues confronting California. For example, the assessment only briefly discusses high-priority issues related to children and youth in foster care and the importance of providing care to individuals who are incompetent to stand trial. In addition, the data available on the need for and supply of behavioral health services is limited and of mixed quality. 0The assessment compiles much of the existing data, but many key questions remain unanswered. For example, focus group participants reported that people too often end up "boarding" in emergency departments (i.e., staying under watch without receiving treatment while they await a placement elsewhere) for days and sometimes even weeks. However, statewide data on the number and length of boarding incidents are not available.

Given these limitations, it is important to highlight that the assessment is not a set of policy recommendations, nor is it a description of DHCS' plans for specific behavioral health initiatives. While it offers valuable information, the assessment is not intended to serve as the sole source of information for DHCS; the Administration will continue to rely on a variety of data sources, stakeholder feedback and additional analyses as it implements behavioral health initiatives. DHCS will offer further information and opportunities for stakeholder input on specific initiatives and policy changes in the months ahead.

Mental Health Parity Act

On September 25, 2020, Governor Newsom signed Senate Bill 855 which strengthens coverage of mental health and substance use disorder (MH/SUD) treatment and applies to all California health plans and disability insurance policies issued, amended, or renewed on or after January 1, 2021. Among other changes, SB 855:

- Expands the scope of required MH/SUD services that plans must cover under the same terms and conditions applied to other medical conditions
- Defines medically necessary treatment and requires the medical necessity determinations be consistent with generally accepted standards of care.
- Establishes new obligations for payors to arrange for out-of-network coverage of MH/SUD services if medically necessary treatment is not available in network.

[29] California Health and Human Services Agency, Children and Youth Behavioral Health Initiative, May Revision 2021-22, https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

- Prohibits plans and insurers from limiting MH/SUD benefits or coverage to short-term or acute treatment.

Bill Text - SB-855 Health coverage: mental health or substance use disorders.

Major New and Planned Behavioral Health Initiatives
New Initiatives
• CalAIM, which modernizes, improves, and simplifies Medi-Cal's behavioral health system,30 including the criteria to access SMHS, payment reform, and payment methodologies and mechanisms. It will also help Medi-Cal enrollees secure better-integrated care across physical health, mental health, SUD treatment and community supports.[31]
• Pre-release and reentry services included in the CalAIM proposal to strengthen behavioral health supports for the justice-involved population as part of CalAIM, including MAT, pre-release services to help individuals receive needed services before they return to the community, and connection to ongoing services, including those with mental illness, substance use disorders and complex medical conditions.[32]
• The Children and Youth Behavioral Health Initiative (CYBHI), which encompasses a broad set of initiatives to transform the behavioral health continuum of care for children and youth across all payers by investing over $4 billion in community- and school-linked services and infrastructure, virtual care service platforms, expansion of evidence-based care delivery practices, workforce development and training, program coordination and evaluations, and public awareness and education campaigns.[33]
• The Behavioral Health Continuum Infrastructure Program (BHCIP), which provides $2.2 billion in funding. Starting in fiscal year 2021-22, DHCS will award over $2 billion for competitive grants to counties, tribal entities, and nonprofit and for-profit entities to build new or expand existing capacity in the continuum of public and private behavioral health facilities, including Crisis Care Mobile Units. Funding will be only for new or expanding infrastructure (brick-and-mortar projects) and not direct care delivery.[34,35]
• The California Department of Social Services Community Care Expansion Program will fund the acquisition, construction and rehabilitation of adult and senior care

[30] These programs include services provided through Medi-Cal managed care plans, SMHS, Drug Medi-Cal (DMC) and DMC-ODS.

[31] See CalAIM Proposal, https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf.

[32] CalAIM In Lieu of Services Informational Webinar.

[33] California Health and Human Services Agency, Children and Youth Behavioral Health Initiative, May Revision 2021-22, https://cdn-west-prod-chhs-01.dsh.ca.gov/chhs/uploads/2021/05/CHHS-Children-and-Youth-Behavioral-Health-Initiative-May-Revision-2021-22-Detailed-Proposal-FINAL.pdf.

[34] "Behavioral Health Continuum Infrastructure Program and Community Care Expansion Listening Session," DHCS, October 2021. Available at https://ahpnet.adobeconnect.com/p5w2e0xlbaxx/.

[35] "Request for Application: Crisis Care Mobile Units Program," DHCS, August 16, 2021, Available at https://www.dhcs.ca.gov/Documents/CSD_YV/BHRRP/DHCS-Mobile-Crisis-and-Non-Crisis-RFA-7-22-21.pdf.

facilities that serve applicants and recipients of Supplemental Security Income (SSI), including individuals who are disabled, seriously mentally ill, or at risk of or experiencing homelessness.

- The Behavioral Health Integration Incentives Program, which incentivizes improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed care plan network.[36]
- The California MAT Expansion Project, which aims to increase access to MAT, reduce unmet treatment need and reduce opioid overdose–related deaths through the provision of prevention, treatment and recovery services.[37] The program helps ensure integrated SUD treatment across populations and treatment settings, including in jails, prisons, emergency departments, hospitals, primary care clinics and mental health clinics.
- The California Bridge Program, investing $60 million ($20 million through State General Fund and $40 million through the Home and Community-Based Services Spending Plan) to support MAT integration in emergency departments and support the role of behavioral health navigators to engage patients and connect them with ongoing treatment.
- The development of programs and services to address the behavioral health needs of AI/AN individuals, including the Tribal MAT Project, which aims to promote opioid safety, improve the availability and provision of MAT, and facilitate wider access to naloxone with special consideration for Tribal and Urban Indian values and culture, and the inclusion of traditional healers and natural helpers as part of CalAIM.[38]
- CalHOPE, a crisis counseling assistance and training program funded by the Federal Emergency Management Agency, which delivers crisis support for communities impacted by a national disaster through free outreach, crisis counseling and support services, including a 24/7 phone line, online chat options, a public communications campaign and student support.[39]
- Dyadic treatment—two-generation program that provides services and benefits to children and their primary caregivers—for families of children enrolled in Medi-Cal, without requiring the child to have a diagnosis.[40] This recent policy affirms the state's commitment to providing preventive behavioral health care services to young children in order to prevent a behavioral health related diagnosis. Similarly, Medi-Cal

[36] "Behavioral Health Integration Incentive Program Application," DHCS, https://www.dhcs.ca.gov/provgovpart/Pages/VBP_BHI_IncProApp.aspx.

[37] "The California MAT Expansion Project Overview," DHCS, Available at https://www.dhcs.ca.gov/individuals/Pages/State-Targeted-Response-to-Opioid-Crisis-Grant.aspx.

[38] "Tribal MAT Project," MAT Expansion Project. Available at http://www.californiamat.org/matproject/tribal-mat-program/.

[39] "CalHOPE," DHCS, Available at https://www.calhope.org/Pages/default.aspx.

[40] 2021-22 Governor's May Revision Budget, Department of Health Care Services, Available at https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2021-22-MR-Highlights.pdf.

also covers family therapy for adults living with a mental health condition as well as for children under age 21 who have a mental health condition or who have a history of risk factors, such as death of a parent/guardian, foster home placement, or separation from a parent/guardian due to incarceration or immigration.[41]

- A $20 million investment to build capacity for California's National Suicide Prevention Lifeline centers to develop the 988 network, a robust statewide alternative to 911 for individuals who are feeling suicidal or seeking help for a behavioral health crisis.[42]
- New Peer Support Services benefit in Medi-Cal, effective July 2022, allowing people with lived experience to provide specialty mental health and substance use disorder treatment services in counties that are able to fund this service expansion.
- The Mental Health Services Oversight and Accountability Commission Student Mental Health Initiative, which provides grants for partnerships between county mental health agencies and local education agencies to deliver school-based mental health services to young people and their families. These partnerships support outreach to identify early signs of unmet mental health needs, reduce stigma and discrimination, and prevent unmet mental health needs from becoming severe and disabling.
- The 2018-19 State Budget included $100 million over three years and the Budget Act of 2021 allocated an additional $47.6 million dollars to support an expansion of the California Department of State Hospitals Diversion Program. The funds will be used by county pre-trial mental health diversion programs for individuals living with serious mental illness who are deemed incompetent to stand trial.

Planned Initiatives

- A planned Medicaid 1115 demonstration waiver to expand care for adults living with serious mental illness (SMI) and children and youth living with serious emotional disturbance (SED). If approved by the Centers for Medicare & Medicaid Services (CMS), it will allow California to secure federal Medicaid matching funds for additional mental health treatment options, including services in a broader array of residential and community settings.
- New opportunities for counties to establish or expand mobile crisis services for Medi-Cal enrollees using enhanced federal funding available under the American Rescue Plan Act of 2021 (ARPA), beginning on or after April 1, 2022.[43]
- Plans to pilot contingency management within outpatient treatment settings as part

---

[41] "Psychological Services," Department of Health Care Services. Available at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol.pdf.

[42] "California Dedicates $20 Million to Support New Mental Health '988' Crisis Hotline," DHCS, September 3, 2021, Available at https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2021/21-06-988-Line.pdf.

[43] "American Rescue Plan Provides a New Opportunity for States to Invest in Equitable, Comprehensive and Integrated Crisis Services," State Health & Value Strategies, April 30, 2021, Available at https://www.shvs.org/american-rescue-plan-provides-a-new-opportunity-for-states-to-invest-in-equitable-comprehensive-and-integrated-crisis-services/.

of Medi-Cal's DMC-ODS program. Contingency management, which promotes healthy behaviors through positive reinforcement, is the most effective treatment option for many individuals living with stimulant use disorder.

- Providing Access and Transforming Health funds, which will support a multiyear effort to shift delivery systems and advance the coordination and delivery of services for individuals who are justice-involved (supporting pre-release and reentry proposals) and supporting a significant expansion of the system of care for homelessness.
- Community-Based Residential Continuum Pilots for Vulnerable, Aging and Disabled Populations funding, which will provide medical and supportive services in the home, independent living settings and community care settings, including for people living with behavioral health conditions.
- Housing and Homelessness Incentive Program, as part of the state's overarching home and community-based services (HCBS) spending plan, managed care plans can earn incentive payments for investments and progress in addressing homelessness and keeping individuals housed. Managed care plans will earn funds by meeting specified metrics and will also need to develop a homelessness response plan in partnership with local entities (e.g., public health, county behavioral health public hospitals, social services, etc.) on how incentive payments would be integrated into the homeless system.

III. Framework for a Core Continuum of Care

For this assessment, DHCS established a set of principles and defined a core continuum of behavioral health services, making it possible to compare "what is" in California to "what should be." The framework is based in part on national models such as SAMHSA's "Description of a Good and Modern Addictions and Mental Health System" (see the Appendix C for more details).[44] It also reflects DHCS' review of earlier work done in California, the insights of California stakeholders and experts, and the lessons emerging from the COVID-19 pandemic and other recent events in California.

3.1 Key Principles

The framework for assessing the behavioral health system in California was informed by the following principles:

- **Person centered.** It is important that people who live with mental health and substance use disorders are at the center of the behavioral health system. This means that their lived experiences and personal priorities should be paramount when it comes to defining the optimal continuum of care, as well as that they have a key role to play in shaping behavioral health policies and practices. It will require active listening by DHCS and other agencies charged with designing and implementing policies in partnership with those whose lives are affected by them.

- **Focus on equity.** All care provided under the continuum should be designed and delivered in a way that actively addresses disparities by race, ethnicity, ability, sexual orientation, and gender identity. This includes examining where providers are located, investing in a diverse behavioral health workforce, and addressing racism and discrimination with a specific focus on individuals who are experiencing homelessness, justice-involved and other populations who are disproportionately impacted by systemic racism and discrimination.[45]

- **Least restrictive setting.** Services always should be provided in the least restrictive setting that is appropriate for the care and supports needed. While it sometimes is necessary for people to receive inpatient or residential services, the unnecessary use of an inpatient or residential bed is a powerful signal that more community-based and crisis services are required (including housing supports and other community supports).

---

[44] "Description of a Good and Modern Addictions and Mental Health Service System," SAMHSA, April 2011. Available at https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

[45] "Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S.," SAMHSA, Accessed October 20, 2021. Available at https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf.

- **Full array of services.** The core continuum of care should include a full range of services and provider types for both children and adults are identified, reflecting that many people may require only preventive or outpatient services while some people may at times need short-term residential or hospital-based care to keep them safe and/or to address physical health issues. It also requires looking beyond medical care alone to consider community supports and the importance of housing, food, employment, connection, and community.

The Importance of Telehealth

During the pandemic, telehealth services emerged as an important option for patients unable to access in-person services. Between 2019 and 2020, there was a 25-time national increase in the total volume of behavioral health–related telehealth visits.[46] During the pandemic, approximately 50 percent of mild to moderate mental health services were delivered through telehealth to enrollees 21 years and older.[47]

Building on this momentum, California is actively removing policy barriers to telehealth utilization and reimbursement. In addition, the pandemic prompted DHCS to issue grants for providers to allow purchase of telehealth equipment. In June 2020, DHCS launched a new broadband benefit for individuals with Medi-Cal seeking to use telehealth services. The Federal Communications Commission Emergency Broadband Benefit provides all Medi-Cal beneficiaries up to $50 of assistance per month to cover internet costs.

As work on improving behavioral health services continues in California, it will be important to consider how the changing landscape of telehealth services can continue to be used to strengthen mental health and substance use disorder services even after the pandemic has further receded.

- **Family-based care.** The care provided throughout the continuum should reflect the central role of families and communities in the mental health and well-being of individuals. For children and youth in particular, it is critical that they are treated in the context of their families and that their parent(s) or guardian(s) receive help with behavioral health issues for the sake of their own well-being and because of the effect on their children's social and emotional health.
- **Community-based, whole-person care.** Consistent with the CalAIM initiative's focus on whole-person care, behavioral health services should be integrated with physical health services, oral care and community supports, especially given the high rate of comorbidities among those with mental health and substance use disorders. For many people living with a behavioral health condition, housing, meals, employment assistance and community-based connections that address

[46] "Insights on utilization of behavioral health services in the context of COVID-19." McKinsey & Company. Accessed October 28, 2021. Available at https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/insights-on-utilization-of-behavioral-health-services-in-the-context-of-covid-19.

[47] California Department of Health Care Services, Stakeholder Advisory Committee Meeting, February 11, 2021. Available at https://www.dhcs.ca.gov/services/Documents/SAC-presentations-021121.pdf.

isolation are as important to health and well-being as are more traditional services.

- **Culturally responsive care.** It is critical that services be provided in a culturally responsive way to meet the needs of individuals, considering their personal priorities, age, race, ethnicity, sexuality, gender identity and other salient factors. This encompasses the need for linguistically appropriate care as well as, more broadly, the importance of providers of behavioral health services being aware of, trained in and/or share exposure to racism, trauma (historical and individual), discrimination, stigma, incarceration and other foundational experiences.
- **Prevention and early intervention.** A strong focus on prevention and early intervention is foundational to the continuum, including public health– and community-based initiatives that recognize the importance of building resilience and coping skills for all California residents. Starting early can prevent worsening of problems that can cause harm to individuals and their families.
- **Strong and well-trained workforce.** The continuum of care should support a diverse, well-trained, and appropriately paid workforce that includes peers, community-based practitioners and other individuals who have lived recovery experiences. It is important that the behavioral health workforce reflect California's diversity, allowing people to receive care from people who speak their language and share their culture, and that the workforce receives ongoing training and support in implementing evidence-based treatments.
- **Data-driven and evidence-based treatments.** California's behavioral health system should reflect the latest data and research on what works and what does not when it comes to prevention and treatment. Even if it requires making uncomfortable changes, it is critical to identify and implement evidence-based practices such as contingency management for individuals living with stimulant use disorder, Assertive Community Treatment (ACT) teams and multisystemic therapy. Just as important is gathering and using data to evaluate the impact of policy and program changes and pivoting when needed.
- **Locally tailored.** The continuum of care should reflect California's geographic diversity, which includes densely populated urban areas and sparsely populated rural regions. California's county- and tribal entity-led systems of care already provide a strong local base and focus, but care delivery can be further tailored based on the local community's needs, such as through the use of telehealth, regional providers and centers of excellence.

3.2 Core Continuum of Care

The core continuum of care used for this assessment includes a variety of types of services with different levels of intensity that should be available and easily accessible to all individuals. It emphasizes the role of "upstream" behavioral health services that maximize well-being and recovery; promote resiliency and community-based care; and minimize utilization of crisis services, emergency departments, inpatient admissions, incarceration, and involvement with the criminal and juvenile justice systems. The continuum also recognizes that individuals may take advantage of services throughout the continuum at any point in time. For example, an individual may receive outpatient therapy, peer support services, medication-assisted treatment for opioid use disorders

and clinically managed, low-intensity residential services simultaneously. In addition, services that are depicted in a single service category in the continuum may be provided across multiple levels of care in the continuum below. For example, peer services can be provided as part of outpatient services, crisis services and intensive outpatient treatment services. The core continuum of care includes the following and is illustrated in Figure 1b:

- **Prevention and wellness services** for mental health and substance use issues, including services, activities and assessments that help identify individuals at risk of a mental health or substance use disorder; offer communities, families and individuals support in coping with stress and trauma; disseminate information on ways to promote resiliency; and discourage risky behaviors.
- **Outpatient services**, including a variety of traditional clinical outpatient services such as individual and group therapy and ambulatory detoxification services.
- **Peer and recovery services** delivered in the community that can be provided by individuals with lived experience, including young adults and family members.
- **Community supports**, including flexible services designed to enable individuals to remain in their homes and participate in their communities, such as supportive housing, case management, supported employment and supported education.
- **Intensive outpatient treatment services**, including services such as Full-Service Partnerships, ACT, and substance use intensive outpatient services that are delivered using a multidisciplinary approach to support individuals living with higher-acuity behavioral health needs.
- **Residential treatment** provided on a short-term basis to divert individuals from or as a step-down from intensive services.
- **Crisis services**, including a range of services and supports such as crisis call centers, mobile crisis services and crisis residential services that assess, stabilize, and treat individuals experiencing acute distress who may require hospitalization.
- **Intensive treatment services** that are provided in structured, facility-based settings to individuals who require 24 hour/7 days per week care, including inpatient psychiatric treatment and clinically managed inpatient services.

In addition, withdrawal management (WM), or detoxification, services, are provided across multiple levels of care to provide short-term supervision and assistance to people who are reducing or terminating the use of a substance on which they are physically dependent. These services are critical to preventing or alleviating medical complications associated with reducing or terminating use of a substance.

It is important to note that the continuum includes some services for which data are not yet available for a variety of reasons. These data are either not collected, difficult to analyze (due to the complex distribution of California's licensing and certification authorities across several departments) or of poor quality. As a result, some of the services are not described in detail in this assessment. Even for services for which data are available, there sometimes are significant issues with the quality and scope of the data, making it important to review all caveats and qualifications associated with the data presented in the assessment. For details, see the Appendix C.

Figure 1b. **Core Continuum of Care**

Prevention and Wellness Services

Prevention and wellness services, including services, activities and assessments that educate and support individuals to maintain healthy lifestyles and prevent acute or chronic conditions, like wellness checks and health promotion activities

- Primary care wellness checks
- General health screens, tests, and immunization
- Health promotion activities
- Wellness Centers

Outpatient Services

Outpatient services, including a variety of traditional clinical outpatient services like individual and group therapy, ambulatory detoxification services

- Assessment
- Specialized Evaluations (psychological, neurological)
- Service planning
- Individual evidenced based therapies (e.g., contingency management, CBT)
- Group therapy
- Family therapy
- School based mental health services*
- Medication management
- Narcotic treatment program*
- SUD Pharmacotherapy (including OBOTs)*
- Laboratory service

Peer and Recovery Services

Peer and recovery services delivered in the community that can be provided by individuals with lived experience, including young adults and family members

- Peer support
- Family support
- Recovery support coaching
- Peer-based respite services
- Recovery housing

Community Services and Supports

Community supports include flexible services that are designed to enable individuals to remain in their homes and participate in their communities, like supported housing, case management, supported employment and supported education

- Parent/caregiver support
- Skill building (social, daily living, cognitive)
- Case management
- Behavioral management
- Supported employment
- Supported education
- Permanent supported housing/tenancy supports/other housing supports*
- Therapeutic mentoring
- Traditional healing services
- Consumer/family education
- Consultation to caregivers

Intensive Outpatient Treatment Services

Intensive outpatient treatment services including services such as ACT and substance abuse intensive outpatient services that are delivered using a multi-disciplinary approach to support individuals with higher acuity behavioral health needs

- Full Service Partnership (FSP) Programs
- Assertive community treatment*
- Intensive home-based treatment
- Multi-systemic therapy
- Intensive case management (e.g., High Fidelity Wraparound)
- Substance abuse intensive outpatient services*
- Partial hospitalization*
- Day Treatment
- Ambulatory withdrawal management (Level 1 WM and Level 2 WM)*

Intensive Outpatient Treatment Services

SUD residential treatment provided in short-term residential settings to divert individuals from or as a step-down from intensive services

- Clinically managed low-intensity residential services (ASAM level 3.1)*
- Clinically managed population specific high-intensity residential services (ASAM level 3.3)*
- Clinically managed high-intensity residential services (ASAM level 3.5)*
- Clinically managed residential withdrawal management (ASAM level 3.2-WM)*
- Residential services specific to perinatal population
- Adult mental health residential
- Children's mental health residential services
- Mental health rehabilitation centers (MHRC)*
- Short-term residential therapeutic program (STRTP)*

Crisis Services

Crisis services include a range of services and supports, such as crisis call centers, mobile crisis services and crisis residential services that assess, stabilize, and treat individuals experiencing acute distress

- Crisis call centers
- Adult mobile crisis services*
- Youth mobile crisis*
- Family Urgent Response System
- Peer based crisis respite services
- Mental health urgent care/outpatient crisis programs
- Crisis stabilization units*
- Psychiatric emergency programs
- Adult crisis residential*

Intensive Treatment Services

Intensive treatment services are provided in structured, facility-based settings to individuals who require constant medical monitoring

- Medically monitored intensive inpatient services (ASAM level 3.7)*
- Medically managed intensive inpatient services (ASAM level 4.0)*
- Medically monitored inpatient withdrawal management (ASAM level 3.7-WM)*
- Medically managed intensive inpatient withdrawal management (ASAM level 4.0-WM)*
- Psychiatric residential treatment facility (PRTF)**
- Inpatient treatment services*
- Peer crisis respite
- Sobering centers*
- Short-term residential therapeutic program (STRTP)*

* Service where quantitative data are available and presented in the behavioral health assessment.

** California currently does not license any facilities at the PRTF level of care.

*** DHCS is rebranding the menu of 14 in lieu of services (ILOS) being launched on January 1, 2022, as “Community Supports.” Community Supports are medically appropriate and cost-effective alternatives to services or settings covered under the Medi-Cal State Plan that are optional for health plans to offer and for members to utilize.

IV. The State of Behavioral Health in California

Overall, close to one in ten California adults (9.2 percent) has a substance use disorder, and nearly one in 20 (4.5 percent) has a serious mental illness.[48] This means that there are some 2.8 million residents with a substance use disorder and 1.4 million with a serious mental illness. Many of these adults living with SMI or SUD are enrolled in Medi-Cal, which plays a particularly important role for people living with SMI and SUD. Many others receive services through county and tribal-led entities.

Private insurers cover over 21 million Californians and also play a key role.[49] However, a number of stakeholders reported that people living with the most serious behavioral health conditions – severe mental illness, serious emotional disturbance among children and youth, life-threatening eating disorders - often end up served through the public behavioral health system. A significant number, however, do not appear to be receiving any treatment for their condition(s).[50] While not unique to California, the mismatch between the need for and the availability of behavioral health services is a major reason it is critical to continue to strengthen the behavioral health system and to connect people to care. A recent national consumer study found that patients with private insurance were more likely to rate their mental health provider network ("provider network" includes physicians, clinicians, other health care professionals and their institutions that comprise the network), as inadequate compared with their medical provider network.[51] These findings coupled with the high rate of denials of claims for mental health treatment under private insurance suggests that more individuals with serious behavioral health conditions may eventually rely on the public behavioral health system for their services.[52]

This section provides highlights from an analysis of the prevalence of behavioral health conditions in California and, when available, the extent to which people appear to be receiving services for such conditions. It relies primarily on data from the National Survey of Drug Use and Health (NSDUH) to examine prevalence rates in California relative to the United States as a whole. Drawing from administrative claims data, this section also provides county-level estimates of the rate of SMI and SUD among adults

---

[48] 2018-2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA. Available at https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

[49] Kaiser Family Foundation. Health Insurance Coverage of the Total Population: https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[50] See additional information under 'Many California residents with a behavioral health condition struggle to get treatment' on page 31 for more details.

[51] Busch SH, Kyanko K. Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults with Private Insurance. *JAMA Netw Open.* 2021;4(10):e2130770. doi:10.1001/jamanetworkopen.2021.30770.

[52] N.D. Cal., No. 3:14-cv-02346-JCS, 3/5/19.

enrolled in Medi-Cal, as well as the rate of SED among children and youth in Medi-Cal. While Medi-Cal administrative claims data are valuable because they can provide county-level information, they likely understate the prevalence of behavioral health conditions; such conditions often are undiagnosed or not recorded in claims for physical health services. As such, these estimates should be treated with caution. DHCS believes they are relatively reliable for purposes of examining differences in prevalence rates across counties and key sub-populations, but they are not ideal for determining the gross number of individuals living with such conditions.

For a more detailed discussion of methods and data sources, as well as a more in-depth discussion of the results of the analysis, see Appendices B and C.

4.1 Key Findings

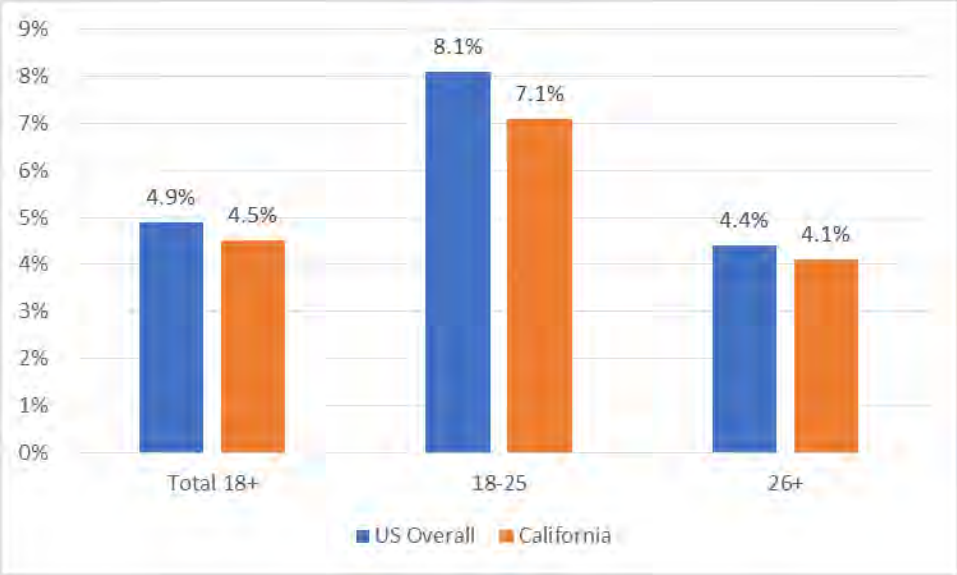
- A significant and increasing number of California residents are living with a mental health condition or substance use disorder. Relative to the country as a whole, California adults are somewhat more likely to have a substance use disorder and less likely to have a serious mental illness. The rate of serious mental illness in California has increased by more than 50 percent from 2008 to 2019. [53] A larger and growing number of California residents experience a mental, behavioral or emotional disorder (any mental illness) that does not meet the clinical threshold for SMI, which leads to functional impairment that substantially interferes with or limits one or more major life activities.[54,55] These individuals may experience mood disorders, including mild depression and anxiety, that can be treated effectively with different forms of evidence-based psychotherapy, such as CBT and DBT, which are structured treatment modalities.
- **Young adults have the highest rates of serious mental illness and substance use disorders.** Compared to other age groups, individuals aged 18 to 25 have the highest rate of serious mental illness—7.1 percent compared to 4.1 percent for all other California adults. Similarly, these young adults are nearly twice as likely to have a substance use disorder as older adults (16.1 percent versus 8.1 percent).

[53] SAMHSA. California Behavioral Health Barometer Volume 6. https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.

[54] SAMHSA. 2018-2019 NSDUH State Specific Tables. January 28, 2021. Available at https://www.samhsa.gov/data/report/2018-2019-nsduh-state-specific-tables/.

[55] SAMHSA. 2017-2018 NSDUH Model-Based Prevalence Estimates (50 States and the District of Columbia). December 18, 2019. Available at https://www.samhsa.gov/data/report/2017-2018-nsduh-state-prevalence-estimates.

Figure 3. **Percentage of Individuals Aged 18+ Living with Serious Mental Illness in California Relative to United States Overall[56]**



- Many children in California are living with a serious emotional disturbance, and behavioral health conditions and suicide rates are rising. One in 13 children in California has a serious emotional disturbance, with rates higher for low-income children and those who are Black or Latino relative to other racial and ethnic groups. In recent years, the suicide rate among youth in California has been rising, and the pandemic appears to have worsened the situation.[57] Nationwide, visits to emergency departments due to a mental health crisis have climbed by 24 percent for children between the ages of 5 and 11 and 31 percent for those ages 12 to 17.[58]
- **Marginalized groups experience higher rates of behavioral health conditions and more difficulties securing care.** As in the rest of the country, marginalized groups in California often are at higher risk for behavioral health issues but also are less likely to be able to access services. For example, AI/AN populations nationally report higher rates of posttraumatic stress disorder and alcohol dependence than any other ethnic/racial group, while Black and Latino children in California face

---

[56] Source: Based on 2018-2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates, SAMHSA. Available at https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

[57] Holzer C and Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

[58] RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3.

relatively high rates of serious emotional disturbance. At the same time, they may face additional barriers to care. Black Californians, for example, are far less likely to report receiving mental health services for themselves or a family member than other racial and ethnic groups (16 percent of Black Californians versus 23 percent of white, 25 percent of Asian and 29 percent of Latino Californians).[59]

- Individuals who are justice-involved experience significantly higher rates of mental health conditions and substance use disorders and often end up incarcerated because of those conditions. In California, close to one in three adults in prison (30 percent) received mental health services in 2017, more than doubling the rate since 2000. Jails typically have even higher rates of individuals living with mental health and substance use disorders, largely because people may have been arrested and incarcerated for nuisance crimes associated with their conditions (e.g., erratic behavior due to psychosis, possession of illicit drugs). While rates vary by jail and over time, a conservative estimate is that more than 60 percent of adults in jail have a substance use disorder and a quarter to a third have a serious mental illness. Further, data suggest that over half of all youth in the county-based juvenile justice system in California have an open mental health case.[60]
- **Medi-Cal plays a major role in covering individuals living with serious mental illness and substance use disorders.** The rate of serious mental illness among Medicaid enrollees nationally is nearly double the rate among individuals with other sources of insurance and is also higher than the rate among individuals who are uninsured.[61] Medi-Cal claims data suggest that this trend holds in California as well. For close to half of California residents with a substance use disorder, Medi-Cal is the primary source of coverage.[62]
- **Many California residents with a behavioral health condition experience barriers to get treatment.** Among Californians seeking mental health services, more than four in ten (43 percent) reported that it was somewhat or very difficult to secure an appointment with a provider who accepts their insurance. By contrast, 15 percent of Californians seeking physical health services reported that it was

---

[59] "The 2021 CHCF California Health Policy Survey." California Health Care Foundation. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

[60] "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," Californian Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/wp-content/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

[61] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm.

[62] National Health Law Program. Substance use Disorders in Medi-Cal: An Overview. https://healthlaw.org/resource/substance-use-disorders-in-medi-cal-an-overview/#_ftn1.

somewhat or very difficult to find a provider who accepted their insurance.[63] Among those with serious mental illness who are enrolled in Medi-Cal, a substantial share—as much as one-third or more—do not receive any Medi-Cal specialty mental health services.[64] Similar issues arise with respect to those with substance use disorders; nationally, nearly 90 percent of people living with a substance use disorder do not receive treatment, and in California, the rate at which residents accessed treatment for a substance use disorder declined during the pandemic.[65] In some instances, people with significant behavioral health needs who seek care may be rejected because their needs are deemed to be "too severe," or because they have a history of incarceration or behaviors that providers decide make them ineligible for their programs and treatment initiatives.

- **County-level variation in the prevalence of behavioral health conditions is marked.** Given the vast differences across California in the economic and demographic characteristics of county residents, there are sizable differences in the county-level rate of behavioral health conditions. Among Medi-Cal enrollees, the rate (as reflected in claims data) of serious mental illness by county ranges from a low of 4.1 percent to a high of 12.1 percent; substance use disorder ranges from 2.1 percent to 8 percent; and SED ranges from less than 1 percent to 7.8 percent.[66] Higher rates of SUD among Medi-Cal enrollees in some counties are correlated with greater loss of life—five of the 10 counties with the highest rates of substance use disorder among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall drug-overdose death rates in 2020.[67]

---

[63] "The 2021 CHCF California Health Policy Survey." California Health Care Foundation. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

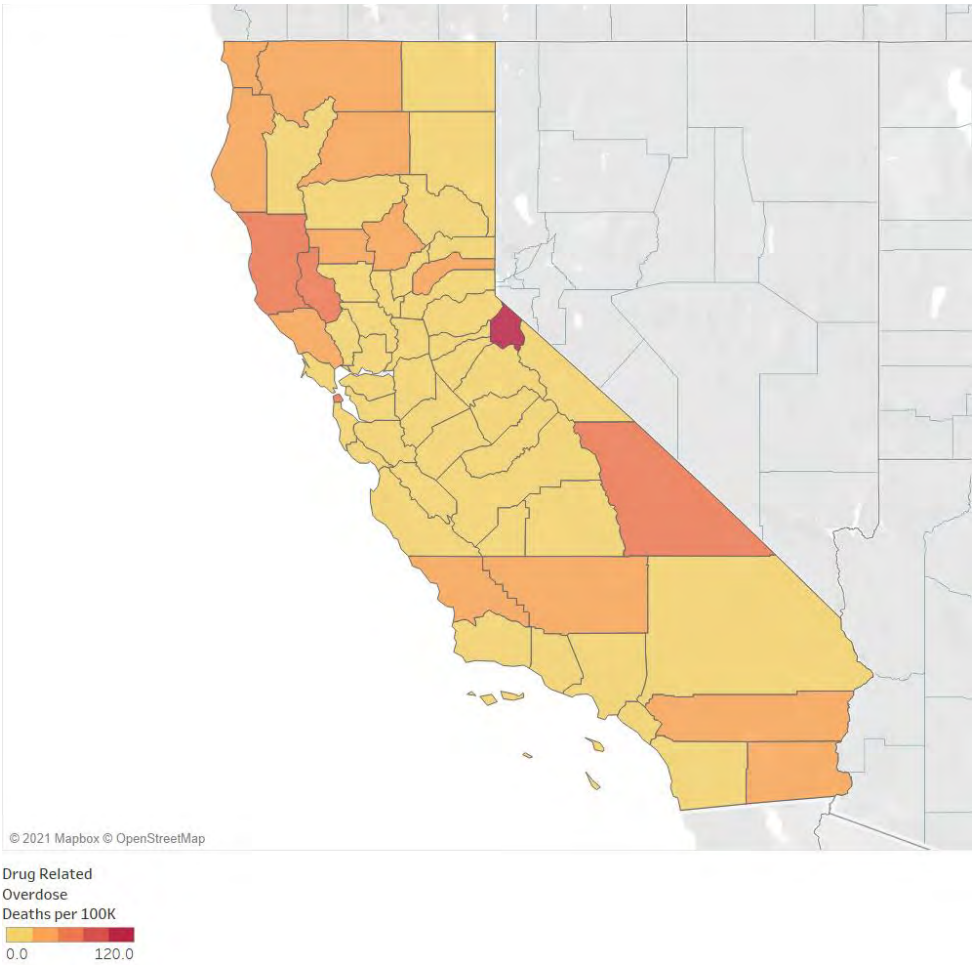
[64] Less than 4 percent of adult Medi-Cal beneficiaries in California received a specialty mental health service in 2019. Analysis of Medi-Cal claims data suggests that some 6.3 percent of Medicaid beneficiaries had SMI in 2019, implying that many adult Medi-Cal beneficiaries with SMI fail to receive treatment. Note that some Medi-Cal enrolled individuals may have received non-Medi-Cal reimbursable SMHS services that are not captured in these data points.

[65] "The 2021 CHCF California Health Policy Survey." California Health Care Foundation. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

[66] While there are limitations on how claims-based data can be used, they likely serve as a relatively reliable proxy of county-level variation. See appendix C for additional information regarding the limitations of these claims-based measures.

[67] Data on drug-related overdose death rates from California Overdose Surveillance Dashboard. Data based on Death certificate data from California Department for Public Health-Center for Health Statistics and Informatics (CHSI) vital statistics - California Comprehensive Death File. Available at: https://skylab.cdph.ca.gov/ODdash/.

Figure 4. **Overall Drug-Related Overdose Death Rate per 100,000 by County in 2020**[68]



[68] Ibid.

V. Service Challenges Across the Behavioral Health Continuum of Care

California has made and continues to make significant investments in expanding access and coverage for behavioral health services along the continuum of care, yet more can be done to improve services. The findings in this section describe gaps across the continuum of care outlined in Figure 1, with an additional focus on the subset of key services for which data are available (marked by a * in Figure 1b). Some insights can be gleaned on the other services, but they are not addressed comprehensively below. This chapter also separately reviews the available data on MAT and withdrawal management services, which should be available to individuals receiving services at all levels of care in the continuum—from outpatient services to inpatient and residential care. Note that Section VI of this report focuses on service gaps for children and youth, individuals who are justice-involved, and AI/AN communities.

5.1 Outpatient Services

Takeaway

There is a shortage of psychiatrists and other individual practitioners, particularly in the Medi-Cal program. Smaller counties report greater shortages of outpatient services, especially mental health clinics.

Outpatient services serve as a key access point in a comprehensive and effective continuum of care. They encompass preventive care, diagnostic assessments, different therapy, and treatment modalities (e.g., individual, group and family) and school-based and linked behavioral health services, among others. For the purposes of this assessment, outpatient services are defined by where the services are provided—in the community—rather than the qualifications of the providers who offer them. Providers of outpatient services can include individual practitioners such as therapists, psychiatrists, and primary care providers. They can include staff at opioid treatment programs (OTPs), referred to in California as Narcotic Treatment Programs (NTPs); community health centers that offer behavioral health services; mental health clinics; and others. Outpatient providers can promote prevention and wellness and can help spot and address behavioral health needs before they worsen and, if they do, refer individuals to more intensive levels of care if necessary, including intensive support services, which are discussed in Section 5.4. For children and adolescents, wide access to preventive and outpatient behavioral health services can be particularly important in preventing behavioral health symptoms from emerging and worsening.

"It is likely that client outcomes would improve and patient experience would be better if there were greater investments in social service supports to optimize outpatient service delivery rather than expand acute care capacity to deal with the imminent pressures on the acute care system."

– County Behavioral Health Director

This assessment specifically examined the availability of the following outpatient services:

- Traditional outpatient services for mental health and substance use disorders, including individual, group and family therapy services.
- School-linked behavioral health services, which refer to counseling and other behavioral health supports provided by counselors, psychologists, and social workers in school settings, are addressed more fully in Section 6.1.
- MAT, which includes services provided by NTPs and other outpatient prescribers, is addressed in Section 5.5. (MAT also can and should be provided in inpatient and residential settings,)
- Ambulatory withdrawal management services (ASAM Level 1.0-WM) and those programs with extended monitoring (ASAM Level 2.0). See Section 5.8 for more information on these services. (Like MAT, withdrawal management services are needed in both outpatient and inpatient/residential settings.)

New Pilot Program Will Explore Effectiveness of Contingency Management in Treating Stimulant Use Disorder

With rising deaths associated with stimulant use, it is critical for California to identify and implement effective treatment options for people living with a stimulant use disorder. In California, opioids still account for the largest share of drug-related deaths in the state, but deaths from methamphetamine and other stimulants have almost quadrupled since 2010.[69] The widely-covered overdose crisis disproportionately affected White and AI/AN populations, but in the past decade, the most dramatic increases in overdose rates have been among Black people due in part to stimulant and polysubstance use.[70] Unlike for

[69] "California Governor, Lawmakers Want State to Pay Addicts to Get Sober," AP, August 26, 2021. Available at cbsnews.com/news/california-contingency-management-pay-to-get-sober/.

[70] Han B, Compton WM, Jones CM, Einstein EB, Volkow ND. Methamphetamine Use, Methamphetamine Use Disorder, and Associated Overdose Deaths Among US Adults. JAMA Psychiatry. 2021 Sep 22. doi: 10.1001/jamapsychiatry.2021.2588. Epub ahead of print. PMID: 34550301.

opioid use disorder and alcohol use disorder, no medications approved by the Food and Drug Administration exist to treat stimulant use disorder.

In response to these trends, DHCS will be implementing a pilot program to evaluate the effectiveness of "contingency management" in treating stimulant use disorders, beginning July 1, 2022, pending CMS approval. Contingency management is an evidence-based practice that reinforces and rewards individuals for positive behavior change consistent with reducing or eliminating their stimulant use. Based on the principle that a behavior will increase if followed by a reward, it delivers incentives (such as gift cards or other rewards) for non-use (or reduced use) of stimulants as evidenced by negative drug tests. The treatment already is in use by the Department of Veterans Affairs and has demonstrated robust outcomes, including reduction or cessation of drug use and longer retention in treatment among individuals living with stimulant use disorders.[71,72,73,74] Under the new pilot program, Medi-Cal enrollees with a diagnosed stimulant use disorder in counties that have opted to participate will receive low-denomination gift cards if they abstain from stimulant use as measured by a drug screen. DHCS will be carefully evaluating the effectiveness of the pilot program and assessing whether to propose to extend it to more California residents after the pilot completes in March 2024.

What data are available, and what do the data say?

The quality and extent of data available on outpatient services is mixed, reflecting in part that the service category includes a vast number of different kinds of treatment providers and services. To gather insight on outpatient services, the assessment relies on a combination of SAMHSA's Behavioral Treatment Locator (see box above); Medi-Cal network adequacy data from county SMHS systems[75]; data on licensed psychiatrists from the Medical Board of California; and quantitative information provided by county behavioral health directors in their survey responses on community health

---

[71] Farrell M, Martin NK, Stockings E, Baez A, Cepeda JA, Degenhardt L, Ali R, Tran LT, Rehm J, Torrens M, Shoptaw S, 2019. Responding to global stimulant use: challenges and opportunities. Lancet. 394, 1652-1667. doi:10.1016/S0140 6736(19)32230-5.

[72] AshaRani P, Hombali A, Seow E, Ong WJ, Tan JH, Subramaniam M, 2020. Non-pharmacological interventions for methamphetamine use disorder: a systematic review, Drug and Alcohol Dependence, doi:https://doi.org/10.1016/j.drugalcdep.2020.108060.

[73] Brown HD, DeFulio A, 2020. Contingency management for the treatment of methamphetamine use disorder: A systematic review. Drug and Alcohol Dependence, 216, https://doi.org/10.1016/j.drugalcdep.2020.108307.

[74] De Crescenzo F, Ciabattini M, D'Alò GL, De Giorgi R, Del Giovane C, Cipriani A, 2018. Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis. PLoS Medicine, 15(12), e1002715. PMCID: PMC6306153.

[75] While there are other licensed clinicians who offer outpatient services to Medi-Cal members through managed care plans (MCPs), the information on SMHS practitioners provides a proxy for the availability of outpatient care available to individuals with SMI or SED.

centers and mental health clinics—programs that offer a range of behavioral health services to individuals who would otherwise not be able to access services in their county.

Taken together, these data indicate that outpatient mental health services are offered in various settings and are available in every county. In total, there are over 600 facilities in California that provide outpatient mental health treatment and nearly 800 that provide some substance use disorder services, according to the SAMHSA Behavioral Health Treatment Services Locator. Table 4 in Appendix B displays county-level information on the number of facilities included in the SAMHSA Behavioral Health Treatment Services Locator that provide outpatient mental health or substance use disorder treatment services. It also shows the number of non-psychiatrist behavioral health providers licensed with county mental health plans (MHPs) in fiscal year 2019. The number of non-psychiatrist behavioral health providers contracted with MHPs varies significantly across counties and by specialty.

SAMHSA's Behavioral Treatment Services Locator as a Source of Data on California's Behavioral Health System: Issues and Considerations

The Behavioral Health Treatment Services Locator is a database maintained by SAMHSA to help people find services in their community, as well as to offer data and information to researchers and other stakeholders. It routinely is used by federal agencies, national organizations, researchers and states for various research and planning efforts. This is in part because it provides relatively detailed information on treatment facilities, including name, location and services offered by mental health and SUD treatment facilities. As such, unlike many other behavioral health surveys and databases, it can be used to produce county-level data.

One issue, however, is that it does not include all behavioral health providers in the United States. It does cover facilities funded by states, administered by the United States Department of Veterans Affairs, and private for-profit and nonprofit facilities that are licensed by a state or a national treatment accreditation organization (e.g., The Joint Commission or the National Committee for Quality Assurance.) This leaves out unlicensed and license-exempt facilities. The locator also generally does not provide information on individuals in private practice or a small group practice unless they are licensed or certified as a clinic. Although the Treatment Locator is not a comprehensive database of every behavioral health treatment provider, DHCS's determination is that it provides useful insight into higher-level trends and patterns in the general availability of outpatient treatment services throughout California.[76]

[76] Comparing the Behavioral Health Treatment Locator to other data sources supports this determination. For example, the SAMHSA Treatment Locator includes information on availability of DEA-waivered buprenorphine prescribers that is generally consistent with data provided directly from the DEA. The Treatment Locator data indicate that there are two counties in California that do not have any DEA-waivered buprenorphine prescribers available. Comparatively, data from the US DEA suggest that there is only one county that does not have any buprenorphine prescribers available.

In addition:

- The SAMHSA Behavioral Health Treatment Services Locator shows that twenty-three of 58 counties have mental health clinics and twenty counties have community health centers that provide outpatient mental health treatment services.[77]
- The SAMHSA Behavioral Health Treatment Services Locator indicates that five counties do not have any outpatient mental health treatment services available through mental health clinics, community health centers or other facilities. Most of these counties have fewer than 30,000 residents. Although these counties do not have any such facilities documented in the SAMHSA Treatment Locator, each of these counties has at last three county-contracted SMHS providers available.

Harm Reduction Efforts

California is committed to investing in evidence-based harm reduction efforts to prevent overdose and make drug use safer for people not yet ready for treatment. Currently, there are more than 50 authorized **syringe services programs (SSPs)** providing sterile syringes, fentanyl testing strips and naloxone, along with overdose prevention education and linkages to physical, mental health and SUD treatment services. The state's 2019 budget committed $15.2 million in grants over four years to SSPs to support infrastructure and staffing, though many programs still report funding challenges.

In addition, the state has worked to **expand access to naloxone** through a number of initiatives. This includes the establishment of a standing order, which expands access to naloxone for California residents and allows organizations that cannot prescribe naloxone to distribute it to those at risk of experiencing an opioid-related overdose and those in a position to assist during an opioid-related overdose

In addition, California operates the Naloxone Distribution Project (NDP), funded by SAMHSA and administered by DHCS, which distributes free naloxone to a wide range of organizations, including first responders, community organizations, schools, SUD treatment providers, hospitals and EDs. Since October 2018, the NDP has

[77] These facilities were identified using data downloaded from the SAMHSA Behavioral Health Treatment Services Locator in July 2021. Additional information regarding the SAMHSA Behavioral Health Treatment Services Locator and how these data were analyzed may be found in Appendix C.

distributed over 600,000 units of naloxone, and recorded over 30,000 overdose reversals.[78,79,80,81]

- In fiscal year 2019, small counties like Sierra and Alpine had only three and four, respectively, SMHS contracted behavioral health providers, while larger counties like Los Angeles had nearly 4,500. On a per capita basis, however, some small counties like Sierra and Alpine have more SMHS contracted providers per 10,000 residents than larger counties. Alpine and Sierra had 38.5 and 9.9 respectively, SMHS contracted providers per 10,000 residents relative to only 4.5 providers per 10,000 residents in Los Angeles County.
- There is a shortage and maldistribution of psychiatrists and other behavioral health professionals across the state. Data provided by the Medical Board of California indicate that eight counties do not have any psychiatrists, and the number of psychiatrists per 100,000 residents ranges from 1.7 in San Benito County to 68.1 in Marin County. Additionally, the state has 536 designated mental health professional shortage areas (HPSAs) or areas with a shortage of psychiatrists as of September 2020.[82] While California-specific data were not available, national Medicaid surveys indicate that Medicaid participation among psychiatrists is low.[83] Nationally, approximately 55% of psychiatrists accept private insurance, and slightly more than 40% accept Medicaid.[84] A recent study found that ratios of behavioral health

---

[78] "Directory of Syringe Services Programs in California," California Department of Public Health. Available at: https://www.cdph.ca.gov/programs/cid/doa/pages/oa_prev_sepdirectory.aspx.

[79] California Department of Public Health, "Policy Changes," last modified Dec. 9, 2019, Available at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Policy-Changes.aspx.

[80] "Harm Reduction Resources for People Who Use Drugs in California," National Harm Reduction Coalition, Accessed November 23, 2020. Available at https://harmreduction.org/our-work/action/california/.

[81] Naloxone Distribution Project," DHCS, Accessed November 23, 2020. Available at https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx.

[82] Federal regulations define a mental health HPSA as having a population-to-provider ratio of at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community). https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[83] https://www.macpac.gov/publication/physician-acceptance-of-new-medicaid-patients-new-findings/; https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

[84] Bishop TF, Press MJ, Keyhani S, Pincus HA. Acceptance of insurance by psychiatrists and the implications for access to mental health care. JAMA Psychiatry. 2014 Feb;71(2):176-81. doi: 10.1001/jamapsychiatry.2013.2862. PMID: 24337499; PMCID: PMC3967759.

professionals (e.g., LMFTs, LCSWs, psychologists and psychiatrists) to population differ quite considerably across California with the lowest ratios in the Inland Empire and San Joaquin Valley.[85]

What did the survey and focus groups say?

In general, the county surveys and focus groups suggested that there was a need for more outpatient services. In a few counties, the need was urgent. Nineteen counties (32 percent) cited a need for additional outpatient mental health treatment services, while a relatively smaller percentage of counties reported a need for additional outpatient SUD providers. In some cases, individuals who rely on the public behavioral health system seek care from the ED because they cannot access outpatient services through a Medi-Cal provider in a timely manner.

Among the privately insured, families of individuals living with mental illness in California reported a lack of affordable and timely access to outpatient psychiatric care in NAMI's 2020-2021 Family Report. Because a significant number of psychiatrists do not accept insurance, families and individuals seeking care may need to pay out of pocket to access care. Among insured individuals, out of pocket costs, including co-pays and deductibles may be prohibitive; 29% of family members reported the costs of insurance as a barrier for seeking care for their loved one.[86] Family members also cited extensive wait times between appointments for their loved ones as barrier to care despite the Timely Access Regulations standard of ten days for a follow-up appointment following the request.[87,88]

Please see Section 6.1, Children and Youth, for a discussion of outpatient services for children and youth, including school-linked health services and psychiatry.

---

[85] Coffman J, Bates T, Spetz J. California's Current and Future Behavioral Health Workforce. Heal. Cent. UCSF. February 2018. Available at https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-healthworkforce.

[86] NAMI California. The 2020-2021 Annual State of the Communities Report with Families. November 2021. Available at https://namica.org/wp-content/uploads/2021/11/NAMI-2020-21-Families-report_F-web.pdf.

[87] NAMI California. The 2020-2021 Annual State of the Communities Report with Families. November 2021. Available at https://namica.org/wp-content/uploads/2021/11/NAMI-2020-21-Families-report_F-web.pdf.

[88] 21 Timely Access to Care. Dep. Manag. Health Care. https://www.dmhc.ca.gov/healthcareincalifornia/yourhealthcarerights/timelyaccesstocare.aspx (accessed Sept 22, 2021).

Outpatient Services Success Story

During the COVID-19 pandemic, telehealth services emerged as an important option for patients unable to access in-person outpatient services. One study of California community health centers found that total behavioral health visits remained stable during the pandemic because telehealth visits—specifically, audio or telephone visits—fully replaced in-person appointments.[89] Contra Costa County has successfully piloted and rolled out telepsychiatry for all county mental health clinics. Ventura County also expanded telehealth services to support triage and assessment of new clients.

The Solano County Behavioral Health Department embedded substance use liaisons (mental health clinicians or certified alcohol/drug abuse staff) within Full-Service Partnership and outpatient programs to support co-occurring treatment capacity. The county integrated the access line to screen for both mental health and substance use disorders and offered systemwide training to all staff and contractors on integrated mental health and SUD treatment, harm reduction, stages of change, ASAM, and motivational interviewing (continuing to the present). This has helped increase identification of SUD needs for people who call the access line.

5.2 Peer and Recovery Supports

Takeaway

Peer and recovery support services are an area of great interest and potential. While they are not yet available throughout California, with higher needs especially for youth and their families, these services can expand the behavioral health workforce, engage people in care and contribute to equity efforts.

Peer and recovery supports are services that promote recovery among individuals living with mental health and SUD needs. They are provided by individuals who are themselves in recovery or otherwise have lived experience with mental health issues and/or SUD. In some instances, they are provided by family members of youth with lived experience. Using their own experience and other skills, peers offer encouragement, help keep people engaged in treatment and build a sense of community. Peers can provide services at different stages in the recovery process and through multiple avenues, including face-to-face and telephonic activities, peer respite services (covered in greater detail in the crisis services section in 5.7), recovery groups, or participating on treatment teams. They might serve as staff in a wellness center, drop-in program or intensive outpatient program; serve as part of a crisis team; or meet

[89] Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. 2021;325(11):1106-1107. doi:10.1001/jama.2021.0282.

with people one-on-one or as part of a group in the days and weeks after they are discharged from a hospital or residential treatment facility. Peers often are uniquely well positioned to offer hope to a client, reduce the stigma associated with a behavioral health condition and help clients feel less alone in their struggles. A large body of research indicates that peer support is associated with lower levels of depression and psychosis and reduced hospital admission rates.[90]

What data are available, and what do they say?

At the time of this report, no data are readily available on the extent to which peer support and recovery services are available in California. However, peer services have been shown to be effective in California and have been mostly funded by counties through MHSA and SAMHSA.[91] Following implementation of the new Medi-Cal benefit for peer support specialists for both mental health and substance use disorders, county-level data should be available on certified Medi-Cal peer providers and services. In accordance with state statute, DHCS is developing statewide certification standards that will include the qualifications, range of responsibilities, practice guidelines and curricula for mental health and SUD peer support specialists through a collaborative process that engages peers directly as well as peer organizations and associations. Medi-Cal certification of peer support specialists will begin in July 2022, and the peer benefit will be added to all three behavioral health Medi-Cal specialty delivery systems: SMHS, DMC and DMC-ODS as an optional county benefit.

What did the survey and focus groups say?

Currently, peer support and recovery services are largely "homegrown" programs that funded by counties or supported by larger treatment systems. According to the county survey, they are more common in populous counties like Alameda and Los Angeles, at least half of California counties without peer services programs reported an interest in building out peer services. Among focus group participants, there was particularly strong interest in the following:

- Integrating peer services within different levels of care, including wellness and drop-in centers and crisis services.
- Creating a cohesive statewide continuum of peer service organizations, helping reduce the informal and homegrown aspect of existing initiatives.
- Building out peer support services for individuals living with SUD to better support them in treatment and recovery.
- Ensuring that youth, not only older adults, have access to peer support services.

---

[90] Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*. 2012;11(2):123-128. doi:10.1016/j.wpsyc.2012.05.009.

[91] "Peer Models and Usage in California Behavioral Health and Primary Care Settings," CalMHSA, Integrated Behavioral Health Project, November 2013. Available at http://www.ibhpartners.org/wp-content/uploads/2015/12/PeerModelsBriefRevFINAL.pdf?utm_source=rss&utm_medium=rss.

- Offering family-to-family peer support services for parents (or other caretakers) with children who have a behavioral health condition.

At the same time, the survey and focus groups highlight the importance of resources being made available to support peer services. In the face of more urgent and acute issues (e.g., boarding in EDs), some focus group participants suggested that it is difficult to treat peer support services as a "must have."

Peer and Recovery Supports Success Story

Riverside County Department of Health, Recovery Innovations of California and Oasis Rehabilitation offer peer-operated integrated services to current and former clients (both adults and transitional-age youth) of the county's Department of Mental Health. The services they offer include a resource center that provides information on housing options, employment, and educational opportunities. Monthly activities are also offered at little or no cost. In addition, The Art Works, a gallery in Riverside, an extension of the peer support and resource center, supports the artistic expression of those with mental illness. It offers drama, choir, painting, drawing and crafts programs.[92]

5.3 Community Services and Supports[93]

Takeaway

Community services and supports are a top priority of counties and other stakeholders; most urgently, affordable housing, housing support and supported employment are needed to support community living.

[92] Riverside University Health System Peer Centers. More information available at https://www.rcdmh.org/Children-Services/Peer-Centers.

[93] Community services and supports as defined in this assessment are distinct from CSS funding which fund full service partnerships operated by the counties.

Community supports are flexible services that help people to facilitate and sustain their recovery, remain in their homes with maximum independence and participate in a meaningful way in their communities. When they work as intended, community supports can help people avoid institutional stays or, if someone is institutionalized, they can contribute to shorter lengths of stay and make it easier for the person to return to the community. The psychosocial rehabilitation model and recovery framework, embedded within community supports and also in mental health residential services, help individuals develop the emotional, social, and coping skills required to live in the community as independently as possible. This approach supports individuals in building coping skills for stressful situations and provides resources to reduce future pressures. The exact nature of the community supports that an individual requires will depend on their specific needs and goals, but can include psychosocial support, supported employment, and housing supports.

Loss of Licensed Adult and Senior Care Settings

In recent years, hundreds of licensed adult and senior care settings, which include adult residential facilities and residential care facilities for the elderly, have closed as a result of increasing operating costs and reimbursement rates among other reasons. For example, since 2012, more than a third of licensed residential facilities that serve people under age 60, and more than a quarter of those serving older clients have closed in San Francisco.[94]

Licensed adult and senior care settings provide housing, supervision, care and meals to individuals who are aging, disabled or seriously mentally ill. Individuals living in adult and senior care settings who are recipients of Social Security Income (SSI) receive the Non-Medical Out-of-Home Care Rate (NMOHC), which is higher than the regular SSI rate for persons living independently in homes or apartments, which they pay to the facility. Some counties boost the monthly rate for these homes using a "patch." Stakeholders including advocates and policy makers have called for strategies to sustain and transform adult and senior care settings through increased reimbursement rates, as well as shifting adult and senior care settings to a model that promotes independence for residence through programming that provides life skills and activities in order to improve the quality of care delivered to residents.[95,96]

---

[94] Jocelyn Wiener, "Mental Health 'Catastrophe': Few Options for Residents as Care Homes Close," April 21, 2019. Available at https://www.kqed.org/news/11741821/overlooked-mental-health-catastrophe-vanishing-board-and-care-homes-leave-residents-with-few-options.

[95] "Overlooked mental health "catastrophe:" Vanishing board-and-care-homes leave residents with few options," Jocelyn Wiener, CalMatters, September 17, 2020. Available at https://calmatters.org/projects/board-and-care-homes-closing-in-california-mental-health-crisis/.

[96] "Loss of Board and Care Facilities is at Crisis Level: Undermines California Counties' Efforts to Support Individuals with Serious Mental Illness, Older Adults and Persons with Disabilities at Risk of Homelessness," Steinberg Institute, County of Los Angeles, CBHDA, February 28, 2020. Available at https://namisantaclara.org/wp-content/uploads/2020/11/Loss-of-Board-and-Care-Facilities-is-at-Crisis-Level-2.28.20.pdf.

Community supports are flexible services that help people to facilitate and sustain their recovery, remain in their homes with maximum independence and participate in a meaningful way in their communities. When they work as intended, community supports can help people avoid institutional stays or, if someone is institutionalized, they can contribute to shorter lengths of stay and make it easier for the person to return to the community. The psychosocial rehabilitation model and recovery framework, embedded within community supports and also in mental health residential services, help individuals develop the emotional, social, and coping skills required to live in the community as independently as possible. This approach supports individuals in building coping skills for stressful situations and provides resources to reduce future pressures. The exact nature of the community supports that an individual requires will depend on their specific needs and goals, but can include psychosocial support, supported employment, and housing supports.

Housing Supports

As in other states, individuals living with chronic, often co-occurring mental health conditions and substance use disorders are particularly vulnerable to becoming homeless, and the experience of homelessness contributes to increased mental health and substance use disorder conditions. This means housing supports – which are services that help people living with behavioral health issues to find, move into, and retain housing -- are critical to the treatment and recovery of many people living with significant behavioral health needs. Moreover, a lack of housing supports can perpetuate a costly cycle of avoidable ED visits, inpatient stays, long-term residential stays, or incarceration. If people have nowhere to go when they are ready to “step down” from hospitalization or crisis stabilization services, it contributes to bottlenecks at key points in the continuum of care.

It is important to highlight that housing supports – i.e., services that help people find and remain in their homes – are different from affordable housing, which is a major issue in California. The state’s homelessness crisis is well documented and a pressing priority of the Newsom Administration, which has launched a number of initiatives to work directly on expanding the supply of affordable housing and to provide rental assistance (see Additional California Housing Initiatives box below). Housing supports for people living with behavioral health issues should be considered in addition to addressing the backdrop of rising rates of homelessness and a lack of affordable housing for many of California’s residents. It is critical that housing options and housing supports are designed to work for individuals living with significant behavioral health needs. They otherwise may be denied access to housing programs because their needs are deemed “too severe,” or because a provider is not willing to serve them based on their clinical history and earlier behaviors.

Medi-Cal cannot pay rental subsidies for Medi-Cal enrollees and, historically, it has covered housing supports on a limited basis through small pilots. Now, however, DHCS has established a menu of “Community Supports” (sometimes known as in-lieu-of services or ILOS based on the federal rules authorizing federal Medicaid payment for these services) that managed care plans can offer their enrollees when medically appropriate and deemed to be a cost-effective alternative to a covered Medi-Cal

service. These “community supports” or “in lieu of services,” include a range of housing supports[97]. DHCS is strongly encouraging managed care plans in all counties to offer these services beginning on January 1, 2022, including the following related to housing supports:

- Housing transition navigation services that assist enrollees with obtaining housing, including identifying and resolving barriers to housing and searching for housing.
- Housing deposits that assist with one-time expenses, such as security deposits, setup fees or deposits for utilities, and first and last months’ rent.
- Housing tenancy and sustaining services that provide services such as education, training, coaching and dispute resolution, with a goal of maintaining safe and stable tenancy once housing is secured.
- Short-term post-hospitalization housing that provides enrollees transitioning out of inpatient hospitalization who do not have a residence and have substantial medical or behavioral health needs with the opportunity to continue their medical/psychiatric/SUD treatment in a setting with the supports necessary for recuperation and recovery.
- Recuperative care (medical respite), which is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.
- Day habilitation programs, which are designed to assist enrollees in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the community.
- Sobering centers, which are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. See 5.7 Crisis Services for additional detail on this service.

More details on the community supports (ILOS) available through managed care plans, including program eligibility, can be found here.[98,99,100] Outside of Medi-Cal, counties also pay for housing and housing supports using other funding, including MHSA funds. They also support licensed adult and senior care settings landlord engagement and other housing, housing services and supports.

---

[97] Medi-Cal In Lieu of Services (ILOS) Policy Guide, DHCS, September 2021. Available at https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf.

[98] “The Community Care Expansion Program,” CDSS, Available at https://www.cdss.ca.gov/inforesources/cdss-programs/community-care-expansion.

[99] “Council Administered Grants,” California Business, Consumer Services, and Housing Agency, Available at https://www.bcsh.ca.gov/hcfc/grants.html.

[100] “Grants and Funding,” California Department of Housing and Community Development, Available at https://www.hcd.ca.gov/grants-funding/index.shtml.

Additional California Housing Initiatives

In addition to DHCS-led housing related initiatives, other California agencies are also investing in expanding housing for state residents in need. For example:

- **Community Care Expansion Program**: Through this program, the California Department of Social Services will disburse $805 million beginning July 1, 2021 through June 30, 2027 (pending budget approval) for the acquisition, construction, and rehabilitation of adult and senior care facilities that serve applicants and recipients of Social Security Income (SSI) including individuals who are at risk of or experiencing homelessness.
- **California Interagency Council on Homelessness** : Part of the Business, Consumer Services and Housing Agency, the Council, formerly known as the Homeless Coordinating and Financing Council, administers several grants to local jurisdictions throughout the state, including the Homeless Housing, Assistance and Prevention Program, a four-round grant cycle totaling close to $3 billion to support regional coordination and expand or develop local capacity to address their immediate homelessness challenge, and emergency COVID-19 funding to counties to reduce the spread of COVID-19 by safely getting individuals into shelter and providing immediate housing options.
- **California Department of Housing and Community Development Grants**: In 2019-20, the Department awarded more than $2.5 billion in grants and loans to develop, preserve, and rehabilitate affordable housing units.

Availability of Integrated Housing and Supports

What did the survey and focus groups say?

Survey and focus group participants identified additional critical housing supports for people living with behavioral health needs, as well as some barriers that people face when trying to use those supports that are available, including the following:

- Additional permanent supportive housing options for adults that provide wraparound behavioral health services, such as recovery services (93 percent of respondents).
- Additional general housing with access to county-run supports, such as adult Full-Service Partnerships that provide intensive services and supports and coordinate access to housing, education, and employment (83 percent of respondents).
- Additional capacity in longer-term adult residential facilities, including board-and-care models (82 percent of county respondents). The “linear continuum” model in which individuals are supposed to gradually step down from hospital services through less supervised settings to independent living has failed in most cases to move people toward independent living. People living with mental illness and SUD challenges need more treatment-supported environments.[101]

[101] Barbato A, D'Avanzo B, Harvey C, Lesage A, Maone A. Editorial: From Residential Care to Supported Housing. Front Psychiatry. 2020;11:560. Published 2020 Jun. 12. doi:10.3389/fpsyt.2020.00560. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7303362/.

- Additional sober living or recovery residences for individuals living with SUD (71 percent of respondents).
- Additional housing capacity, due to low vacancy rates in many counties (95 percent of respondents).
- Unaffordable housing options (e.g., SSI payments are insufficient to pay for client housing) (85 percent of respondents).
- Housing providers unwilling to accept behavioral health clients (75 percent of respondents). Focus group respondents noted that individuals living with particularly significant behavioral health needs, problematic behaviors or histories may be particularly difficult to link to housing.
- Barriers to building or siting housing for individuals living with mental health issues and individuals living with substance use disorders (68 percent of respondents).

In addition, some focus group members raised concerns about the possibility of additional investments in longer-term, nonintegrated housing, especially for individuals living with mental illness. While these participants are deeply concerned about the lack of appropriate housing options for people living with mental illness, they recommended that the state pursue strategies that allow individuals living with behavioral health conditions to live and reside in integrated communities. If people living with mental health issues are concentrated in certain buildings or facilities, it can contribute to stigma and leave them isolated and on the margins of society.

These findings were consistent with NAMI California's Annual 2020-2021 Family Report which highlights a lack of available housing and housing supports as a common barrier to care for individuals living with mental illness and their families, and calls for increased state investments in both of these areas.[102]

[102] NAMI California. The 2020-2021 Annual State of the Communities Report with Families. November 2021. Available at https://namica.org/wp-content/uploads/2021/11/NAMI-2020-21-Families-report_F-web.pdf.

Housing Supports Success Story

Los Angeles County offers the Homeless Care Support Services (HCSS) program through Whole Person Care (WPC). HCSS provides Medi-Cal enrollees experiencing homelessness with comprehensive wraparound services to improve health, address housing needs and decrease the use of high-cost health care services. Participants are connected to permanent housing opportunities and receive rent subsidies either through Section 8 federal funding or through the county's flexible housing pool funds. Thus far, Los Angeles County has enrolled 13,449 unique Medi-Cal enrollees in HCSS.[103]

Napa County also credits its 86 percent WPC enrollee housing retention rate to housing supportive services provided by community-based partners.

Supported Employment

For many, employment is not only a determinant of health and well-being, including mental health, but also an antidote to social exclusion.[104]

Supported employment services provide the help individuals living with behavioral health issues need to obtain and maintain paid competitive jobs in the community. Supported employment services can include vocational assessment, help finding jobs and job skills training. Supported employment also provides coaches who work at the job location and help the individual learn tasks, identify job modifications and work with the employer to troubleshoot issues.

Individual Placement and Support (IPS) is an evidence-based model of supported employment for people living with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar disorder, depression). It is increasingly being used by California counties as it is shown to be more effective at helping individuals living with SMI retain their jobs for longer and earn more money than people in traditional employment programs[105]

---

[103] "Whole Person Care: A Mid-Point Check-In, DHCS, March 2019. Available at "https://www.dhcs.ca.gov/services/Documents/Harbage_WPC_MidPointPaper.pdf.

[104] Bond GR, Drake RE, Becker DR. An update on Individual Placement and Support. World Psychiatry. 2020;19(3):390-391. doi:10.1002/wps.20784.

[105] Bond GR, Drake RE, Campbell K. Effectiveness of individual placement and support supported employment for young adults. Early Interv Psychiatry. 2016;10(4):300-307. doi:10.1111/eip.12175.

Availability of Supported Employment

What data are available, and what do the data say?

Supported employment programs for individuals living with behavioral health needs are available in many California counties and are funded using state dollars. For example, California Mental Health Cooperative Programs provide collaborative employment services to assist individuals living with severe psychiatric disabilities in entering or reentering their community workforce. Twenty-five cooperative agreements jointly negotiated and maintained by county mental health and local Department of Rehabilitation field offices provide specialized employment services, including counseling and guidance, vocational exploration, specialized employment assessments, vocational training, college and university education, transportation, and work clothing.[106] In addition, California counties, including Solano and Alameda, use MHSA funds to provide supported employment services, largely using the Individual Placement and Support (IPS) model, for individuals living with behavioral health conditions.[107] Supported employment services are not covered under the Medi-Cal program. The Department of Rehabilitation provides support and vocational rehabilitation services to individuals, including individual and youth living with significant disabilities, to help individuals learn and perform their job duties and maintain employment.

What did the survey and focus groups say?

Focus group participants emphasized the importance of building in social supports, including supported employment that links individuals to job and employment connections in the community, alongside housing supports to foster community integration for individuals living with behavioral health needs.

---

[106] Adult: California Mental Health Cooperative Programs Employment with Support, DHCS. Accessed September 8, 2021. Available at https://www.dhcs.ca.gov/services/MH/Pages/Adult-Employment_with_Support.aspx.

[107] Issue Brief: Employment, California Association of Local Behavioral Health Boards and Commissions, October 2021. Available at https://www.calbhbc.org/uploads/5/8/5/3/58536227/issue_brief_-_employment.pdf.

Supported Employment Success Story

Similar to many other California counties, San Diego has invested in expanding employment opportunities for individuals living with behavioral health needs. It has provided a series of annual trainings for its county behavioral health providers to encourage them to build supported employment capacity, hosted employment socials to introduce program participants to potential employers in nonwork settings and developed a consumer and employer toolkit. The county's latest Five-Year Strategic Employment Plan (fiscal years 2020-24) builds on its earlier efforts in this area and reflects input from an array of stakeholders, including individuals with lived experience. Among other things, San Diego is expanding its use of evidence-based employment support models for transitional-age youth[108] and individuals living with SUD, enhancing data collection and analysis, and championing peer employment and advocacy.[109]

5.4 Intensive Support Services

Takeaway

More can be done for intensive support services across the state, to address backlogs in hospitals and residential care settings and to support individuals in community living.

Intensive support services are community-based services that are designed to meet the needs of adults, children and youth who are sufficiently stable and safe to remain in the community, but who require significantly more support than traditional outpatient services to do so. Often, individuals are enrolled in an intensive support service as part of transitioning from residential care, but they might also be enrolled in such a service if they have a condition that is worsening that otherwise might require hospitalization or residential treatment. For those living with SMI, the need for intensive services may be ongoing and not part of a transition. There is a growing emphasis across the country and in California on providing evidence-based and informed intensive support services to better enable adults, children and youth living with significant mental health needs to remain in their homes and communities. For example, intensive in-home services,

---

[108] Transitional-age youth are young people between the ages of 16 and 24 (American Academy of Child and Adolescent Psychiatry) who are in transition from state custody or foster care environments and are at risk.

[109] San Diego Behavioral Health Work Well Five-Year Strategic Employment Plan FY 2020 to 2024, County of San Diego Health and Human Services Agency. Accessed September 8, 2021. Available at https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/NOC/MHSA/BHS%20Five%20Year%20Strategic%20Employment%20Plan%20(8.6.2020).pdf.

covered in California's specialty mental health services as intensive in-home services, are designed to help children and adolescents avoid out-of-home placement due to mental health needs. These programs are often characterized by the use of a multidisciplinary team approach to provide intensive and integrated treatment to individuals who are involved in multiple systems of care.

The key intensive support services addressed in this section include:

- Intensive Outpatient Programs (IOPs), which consist of a prearranged schedule of core services (e.g., individual counseling, group therapy, family psychoeducation and case management provided for a specified number of hours per week). Under Medi-Cal rules, individuals living with SUD eligible for this service must be provided with at least nine hours of services per week.
- Partial Hospitalization Programs (PHPs), which are very similar to IOPs in terms of the services they offer but instead provide care for 20 or more hours per week. In Medi-Cal, DMC-ODS counties can opt to provide PHPs.
- Day treatment, which is similar to IOPs and PHPs in terms of the services offered and the range of hours care is provided. Day treatment is a structured, multidisciplinary program that includes community meetings, therapy, and skill-building groups. In Medi-Cal, day treatment programs include at least three hours of services per day.
- Homebuilders - Intensive Family Preservation and Reunification Services. Homebuilders provides intensive, in-home counseling, skill-building and support services for families who have children (0-18 years) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Homebuilders intervenes at the point of crisis and responds to families in a natural setting, creates concrete goals for families and utilizes research-based intervention strategies to teach new skills and facilitate behavior change. Homebuilders is important for youth in immediate danger to provide ongoing, all-encompassing support that immediately promote safe practices
- Assertive Community Treatment (ACT), an evidence-based practice that offers a wide range of medical and social services to people living with severe functional impairments associated with serious mental illness. Provided by a multidisciplinary team, the services are provided 24 hours a day, seven days a week for as long as needed and wherever they are needed. ACT is designed to be delivered with fidelity to national evidence-based criteria. ACT has demonstrated success in improving mental health outcomes and reducing the likelihood of re-arrest or institutionalization for adults living with significant mental health needs.[110]

---

[110] "A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails into Community-Based Treatment that Works," ACLU, July 2014. Available at https://www.prisonlegalnews.org/media/publications/A%20Way%20Forward%20-%20Diverting%20People%20with%20Mental%20Illness%20from%20Inhumane%20and%20Expensive%20Jails%20into%20Community-Based%20Treatment%20that%20Works%2C%20ACLU%20%26%20Bazelon%2C%202014.pdf .

- **Forensic Assertive Community Treatment** (FACT), a service delivery model for individuals living with SMI and who are involved in the criminal justice system. FACT builds on the ACT model (described above), and adjusts based on criminal justice issues, specifically addressing criminogenic risks and needs. FACT attempts to bridge the behavioral health and criminal justice systems using multidisciplinary teams and intensive, continuous engagement.[111]
- Assisted outpatient treatment (AOT) programs, which (a) identify persons with serious mental illness who are not engaged in treatment, (b) assess if there is substantial risk for deterioration and/or involuntary detention (under Welfare and Institutions Code §5150) which could be mitigated by provision of appropriate services, and (c) petition the court to order participation in such services if the individual is not able to be successfully engaged by other means. These programs must be delivered ethically and consistent with SAMHSA's policy guidelines for involuntary commitment.[112]

Full-Service Partnerships

Full-Service Partnership (FSP) programs provide intensive, community-based mental health services for clients with complex needs. This population includes adults living with serious mental illnesses—and often a co-occurring substance use disorder—and youth living with behavioral needs, who are experiencing and/or at risk of institutionalization, homelessness, incarceration, or psychiatric hospitalization. The foundation of Full-Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness. The programs assist with housing, employment, and education in addition to providing integrated mental health and substance use treatment services. With a unique team-based approach, low staff-to-client ratio and 24/7 crisis availability, FSPs emphasize strengthening or cultivating clients' natural supports, such as their relationships with family and friends, so they can maintain wellness and utilize services in their own home or community. The program is funded by MHSA dollars.

What data are available, and what do the data say?

Data from the SAMHSA Behavioral Health Treatment Services Locator were used to identify facilities that provide intensive outpatient treatment (IOP) and partial hospitalization services for mental health issues and SUD. Both IOP and partial hospitalization programs (PHPs) provide intensive treatment and supports to address addictions, depression, eating disorders, or other dependencies that do not require

[111] "Forensic Assertive Community Treatment (FACT)," SAMHSA, Available at https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf.

[112] Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice, SAMHSA, 2019. Available at https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.

detoxification or round-the-clock supervision. The main difference between IOPs and PHPs is the length of time. IOPs are three days a week for a few hours each day. PHPs are longer, at least four hours per day, and at least five days a week.

According to these data, the majority of counties in California have at least one facility that provides intensive outpatient treatment for SUD. Only 10 counties do not have any intensive outpatient treatment programs. And only 29 counties, across 205 facilities, offer SUD partial hospitalization services.

Data from the SAMHSA Behavioral Health Treatment Services Locator also suggest that partial hospitalization programs for mental health treatment are relatively rare in California, with only 33 facilities across nine counties. Further, over one-third of the programs providing partial hospitalization services for the treatment of mental health are located in Los Angeles County. Table 5 in Appendix B identifies the counties that have facilities providing intensive outpatient treatment for SUD or partial hospitalization for mental health or SUD.

ACT is available through the publicly funded behavioral health system in select counties in California using state and grant dollars, including MHSA funds. Data from the SAMHSA Behavioral Health Treatment Locator indicate that ACT services are available at 128 different facilities across 30 counties in California. While components of ACT are billable under mental health plans for qualifying Medi-Cal enrollees, including medication support services, ACT is not covered as a discrete, bundled service. In light of the significant needs and cross-sectional involvement of individuals obtaining ACT services, robust monitoring is critical to verify that the teams are delivering services in accordance with fidelity standards and that these teams are producing the intended outcomes (lower ED visits and hospitalizations). It should be noted that FSP teams may provide a multi-disciplinary approach that aligns with some components of ACT (e.g. staffing requirements and team size). The absence of a statewide ACT benefit in the Medi-Cal program complicates efforts in the delivery of and monitoring of ACT teams consistent with national fidelity guidelines and outcomes.

What did the survey and focus groups say?

There are shortages of IOPs, PHPs and day treatment services for adults and adolescents throughout the state. More than half of the counties (57 percent) surveyed reported that they need additional IOPs, PHPs and day treatment services for adults and youth. A significant number of counties (31) offer AOT programs that provider court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement.

Intensive Outpatient Treatment Services Innovations

The **Los Angeles County Department of Mental Health (LACDMH) Full-Service Partnership Program (FSP) Redesign and Transformation initiative** was launched in July 2021 and represents an innovative large-scale approach to align payments and accountability with meaningful life outcomes for clients. The amended three-year contracts, which require the deployment of dedicated service teams responsible for specific client populations, were developed over the past three years in partnership with Third Sector, whose work was funded by the Ballmer Group. The FSP transformation involves 196 contracted and in-house clinics serving more than 15,000 clients with serious mental illness and impacts $300 million in annual MHSA spending (more than half of the MHSA funding allocated to L.A. County Department of Mental Health). Under the new design, contractors can receive up to 6 percent in outcomes payments for achieving specific targets, including retaining the highest-acuity clients in the program voluntarily and helping clients obtain/maintain stable housing, avoid street/jail recidivism and reduce psychiatric hospitalizations. The redesign incorporated feedback across stakeholder groups, including clients, on outcomes targets, incentives, data reporting and the service model. UCLA, through its Public Partnership for Wellbeing with LACDMH (PPfW), supported the development of a unified evidence-based "whatever it takes" model, and is delivering ongoing provider capacity building and technical assistance. LACDMH will receive initial data from providers by November 2021, after which LACDMH will gather data on the new outcomes and enrollment metrics and share new data-actionable reports to show progress in the first quarter. The PPfW has also launched a series of Learning Collaboratives to support continuous improvement. The first incentive payments will be distributed in early 2022, based on progress in the first six months of the new contracts.

5.5 Medications for Addiction Treatment (also known as medication-assisted treatment or MAT)

Takeaway

Despite Medi-Cal coverage of MAT and significant progress, more work can be done to expand provider capacity to prescribe and provide MAT and make it available statewide, especially in rural areas.

Promoting access to medication for OUD and alcohol use disorder in all treatment settings and at all levels of care along the continuum is a key priority for California. For OUD, the medications include methadone provided through NTPs as well as buprenorphine provided by physicians, nurse practitioners (NPs) and physician assistants (PAs) who have registered with the United States Drug Enforcement Agency

and received a waiver from SAMHSA to do so.[113] Medications for alcohol use disorder include naltrexone, disulfiram and acamprosate. There are no special requirements that providers must meet to prescribe these medications, though awareness of their effectiveness and availability remains limited. Nationally, fewer than one in 10 adults receive any treatment for alcohol use disorder, and only 1.6 percent of them use MAT.[114]

California has multiple efforts underway across the state and in the Medi-Cal program aimed at expanding access to all forms of such medications regardless of where individuals receive treatment for their SUD. For example, the state is in the process of explicitly adding coverage of MAT to all levels of care (e.g., outpatient, intensive outpatient, and residential treatment) covered under the Medi-Cal State Plan. In addition, the state is using state opioid response grant dollars to fund a California MAT Expansion Project that includes numerous components aimed at expanding access to MAT for hard-to-reach populations, including the Tribal MAT Project, which seeks to improve access for Tribal and Urban Indian communities by increasing the number of buprenorphine-waivered prescribers who incorporate the values and cultures of the communities they serve in their practices.

Recently, the federal Drug Enforcement Agency (DEA) released new rules that allow for DEA-registered Opioid Treatment Programs to establish and operate mobile methadone vans without obtaining a separate DEA registration for each mobile component. Mobile MAT units offer services like telehealth sessions, counseling, naloxone, and referrals to wraparound services. A nurse, licensed or certified addiction counselor, and peer support specialist travel in each unit.

Other investments include the California Bridge Program, which uses hospitals and EDs as primary 24/7 access points for MAT and SUD treatment, and expanding MAT in county criminal justice settings to provide coverage of at least two forms of MAT for individuals in jail and drug courts. In addition, California's prison system operates the Integrated Substance Use Disorder Treatment program, a comprehensive approach for treating individuals who are incarcerated that includes assessment, SUD treatment, MAT (where indicated), and robust transition planning when they are preparing to leave prison.[115] Building on its efforts to expand access to MAT for justice-involved

---

[113] In April 2021, the Department of Health and Human Services (HHS) rolled back training and other requirements for physicians and physician extenders who wish to prescribe buprenorphine to treat opioid use disorder, in certain circumstances (e.g., to treat up to 30 patients). Available at https://public-inspection.federalregister.gov/2021-08961.pdf?utm_campaign=pi+subscription+mailing+list&utm_source=federalregister.gov&utm_medium=email.

[114] Han B, Jones CM, Einstein EB, Powell PA, Compton WM. Use of medications for alcohol use disorder in the US: results from the 2019 National Survey on Drug Use and Health. JAMA Psychiatry. Published online June 16, 2021. doi:10.1001/jamapsychiatry.2021.1271.

[115] Expanding MAT in County Criminal Justice Settings: A Learning Collaborative, DHCS and Health Management Associates, 2021. Available at http://www.californiamat.org/wp-content/uploads/2021/01/2021-Jail-MAT-Team-Program-Description-002.pdf.

populations, qualifying people in jail or prison will be able to obtain MAT in the 90-day pre-release period and up to 30 days of MAT (depending on timing of the follow-up visit) to support their reentry into the community if the federal government approves California's Cal-AIM 1115 waiver.

While California has made strides in expanding access to MAT in recent years, DHCS recognizes that barriers to accessing MAT exist and that more work can be done to extend use of MAT.

Availability of MAT

What data are available, and what do the data say?

Since MAT for opioid use disorder is highly regulated by the federal government, there is relatively expansive data available on both NTPs and waivered buprenorphine providers. The assessment relies on data from the United States Drug Enforcement Agency to determine the maximum number of people living with an opioid use disorder in each county who could be treated with buprenorphine. In addition, it uses DHCS licensure data to determine the number of NTPs as well as the number of NTP slots available in each county. Finally, Health Management Associates shared data on the extent to which jails across the state are providing medication for OUD.[116]

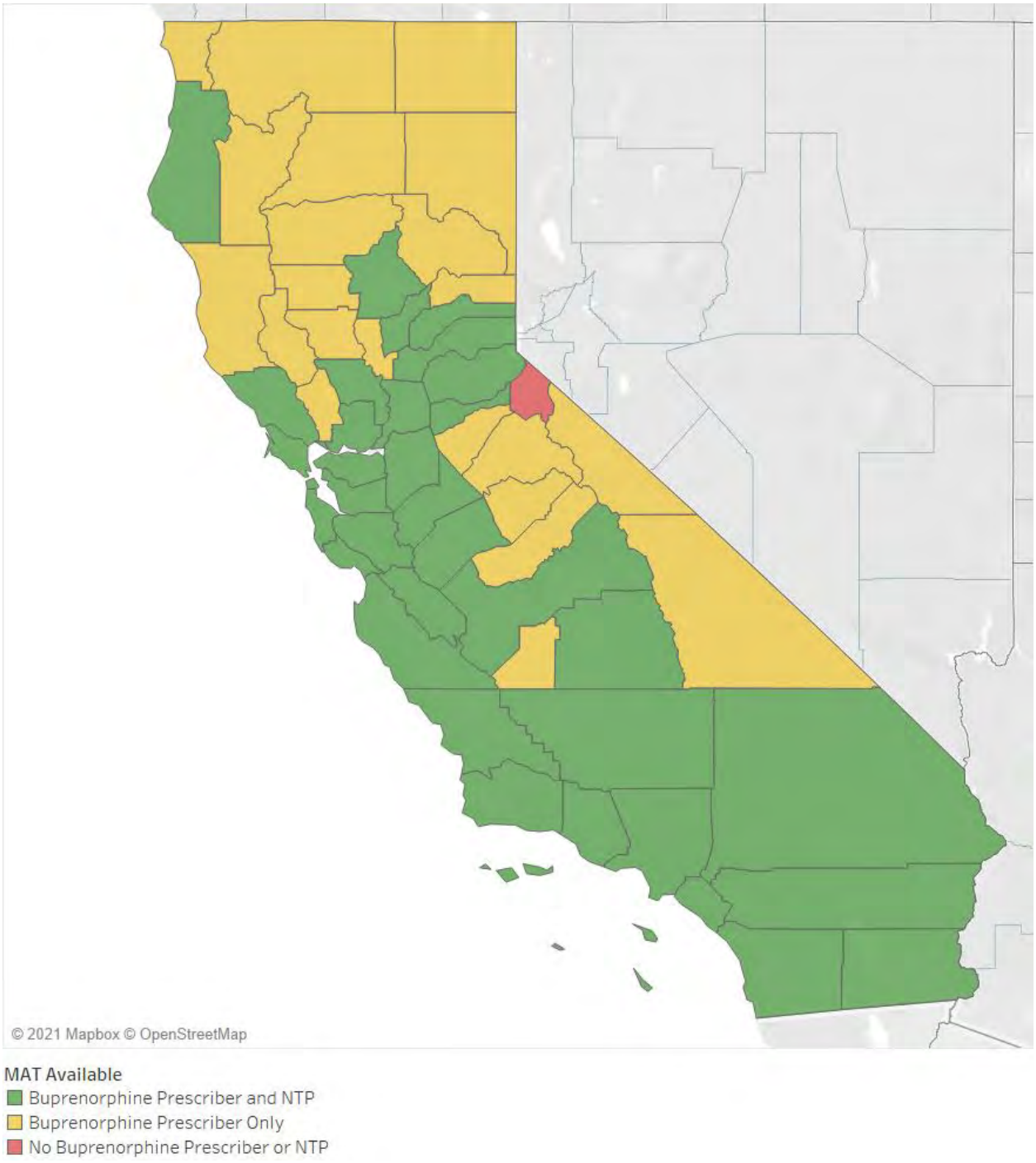
The data indicate that MAT is available in most California counties through NTPs or buprenorphine prescribers, but as discussed below, significant concerns remain about the adequacy of this supply. Specifically:

- NTPs are located in 35 counties in California, which means that individuals residing in the 23 remaining counties must travel to NTPs in neighboring counties to access methadone. The first tribal NTP will open later in 2021. NTPs can also sponsor and operate geographically-separate medication units that offer a more limited set of services – they can administer and dispense medication and collect samples for drug testing. (The sponsoring NTP is responsible for providing the remainder of services not available at medication units, including treatment and recovery supports.) Currently, there are only three licensed medication units in California.
- Fifty-seven of the 58 counties have waivered buprenorphine prescribers. Most counties have fewer than 100 prescribers. Out of all counties with over 100,000 residents, San Francisco has far more prescriber capacity per resident than any other, with 3,554 buprenorphine patient slots per 100,000 residents.
- Only one county appears to lack any NTPs or buprenorphine prescribers, which means that individuals residing in that county must obtain methadone or buprenorphine from providers in neighboring counties.
- For individuals who are justice-involved, 31 counties now provide some medication for OUD in their jails.

[116] Health Management Associates has assisted California DHCS with implementing a learning collaborative focused on expanding MAT in county criminal justice settings.

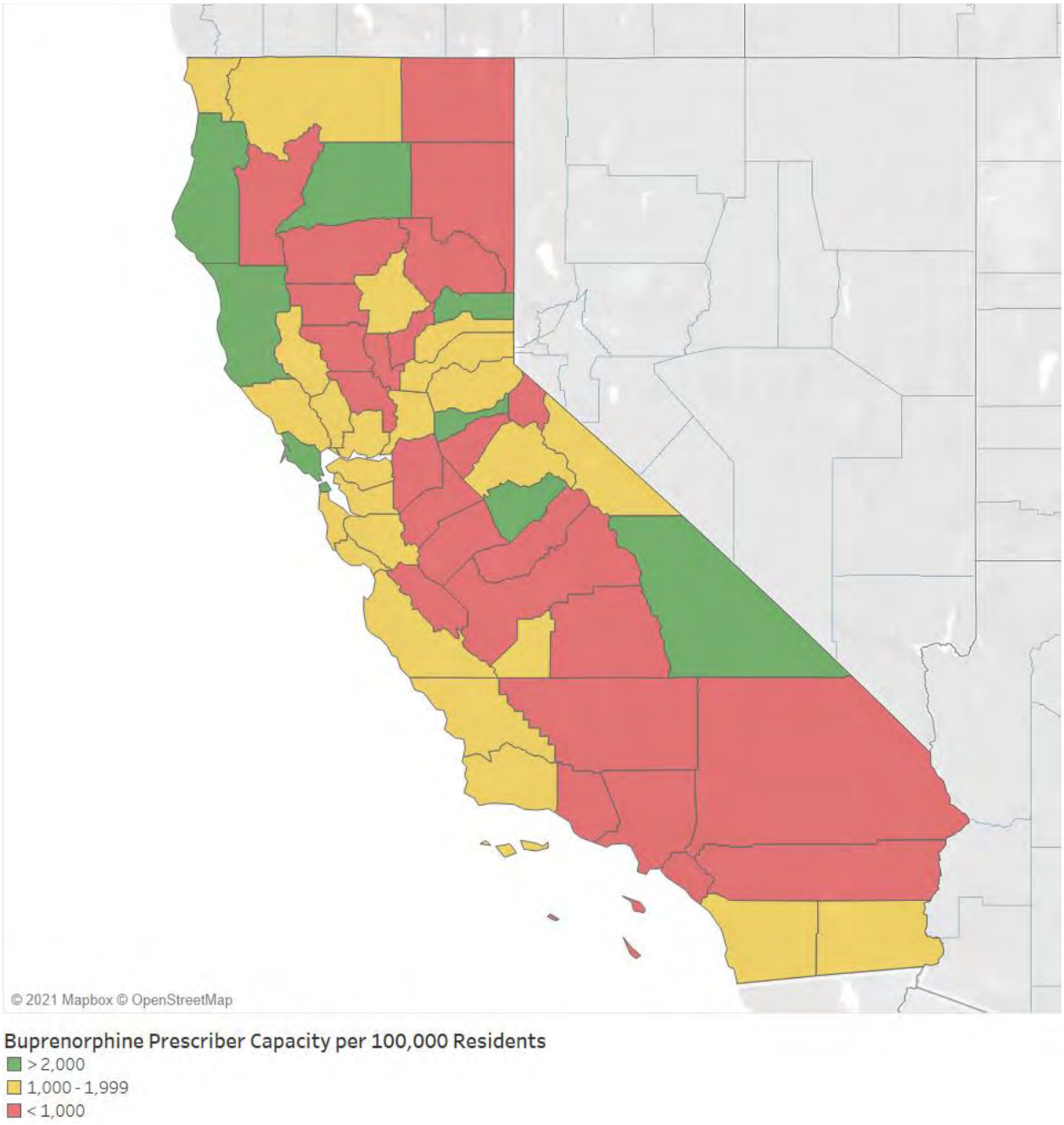
Table 6 in Appendix B displays the number of NTPs and DEA-waivered buprenorphine provider capacity in each county. Figure 5 below shows counties that have buprenorphine prescribers and/or NTPs available, Figure 6 displays buprenorphine prescriber patient capacity per 100,000 residents by county, and Figure 7 displays counties that have medications for MAT program available in their county-run jails.

Figure 5. **Counties with Buprenorphine Prescribers and/or NTPs**[117]



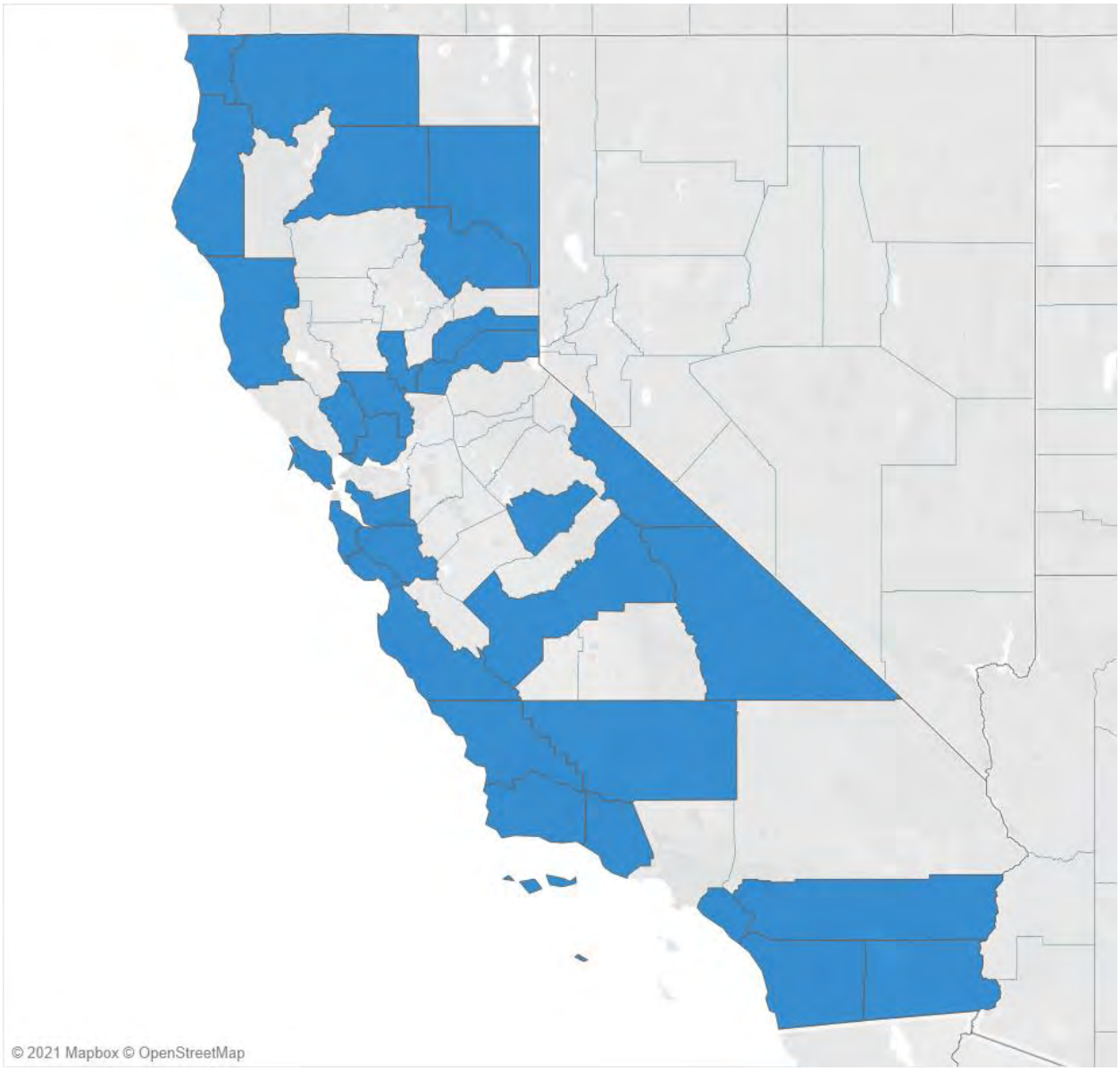
[117] Data on buprenorphine prescribers obtained from US DEA and also available via Addiction Free California data dashboard, available at https://addictionfreeca.org/data-dashboard. Data on NTPs from DHCS licensure data. Data on buprenorphine prescribers and NTPs both accessed in October 2020.

Figure 6. **Total Buprenorphine Prescriber Capacity per 100,000 Residents by County**[118]



[118] Data on buprenorphine prescriber capacity obtained from US DEA and also available via Addiction Free California data dashboard available at https://addictionfreeca.org/data-dashboard. Data accessed in October 2020.

Figure 7. **Counties with Jail-Based MAT Programs**[119]



[119] Data provided by Health Management Associates via personal correspondence in October 2021. Health Management Associates has assisted California DHCS with implementing a learning collaborative focused on expanding MAT in county criminal justice settings.

What did the survey and focus groups say?

Focus group participants noted that there is insufficient availability of MAT providers to treat individuals living with OUD seeking care and cited provider resistance to offering MAT as a key barrier.

Even among providers that have a buprenorphine waiver, not all of them use their waiver and actively prescribe buprenorphine. (Previous research suggests that up to 30 percent of providers do not actually prescribe buprenorphine even though they have a waiver.) Additionally, most providers may not be treating the full caseload of patients they are eligible to treat.

In addition, they reported that California underutilizes the opportunity to use NPs, psychiatric nurses, and PAs to provide MAT services. However, with the signing of AB 890 (Wood, Chapter 265, Statutes of 2020) into law in 2020, which allows waivered NPs to offer MAT independent of physician oversight, California now has the opportunity to expand the workforce capable of offering MAT.

MAT Success Stories

Counties are leading a wide range of innovative efforts to expand access to MAT, many of which are supported by DHCS' MAT Expansion Project. For example, San Luis Obispo County is working to increase rural access to MAT by expanding the county's Behavioral Health Department MAT services and adding a roving x-waivered nurse practitioner and behavioral health staff. San Francisco is also providing same-day low-threshold access to buprenorphine at harm-reduction locations throughout the city via telehealth.

5.6 Mental Health and Substance Use Disorder Residential Treatment

Takeaway

California has expanded access to SUD residential treatment in recent years, but more can be done, particularly in counties that have not yet opted into DMC-ODS and for youth. It remains hard to place individuals living with complex conditions or histories in mental health residential treatment, and some areas have general shortages.

A comprehensive continuum of care helps ensure that individuals obtain care in the least restrictive and most integrated setting possible. It also allows individuals who require residential services offering 24/7 support to receive them when necessary, including as a safe place to prepare individuals to live on their own. DHCS supports the right for individuals to have access to the least restrictive, least intensive setting for care. However, it also recognizes that when people need 24-hour services in a

structured living environment, it is important that they be available. Moreover, there is significant variation in the nature of residential services – some are more restrictive, while others provide support on a continuous basis, but offer more autonomy to residents and promote community integration. There is no one "right" approach to residential services, since people sometimes do require close monitoring and limitations on their movement for safety reasons, and other times people need support without losing freedom of movement. DHCS supports ensuring that the full array of residential services is available to California residents statewide.

What data are available, and what do the data say?

SUD Residential Treatment

In large part because of the Medicaid 1115 waiver demonstration that California secured in 2015 to establish DMC-ODS, California has relatively expansive data on the availability of residential treatment for Medi-Cal enrollees with a SUD.[120] According to DMC-ODS provider reports from DHCS, most counties (60 percent) have some form of SUD residential treatment services available. Among counties participating in the Medicaid 1115 waiver demonstration (known as DMC-ODS counties), clinically managed low-intensity residential treatment services (ASAM Level 3.1) and clinically managed high-intensity residential treatment services (ASAM Level 3.5) are most commonly available for adults. Table 7 in Appendix B displays the number of residential SUD treatment facilities certified at various levels of care in each county.[121] Figure 9 below displays counties that have at least one facility providing ASAM Level 3.1, 3.3, 3.5 or 3.7 SUD residential treatment.

[120] As part of the waiver, California required all participating counties to assess individuals with SUD using an evidence-based tool consistent with ASAM standards to determine the level of care they require. In parallel, counties also were required to determine the level of care provided by each participating residential treatment facility.

[121] Note that this list only includes facilities captured in DMC-ODS provider reports. These reports describe the types of services provided by DMC-ODS licensed facilities. There may be other SUD treatment facilities in the state that are providing ASAM-consistent services beyond those captured in these reports.

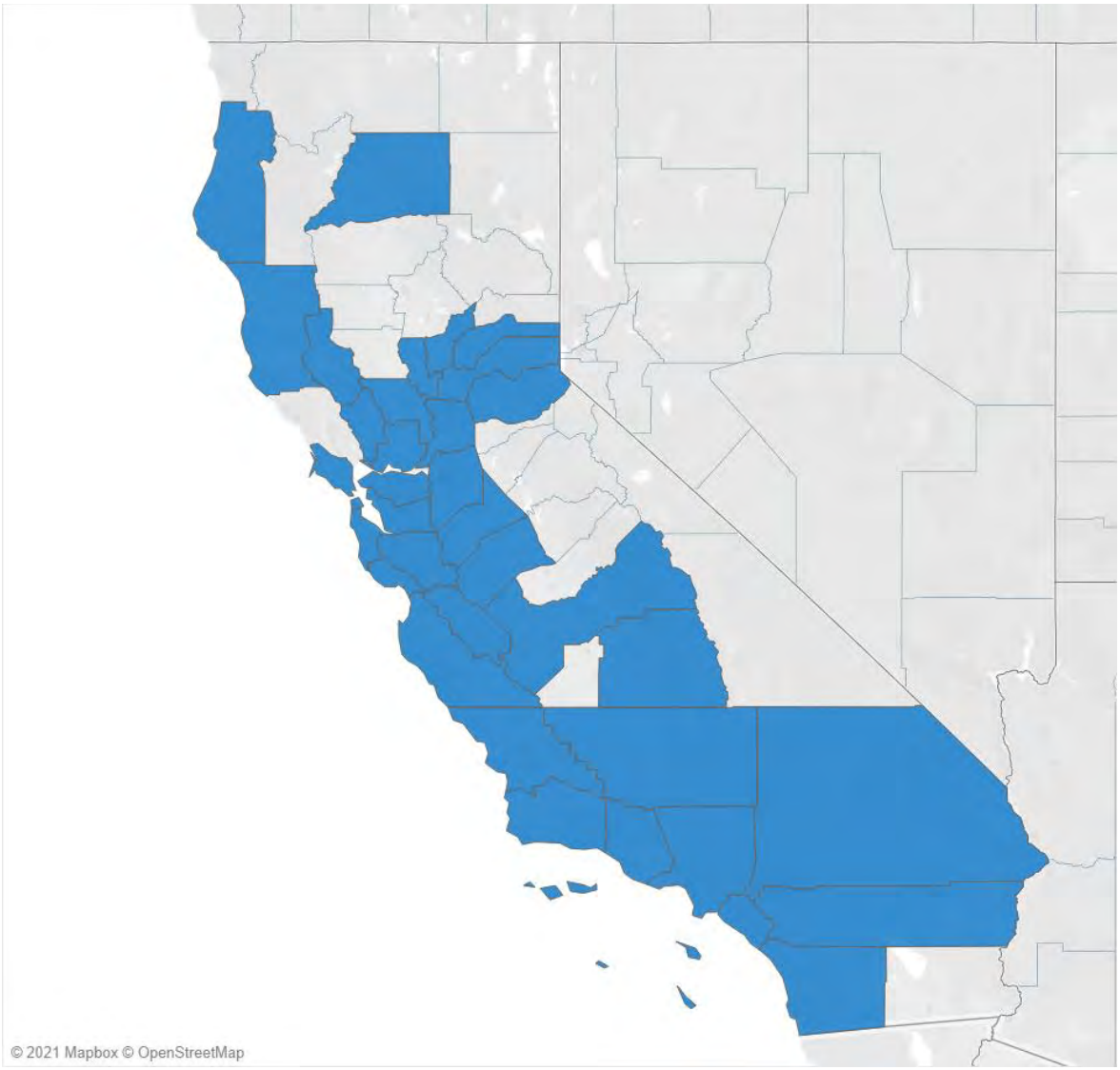
Figure 8. **ASAM Levels of Care**[122]

[122] Guyer, J., et al. Speaking the same language: a toolkit for strengthening patient-centered addiction care in the United States. American Society of Addiction Medicine. https://www.asam.org/asam-criteria/toolkit. Published November 9, 2021.

However, there still are major gaps in SUD residential treatment services across most counties in the state, including many that participate in the DMC-ODS. Counties with gaps in levels of care are required to contract with a provider in a neighboring county to ensure that Medi-Cal enrollees have access to required levels of care. This creates an administrative burden for the county and requires clients to travel long distances to receive the care they need. For instance:

- Seventy percent of counties report urgently needing residential treatment services across the board.
- Seventy-five percent of counties cite a lack of available SUD residential beds specifically for youth patients (45 respondents). This is discussed in Section 6.1.
- Twenty-two counties do not have any residential SUD treatment facilities (see Figure 9 below).
- Facilities offering clinically managed, population-specific, high-intensity residential services (ASAM Level 3.3) or medically monitored services (ASAM Level 3.7) are relatively rare in California—there are only 36 Level 3.3 facilities in operation across nine counties (half of these are located in Los Angeles). There is only one Level 3.7 facility in operation in California, and it is located in Los Angeles County.

Figure 9. **Counties with ASAM Level 3.1, 3.3, 3.5 or 3.7 SUD Residential Treatment Facilities**[123]



Mental Health Treatment

It is more difficult to find clear and distinctive data on adult mental health residential services than SUD residential treatment services, largely because the 1115 waiver establishing DMC-ODS made it necessary for DHCS to clearly define and catalogue the different levels of SUD residential treatment services covered along the ASAM continuum of care. In comparison, the categories of mental health residential treatment services are not as clearly defined. There are a number of broadly inclusive licensure categories of residential treatment for mental health in California, making it difficult to assess the exact nature of available residential services for people living with mental

[123] Source: Data from DMC-ODS provider reports provided by DHCS in July 2021.

health conditions. Social rehabilitation program (SRP) licensure includes crisis residential treatment programs, transitional residential treatment programs and long-term residential treatment programs, as well as adult residential facilities and residential care facilities for the elderly. This means that licensure data alone cannot be used to parse out the different categories. For purposes of this assessment, adult mental health residential treatment includes:

- Community-based residential settings that offer psychiatric care and support for individuals to develop socioemotional and life skills in a home-like setting. Community-based rehabilitative residential treatment settings provide support and rehabilitation services for adults who are transitioning from acute or inpatient settings for longer lengths of stay and include transitional and long-term residential settings, with transitional settings having shorter lengths of stay than long-term residential settings.
- Crisis-focused residential care settings such as crisis stabilization units that are not hospital-level services but offer consistent monitoring and support. (These are covered in Section 5.7)
- Secure, clinically monitored residential treatment facilities, including mental health rehabilitation centers and psychiatric skilled nursing facilities that provide psycho-social rehabilitation, emphasize skills-building and linkage to community supports, and intensive nursing services when medically appropriate.

Currently, licensing data are available on “social rehabilitation programs,” a category that includes transitional and long-term residential settings and crisis residential treatment programs—as well as adult residential facilities and residential care facilities for the elderly. While useful for other purposes, the social rehabilitation licensure category does not on its own indicate whether a setting provides community-based residential care that aligns with the social rehabilitation model of care, as defined in the community supports section under psycho-social rehabilitation in Section 5.3. With the caveat that it offers limited insight into the nature of the residential treatment available, Table 7 in Appendix B shows that 31 counties have settings that are licensed as “social rehabilitation programs.”

To supplement the data in Table 7, Table 8 shares data provided by the California Association of Social Rehabilitation Agencies (CASRA) on member community-based residential programs across the state reflect a social rehabilitation model. The social rehabilitation model focuses on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports. Social rehabilitation is complementary to medical support services. Data from CASRA indicate that such residential programs are primarily concentrated in ten counties across the state, with the bulk of programs located in San Francisco. More specifically, their data suggest that there are at least:

- 19 transitional residential treatment programs that deploy a social rehabilitation model in five counties, and

- Four long-term residential treatment programs with a social rehabilitation model in two counties.

Community-based residential treatment programs are an alternative for individuals living with mental illness who would otherwise be placed in higher levels of care, such as state hospitals and secure residential facilities and can enable individuals to reside in the least restrictive settings and promote community integration; however, they are not widely available across the state despite in many cases providing services that are reimbursable by Medi-Cal.

A second category of licensing data from California provides information on the number of “mental health rehabilitation centers” or “MHRCs,” which provide secure, clinically monitored residential treatment facilities in California. These data indicate MHRCs—facilities that provide individualized intensive support and rehabilitation services for adults transitioning from inpatient care to develop the skills to become self-sufficient and capable of increasing levels of independent functioning—are concentrated in several counties throughout the state. Slightly less than one-third of all counties have MHRCs. According to licensure data from DHCS, there are 28 operational MHRCs across 19 counties, with a total capacity of 1,882 beds. Most of these facilities are operated by private organizations.

In addition to adult specific mental health residential treatment services, California also covers children’s mental health residential treatment services in several different settings that are geared toward children in foster care:

- Short-term residential treatment programs (STRTPs) provide an integrated program of specialized and intensive care and supervision, services and supports, specialty mental health services, mental health treatment; and short-term, 24-hour care and supervision to children. Most counties have at least one STRTP available. According to licensure data from DSS, there are 430 operational STRTPs across 40 counties with a total capacity of 4,206 beds.
- Community treatment facilities (CTFs) provide mental health treatment services to children in a sub-acute, secured, and home-like setting. CTFs serve as an alternative to state hospital stays or out-of-state placement and enable children living with mental health needs to receive treatment in a less restrictive setting. CTFs are relatively rare in California. According to licensure data from DSS, there are only two CTFs in the state and both are located in Los Angeles County.

Using Simulation Modeling to Optimize Mental Health Beds: An Example from San Francisco

In early 2020, the San Francisco Department of Public Health's Mental Health Reform team identified an innovative solution in response to the system's behavioral health bed optimization challenge: simulation modeling. Bed simulation modeling has been used internationally as a risk-free strategy in health care for quantifying residential treatment bed demand and identifying the impact of novel allocations of treatment beds on patient flow. The team developed a model using FY18-19 billing data for more than 25,000 admissions to mental health and substance use residential programs (greater than 24-hour stays) and urgent care settings (Psychiatric Emergency Services at Zuckerberg San Francisco General, Psychiatric Urgent Care, and the Alcohol Sobering Center). The data incorporated the demographics of the patients admitted to these care settings, including gender, age, race and ethnicity, and housing status. The analysis also considered the transitions of individuals across the behavioral health care continuum. The final output provided precise insights about how many beds are needed in each behavioral health bed category to maintain consistent patient flow for adult clients in San Francisco with minimal wait time, which was used to inform additional investments in treatment bed capacity associated with the city's new clinical services program, Mental Health SF.

What did the survey and focus groups say?

Responses from focus group participants on mental health residential and inpatient care are captured in Section 5.9. On SUD, focus group respondents reported that the DMC-ODS program "created a true continuum of care for the first time" and significantly expanded the number of individuals who can access SUD care. They did note, however, that critical challenges remain mostly for SUD residential treatment, including:

- Some focus group participants highlighted that from their perspective, longer lengths of stay are needed for individuals with particularly complex or acute needs for stabilization, treatment, and recovery. They, however, stated that counties are not consistent in approving stays longer than 30 days even when they are essential.
- Many patients with SUD also have a co-occurring mental health condition but focus group participants reflected that residential treatment providers often struggle to treat such individuals, due to lack of expertise and experience managing mental health conditions.
- From the perspective of many focus group participants, there is a shortage of medically monitored intensive inpatient (ASAM Level 3.7) beds across the state. They attribute this to the service being optional under the DMC-ODS waiver, as well as more recently to the reality that the pandemic has required hospitals to dedicate available beds to COVID-19 patients over other conditions, including SUD.
- Focus group participants and county behavioral health directors in their survey responses consistently highlighted that there is a pressing need in mental health and SUD residential treatment facilities for adolescents, which results in young people

sometime receiving care in adult facilities or being sent far away from their homes for treatment.

- Focus group participants noted that individuals with significant mental health needs and with behaviors or histories deemed problematic may be declined by residential treatment providers.
- 71 percent of respondents to the survey of county behavioral health directors identified subacute treatment (including MHRCs and SNFs with special treatment programs) as an urgently needed level of care in their county's adult mental health continuum of care.
- For both adults living with SMI and children living with SED, there are significant needs for more residential treatment options, as discussed further in Section 5.9.

SUD Residential Treatment Success Stories

Humboldt and Modoc Counties have joined five other counties in a DMC-ODS Regional Model for SUD Wellness and Recovery to increase access and capacity in the region for adults and youth living with SUD. For example, youth SUD services are in short supply across all seven counties, but when a provider is added to any of the seven counties, residents across all counties in the regional partnership have access to the new provider. In essence, the regional partnership allows the seven counties to pool their resources when it comes to treating people living with SUD, including with respect to residential treatment.

5.7 Crisis Services

What Is a Behavioral Health Crisis?

A behavioral health crisis is any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community. These crises might include thoughts of suicide; violent, aggressive, or erratic behavior; losing touch with reality; rapid mood swings; or an inability to perform basic daily tasks. They can be due to mental health issues, substance use or a combination of the two. Many people who live with SUD also develop other mental illnesses, just as many people who are diagnosed with mental illness are often diagnosed with SUD. Historically, the treatment of mental health and substance use disorders in California (and much of the rest of the country) has been segregated, but DHCS' position is that the crisis system—and indeed, the full continuum of crisis care over time—should provide integrated mental health and substance use care.

Takeaway

Despite pockets of innovation, California can do more in crisis services, to reduce avoidable ED visits, hospitalizations, and incarceration. Even where crisis services are available, there is strong interest in improving connections to ongoing care.

Throughout California, as in the rest of the country, the family (or friends) of someone in a behavioral health crisis often has no choice but to call 911 or try to persuade the person to voluntarily go to the ED. While sometimes an ED visit or the presence of the police is absolutely required, people often rely on these options simply because there is no alternative. When law enforcement is called, it can lead to an increase in unnecessary arrests and incarceration of people living with acute behavioral health needs. Once on the scene, law enforcement officials must attempt to maintain public safety and they will decide whether to take the person to jail or to a health care facility, regardless of the individual's or family's requests. Among the options currently available to law enforcement, a jail may be one of the least suitable settings in which to provide acute behavioral health care. In contrast to jails, EDs are designed to help assess and stabilize people in crisis, but, if someone does not have a concurrent medical emergency, it is an inefficient use of resources. Moreover, people in behavioral health crisis can end up "boarding" (i.e., staying under watch without receiving treatment while they await a placement elsewhere) in the ED, sometimes for days. In such situations, they may be transferred to an inpatient psychiatric hospital even if they could have been treated in a less restrictive setting if such care were readily available. A growing number of counties are seeking to expand the range of health care supports and destinations available to residents in crisis.

As indicated in Section 3, an organized continuum of crisis services is vital to addressing these issues and diverting individuals who do not have a concurrent medical emergency, inpatient psychiatric hospitals, and incarceration. It should also include addressing a substance use crisis within this continuum as recommended by the SAMHSA Crisis Toolkit. The elements of a crisis response continuum addressed in this section include:

- Mobile crisis teams, which travel to an individual's home or location in the community (e.g., a homeless shelter or street location) to de-escalate a situation and assess the type of care an individual requires. The mobile crisis team links individuals who require further treatment to crisis stabilization services, crisis respite services, sobering centers, crisis residential services and other behavioral health treatment. If necessary, they can help to get a person to the ED for more in-depth assessment and stabilization.
- Crisis stabilization units (CSUs), which, in California, provide behavioral health services (e.g., assessment, case management and therapy) on an "urgent" basis for less than 23 hours. They are designed for people living with a behavioral health condition that requires a timelier response than a regularly scheduled visit,

but that do not require evaluation and stabilization in an ED.[124] Individuals who require additional treatment and observation can be referred to crisis residential services.
    - Crisis respite services, which can provide 24-hour observation and support until a person is stabilized. The services are provided by crisis workers or trained counselors, sometimes including peer support specialists.
- Crisis residential services for individuals who are experiencing an acute psychiatric crisis and could benefit from short-term (usually less than seven days) 24/7 medical and treatment supports.
- Sobering centers, which provide a safe place for individuals waiting for the effects of alcohol or drug intoxication to wear off while being monitored for underlying medical conditions or injury.

Although not discussed in depth in this section, a particularly important part of crisis services is the phone number and call center that people call when a crisis arises. This will be a focus for California in the months ahead as it prepares for implementation of 988, the national crisis hotline for people who are suicidal or otherwise in crisis, which will go into effect by July 16, 2022.

Mobile Crisis Services

What data are available, and what do the data say?

Data collected from the survey of county behavioral health directors suggest there are shortages in the availability of mobile crisis services across the state. To put the existing supply into context, DHCS used the Crisis Resource Need Calculator, a tool developed for the National Association of State Mental Health Program Directors (NASMHPD), to estimate optimal crisis system resource allocations for each of the 58 counties in California.[125] The calculator relies on two inputs: population size and average length of stay for acute inpatient admissions, to determine the level of mobile crisis (and other crisis services, discussed below) needed by a local jurisdiction.[126] The tool is useful in providing a sense of where more resources might be required, but these estimates represent only one factor to consider. It also is critical to account for the unique

---

[124] CA Code § 1810.100. Available at https://www.cdss.ca.gov/shd/res/pdf/1810.pdf.

[125] The Crisis Resource Need Calculator was developed by Recovery International for the National Association of State Mental Health Program Directors and uses data from a cross-state analysis to determine projected utilization of crisis services and other behavioral health services. Available at www.crisisnow.com.

[126] Information on population size by county were taken from the US Census Bureau. Data on average length of stay for acute inpatient psychiatric admissions by county were provided by the California Hospital Association via personal correspondence. Data provided by the California Hospital Admission describe average length of stay by county for psychiatric health facilities, freestanding psychiatric hospitals, and psychiatric units within general acute care hospitals. These data were used to calculate weighted average lengths of stay across all three types of inpatient psychiatric institutions for each county.

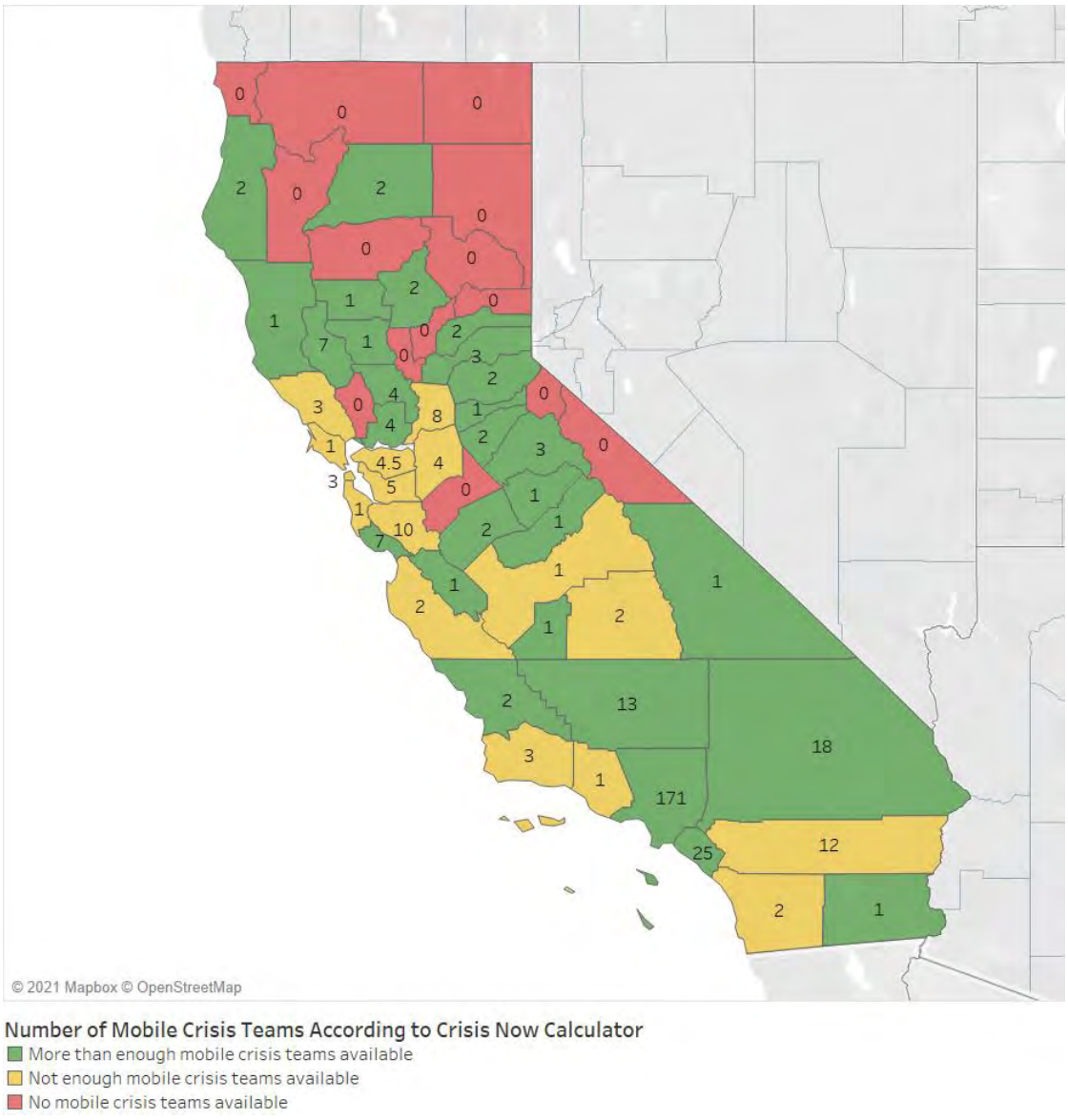
circumstances of each county, population density, travel distances, workforce capacity and regional resources when assessing the need for mobile crisis resources.

The available data and calculator estimates suggest the following:

- Twenty-one counties appear to need additional mobile crisis capacity; 37 counties have sufficient mobile crisis intervention capacity.
- For the 21 counties with gaps in mobile crisis services, the majority need up to twice the number of existing mobile crisis teams, with some counties (San Diego, Fresno, Alameda and Ventura) needing even more.
- Nine counties do not appear to have a sufficient population base to support even one mobile crisis team, underscoring the importance of intercounty, interprofessional (e.g., community paramedics as crisis first responders) or telehealth arrangements for residents in these communities.

Figure 10. **Current Number of Mobile Crisis Teams by County and Estimates of Need for Additional Capacity[127]**

Counties shaded in green may have sufficient mobile crisis teams according to the Crisis Resource Need Calculator. Counties shaded in yellow have mobile crisis teams available but do not have enough mobile crisis teams according to the calculator. Counties shaded in red do not have any mobile crisis teams available. Labels on counties reflect the number of mobile crisis teams available.



[127] Number of mobile crisis teams identified from 2021 survey of county Behavioral Health Directors. Coloring on map based on analysis of Crisis Resource Calculator. Note that the Crisis Resource Calculator is intended to provide a general sense of where additional resources may be needed and cannot definitively identify whether an area has sufficient treatment capacity.

What did the survey and focus groups say?

The availability of mobile crisis services across California is highly variable. The county survey and focus groups indicate the following:

- Approximately one-third of California counties (14) report that they do not operate or contract with any mobile crisis response teams (Table 9 in Appendix B). Most counties with mobile crisis units, however, report operating only one to two teams, making it impossible to respond to many calls simultaneously and lengthening response times to several hours or even a day.
- There are significant workforce issues specifically related to providing mobile crisis services—the 24/7 nature of the services and managing high-risk situations make recruitment and retention of staff to provide mobile crisis services difficult.
- Current Medi-Cal reimbursement procedures fail to adequately account for the full cost of providing these services, such as transportation and downtime between calls for service. Funding is only offered for direct client services.
- Stabilization services following an initial crisis are not generally available in California.
- Mobile crisis units are generally not tailored or equipped to serve children and youth or other specific populations (e.g., individuals living with SUD, individuals living with co-occurring mental health and substance use disorders, individuals living with intellectual/developmental disabilities).

"Mobile crisis services are needed, but they are ineffective unless they have somewhere to take the individual. There is a huge shortage in acute inpatient beds and board-and-cares."

– Drug/Alcohol Program Association

Almost all counties (52) report interest in expanding or improving mobile crisis services. In addition, in October 2021, 46 counties and one tribal entity applied and were selected for either planning or implementation grants for mobile crisis units totaling $205 million. Six counties with no existing mobile crisis capacity are planning to operate or contract with a mobile crisis response team.

"Our hope is to strengthen and expand our current mobile crisis and noncrisis services in order to prevent and divert individuals from involvement in the criminal justice system, including supporting joint mobile crisis and law enforcement intervention services."

– County Behavioral Health Director

In addition to mobile crisis teams, many counties have developed a “co-response” approach in responding to behavioral health crises (75 percent, 45 respondents). Under this approach, law enforcement officers are paired with behavioral health professionals when they respond to calls for service. An additional four counties (7 percent) are planning to operate a law enforcement co-response program. Forty-four counties (73 percent) also report providing law enforcement with specialized training on behavioral health crises and how to respond, including nonclinical engagement, crisis intervention team and de-escalation training.

Alternative Transportation Options for Individuals in Crisis

Modern and trauma-informed systems of care are redesigning how individuals in a behavioral health crisis are transported to a place of safety. For an individual experiencing a behavioral health crisis, the process for involuntary commitment for a mental health evaluation represents one of the highest-risk chances for a negative experience with law enforcement. In most jurisdictions in the United States, law enforcement agencies are primarily responsible for taking individuals into custody for transportation to the nearest hospital for an emergency evaluation.[128] However, in Alameda County, when law enforcement officers initiate an involuntary psychiatric detention (Welfare and Institutions Code (WIC) § 5150) on an adult, rather than transport the patient themselves for evaluation they call for an ambulance instead.[129] During the COVID-19 pandemic, San Francisco also adopted a model where emergency medical services personnel are the preferred resource to transport individuals in crisis from the community to local hospitals for emergency psychiatric evaluations. Of note, Contra Costa County had a similar practice in place for years prior to the pandemic. The recently enacted Community Paramedicine or Triage to Alternate Destination Act offers an opportunity for counties to further develop alternative transportation options that would allow an individual in crisis to be transported from the community to a variety of health facilities using the least restrictive methods possible (i.e., without the use of physical restraints or handcuffs).

[128] State Standards for Initiating Involuntary Treatment. Available at https://www.treatmentadvocacycenter.org/storage/documents/state-standards/state-standards-for-initiating-involuntary-treatment.pdf.

[129] Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med. 2014 Feb;15(1):1-6. doi: 10.5811/westjem.2013.6.17848. PMID: 24578760; PMCID: PMC3935777.

Availability of Crisis Stabilization Units

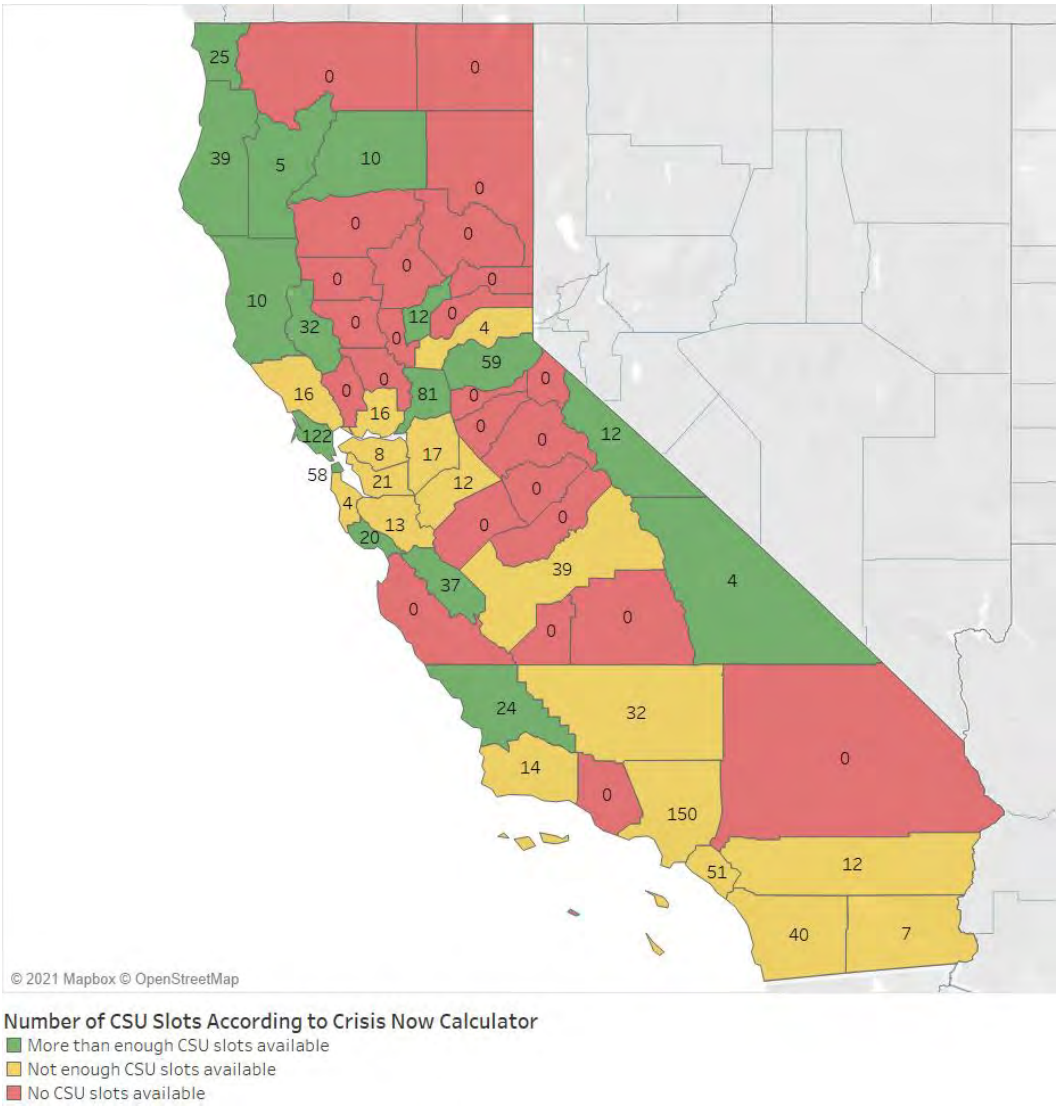
What data are available, and what do the data say?

Data on the number of CSUs available in California were obtained from results of the survey of county behavioral health directors as well as DHCS licensure data. Similar to the process used to measure availability of mobile crisis services, the Crisis Resource Need Calculator was combined with these data on the number of CSUs by county to determine the need for additional CSU bed capacity. Based on this analysis, there is considerable need for additional CSU bed capacity. At the time of this study:

- Out of 33 counties with CSUs available, 16 (48 percent) had sufficient CSU capacity.
- Twenty-five counties, both sparsely and densely populated, reported no CSU bed capacity.
- Some areas of the state (multicounty and large single counties) have no CSU capacity, and it may take multiple hours to transport individuals to the nearest CSU. As a result, these individuals are more likely to be transported to an ED or even jail.
- Thirty-nine counties (67 percent of respondents) have insufficient CSU bed capacity; 17 of those have some CSU capacity available.

Figure 11. **Current Number of CSU Slots Available by County and Estimates of Need for Additional Capacity[130]**

Counties shaded in green may have sufficient CSU slots according to the Crisis Resource Need Calculator. Counties shaded in yellow have CSUs available, but do not have enough CSU slots according to the calculator. Counties shaded in red do not have any CSU slots available. Labels on counties reflect the number of CSU slots available.



[130] Number of CSU slots identified from DHCS licensure data accessed in June 2021 as well as a 2021 survey of county Behavioral Health Directors. Coloring on map based on analysis of Crisis Resource Calculator. Note that the Crisis Resource Calculator is intended to provide a general sense of where additional resources may be needed and cannot definitively identify whether an area has sufficient treatment capacity.

What did the survey and focus groups say?

According to information from DHCS and responses to the county survey, 33 counties operate CSUs or other behavioral health crisis programs through EDs or urgent treatment centers. Marin and Los Angeles Counties have more CSUs than any other county, with 10 and nine programs, respectively. Information from DHCS and the county survey indicated:

- Most counties (33 out of 58) operate at least one CSU.
- Most counties with a CSU operate between one and five facilities.
- Two counties are in the process of planning to implement CSU services.
- All CSUs operating in California counties serve adults, and most also serve children and youth (85 percent, 22 respondents out of 26 counties with one or more CSUs).

The county survey and focus group participants identified several additional concerns. For instance, the majority of CSUs end up serving at least some people for longer than 23 hours (85 percent, 22 respondents out of 26 counties with one or more CSUs), often because of the difficulty of finding them an inpatient psychiatric bed or alternative lower level of residential care which allows safe discharge. When they have to hold people for longer than 72 hours, staff must seek an involuntary hold (Welfare and Institutions Code (WIC) § 5250) to allow services to continue for up to an additional 14 days.[131] County behavioral health directors reflected that hospitals often view people living with involuntary holds as likely to be high need and difficult to serve, making it less likely these patients will be accepted.

Counties also highlighted the need to improve access to inpatient care for children/youth and adults and to secure, subacute levels of care (MHRCs) for adults (68 percent, 15 respondents). In addition, survey respondents stated that CSU staffing ratios, the time limitation on reimbursement (20 hours) and reimbursement rates pose challenges to developing CSU capacity. Finally, focus group participants indicated that existing licensing and other regulations prevent colocation of mental health and SUD services in a CSU—a barrier to serving people living with co-occurring conditions.

[131] California Code, ARTICLE 4. Certification for Intensive Treatment (2015). Available at https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5250.&lawCode=WIC.

Crisis Services Success Stories

Santa Cruz County's Rapid Connect Program provides outreach and linkages to all individuals served in their Crisis Stabilization Program—connecting them with follow-up services and supports and addressing barriers to treatment prior to discharge.

The Behavioral Health Crisis Services Collaborative is a unique public-private collaboration between Sacramento County, Placer County and Dignity Health that engages multiple plan and community-based partners to serve residents of both counties. The facility is sited in the northern region of Sacramento, which lacked sufficient crisis service programs across two counties with growing populations. The entities share governance and regulatory responsibilities related to delivering seamless integrated medical emergency and CSU care on a hospital emergency department campus. In addition, the CSU is linked to a resource center to connect individuals to follow-up care such as peer and family support services.

Availability of Crisis Respite Services (Including Peer Crisis Respite Services)

Crisis respite centers and apartments can provide 24-hour observation and support by crisis workers or trained volunteers until a person is stabilized. In some crisis respite models, peer support specialists are available and provide the necessary assistance to de-escalate a crisis, provide short-term supports and assist the individual in connecting with community services.

What did the survey and focus groups say?

Similar to CSUs, the availability of crisis respite programs varies across the state. For instance, less than 17 percent (10 respondents) of California counties report operating a peer respite center or service. Counties expressed a high interest in and need for more peer respite services. Indeed, several respondents indicated they already were reaching out to other counties with peer-run respite services to seek advice on planning and implementing such services in their own jurisdictions. Even the counties that already offer peer respite services tend to operate a limited number of programs (generally fewer than two).

Two counties have more expansive peer respite services. Sacramento County reported 10 peer respite programs with 110 peer-based crisis respite beds. In addition, San Francisco County operates a crisis respite program—Hummingbird Places—that offer a blend of peer and professional staff counseling, short-term overnight respite services to facilitate stabilization, provide linkages to social services and offer clients the opportunity to connect with longer-term treatment and recovery options.

Short-Term Crisis Residential Programs

California has developed Crisis Residential Treatment Programs (CRTPs) to serve individuals over the age of 18 who are experiencing an acute psychiatric crisis. CRTPs provide short-term intensive and supportive services in a homelike environment and offer self-help skills, peer support, individual and group interventions, social skills and community reintegration services, medication support, co-occurring disorder services, pre-vocational and educational support, and discharge planning.

Other states have developed effective short-term crisis residential services for individuals living with behavioral health conditions, with stays less than seven days. These programs provide crisis relief, resolution and intensive supportive resources for adults who need temporary 24/7 support. Services are provided in an organized, bed-based, nonmedical setting delivered by appropriately trained staff who provide safe 24-hour crisis relieving/resolving intervention and support. These services include medication management (including the use of previously initiated MAT), observation and care coordination in a supervised environment where the client is served even though these are not primary substance use treatment facilities.

"Our county would benefit from an increase in both adult and children's crisis residential beds and locations. Increasing the locations would increase access for reintegration of clients into their community…. An increase in Crisis Response Project locations and beds would benefit our system of care by increasing the flow between hospitals/CSUs and outpatient treatment."

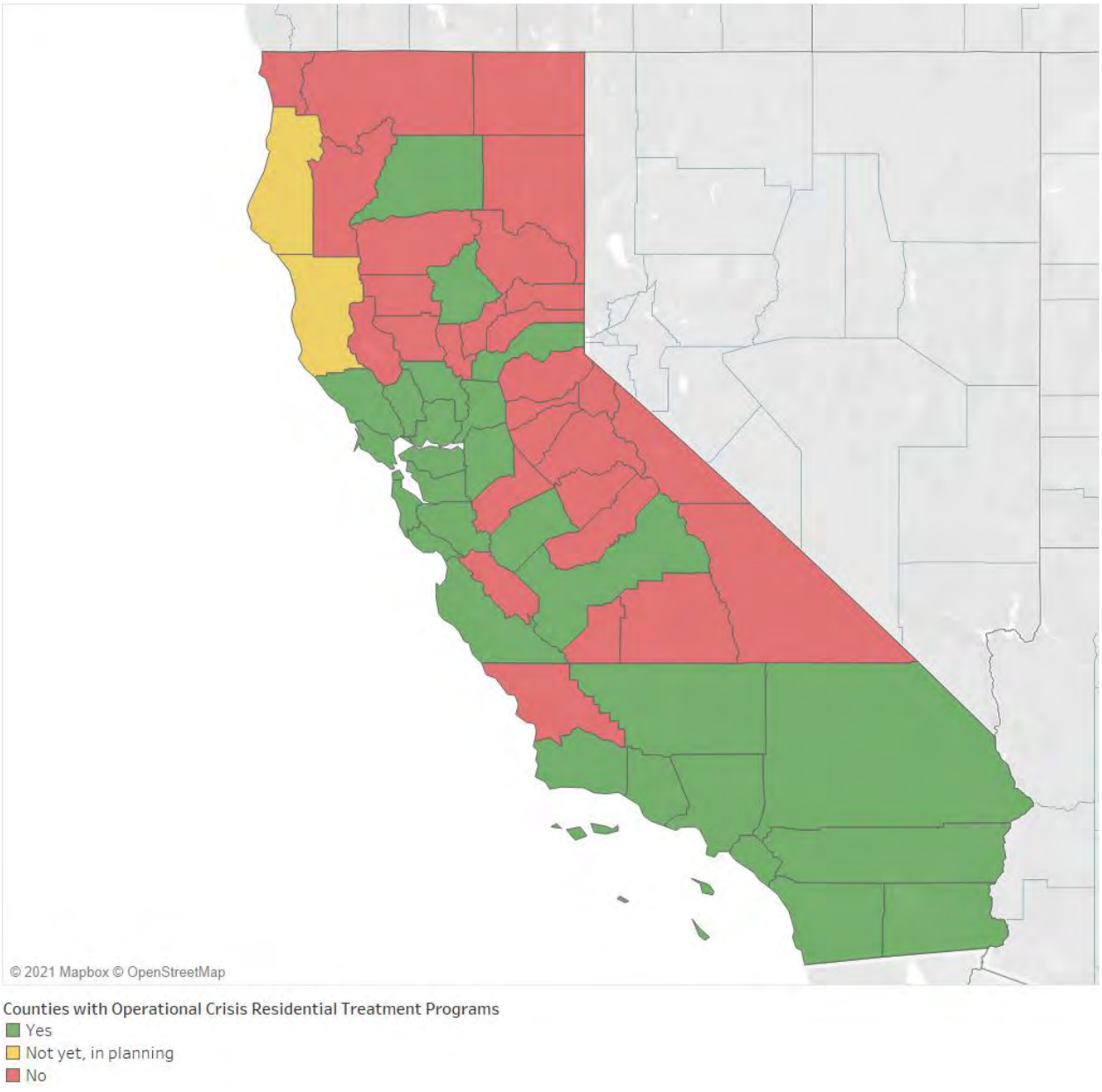
– County Behavioral Health Director

What did the survey and focus groups say?

The availability of CRTPs varies throughout the state. For instance, only half of California counties (47 percent, 28 respondents) report operating or planning to operate (two respondents) a crisis residential treatment facility. Counties currently operating CRTPs report operating or contracting with between one and seven crisis residential treatment facilities for adults, which for the vast majority of respondents falls short of the need. Indeed, more than two-thirds of respondents (68 percent, 19 respondents) with some crisis residential treatment capacity report needing additional capacity. The challenges in crisis residential treatment for children and youth are particularly large. Only five of the 58 counties report operating a CRTP for youth, with no county offering more than one youth-oriented CRTP.

Figure 12. **Current Availability of Crisis Residential Treatment Programs**[132]

Counties shaded in green have crisis residential treatment programs. Counties shaded in yellow do not have operational crisis residential treatment programs but are currently in planning phases. Counties shaded in red do not have operational crisis residential treatment programs.



[132] Source: Based on 2021 survey of county Behavioral Health Directors.

Sobering Centers

Sobering centers can be used to divert individuals from EDs when they require observation and minimal support while recovering from the acute intoxicating effects of alcohol and/or other drugs of abuse. Visitors may be offered medications, wound care and monitoring under medical supervision or simply be invited to rest until they are less intoxicated. After a period of time, clients may be offered support services, including referrals and linkages to ongoing treatment.

What data are available, and what do the data say?

Last year, the California Health Care Foundation undertook an environmental scan of California's sobering centers.[133] The report revealed that 10 sobering centers were in operation as of November 2020, and it identified another six to eight programs being considered or implemented. More recent data on California's sobering centers indicate:

- The total statewide capacity is 168 individuals at any given time.
- These sobering centers have a capacity ranging from 10 to 20 beds, with the exception of Los Angeles County, which can serve up to 50 clients at any given time.
- Thirteen survey respondents (22 percent of counties) reported operating a sobering center.
- An additional six counties (10 percent) plan to create a sobering center.

The number of sobering centers may also increase as a result of DHCS encouraging Medi-Cal MCPs to offer access to sobering centers as a community support or ILOS. Essentially, these are Medi-Cal benefits offered at the option of an MCP. As of October 2021, MCPs in 37 counties have indicated that they intend to offer sobering centers as one of their community supports. Initially, the MCP may not be able to ensure access to a sobering center for all eligible enrollees in a particular county due to limited provider networks, but under contract provisions, they are expected to expand provider networks to be countywide over time.

What did the survey and focus groups say?

Focus group participants also indicated a need for more sobering centers and recommended that services offered in these centers be reimbursable through the DMC-ODS program. Several cautioned against licensing these facilities in the future, citing concerns about the potential for increasing regulations that would limit flexibility to provide low-threshold engagement supports. Several models were referenced in the survey and focus groups. For instance, recovery (sobering) stations in Bakersfield and Delano encourage visitors to connect to both mental health and SUD services during their stay and provide referrals to care based on on-site assessments.

---

[133] Sobering Centers Explained: An Environmental Scan in California, California Health Care Foundation, September 2021. Available at https://www.chcf.org/wp-content/uploads/2021/07/SoberingCentersExplainedEnvironmentalScanCA.pdf.

5.8 Withdrawal Management Services

Takeaway

Coverage of withdrawal management varies significantly across Medi-Cal's delivery systems (DMC, DMC-ODS, MCPs, fee-for-service (FFS)) and skews toward residential settings instead of ambulatory or outpatient settings.

Withdrawal management (WM) refers to the medical and behavioral health care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.[134] WM can be provided in various settings: outpatient (Levels 1-WM and 2-WM), SUD residential (ASAM Level 3.2-WM) and inpatient hospitals (distinct units and freestanding facilities at ASAM Level 4.0-WM). Some individuals living with severe SUD cannot safely undergo the withdrawal process in an outpatient setting. These individuals require an inpatient acute hospital level of care to safely manage the withdrawal process, usually due to co-occurring complex medical conditions or the intensity and duration of their substance use.

Availability of WM Services

What data are available, and what do the data say?

Coverage of and access to WM services in the Medi-Cal program varies by county. DMC-ODS provider reports and DHCS Alcohol and Drug Program Certification data revealed that residential WM programs are more commonly available than are ambulatory WM services. Table 10 in Appendix B displays the number of facilities providing ambulatory and residential SUD WM services in each county in 2021.[135] Figure 13 below shows counties with treatment facilities providing ambulatory or residential WM services. Specific findings include:

- Most counties in California have at least one facility that provides residential ASAM Level 3.2-WM services, with a total of 108 facilities spread across 31 counties.
- Only 15 counties have facilities providing ambulatory WM, and over half of those facilities are located in Los Angeles County.
- Medically monitored inpatient (ASAM Level 3.7) and medically managed inpatient WM services (ASAM Level 4.0-WM), referred to collectively as inpatient WM, are provided by only three facilities in the state; all are located in Los Angeles County.

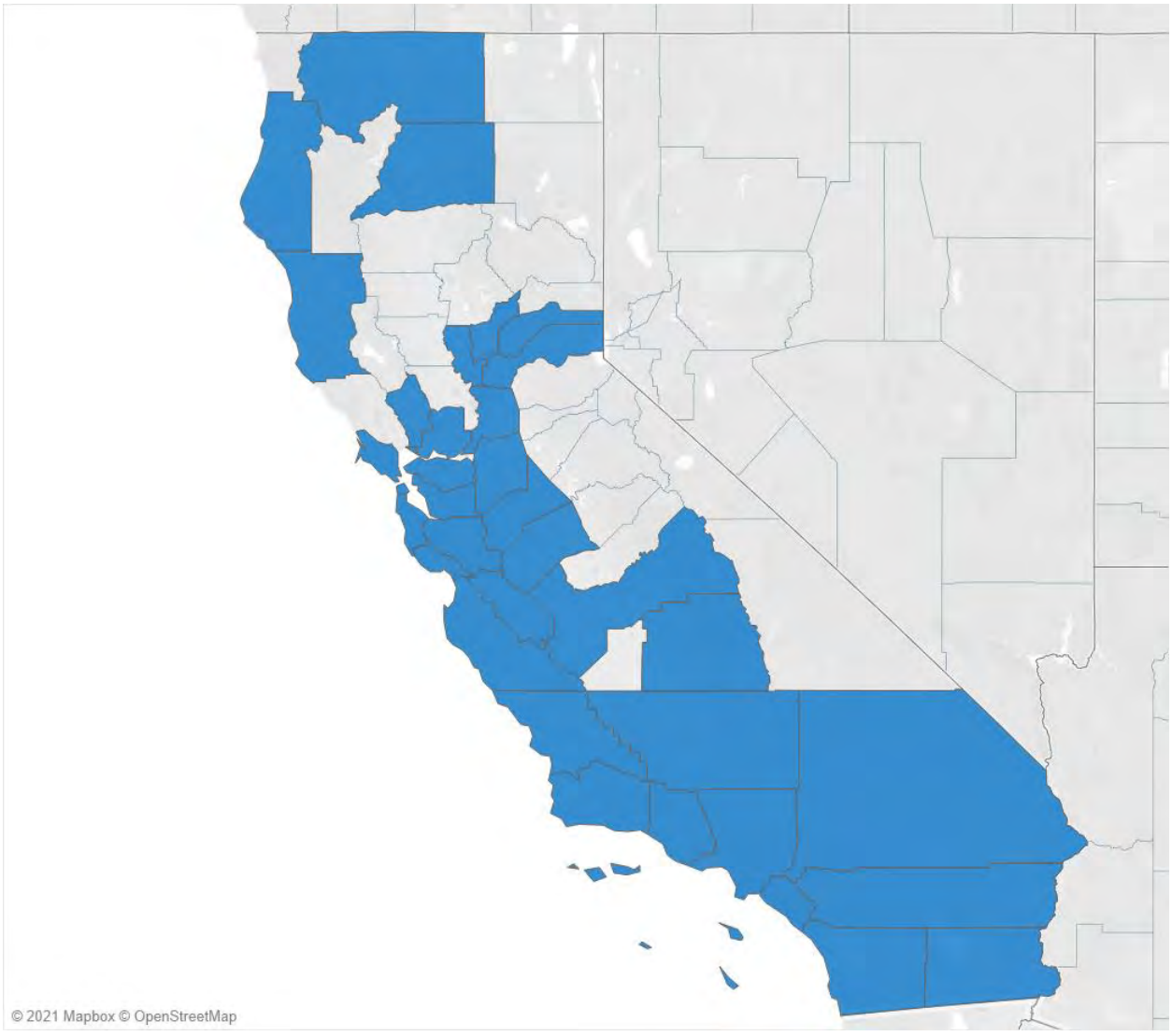
---

[134] Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Geneva: World Health Organization; 2009.

[135] Facilities providing ambulatory WM were identified using DHCS Alcohol and Drug Program Certification data and facilities providing residential WM were identified using DMC-ODS provider reports.

- According to Medi-Cal claims data, the majority (64 percent) of inpatient WM is offered though Medi-Cal's FFS system, which is to say, neither by managed care plans nor by county mental health systems; as a result, stakeholders have reported that few people (clients or providers) may be aware that inpatient WM is a covered benefit.
- Almost two-thirds of MCPs provide fewer than two people a year with inpatient WM, another indication that inpatient WM is rarely covered.

Figure 13. **Counties with Treatment Facilities That Provide Ambulatory or Residential SUD WM[136]**



[136] Source: DHCS Alcohol and Drug Program Certification data accessed in June 2021 and DMC-ODS provider reports provided by DHCS in July 2021.

What did the survey and focus groups say?

Regarding inpatient WM services, information from the survey and focus groups indicates:

- Almost two-thirds of survey respondents indicated additional capacity for WM in acute care hospitals is needed.
- The current inpatient WM approach (program and funding) in California is not well understood by hospitals, treatment providers and Medi-Cal MCPs.
- Health plan participants shared that it is difficult for plans to work with the FFS system to secure approval for WM in acute care hospitals on behalf of their members.

SUD providers also report that hospitals do not always admit individuals who might benefit from inpatient WM due to concerns about payment for these admissions and lack of knowledge that the benefit, called Voluntary Inpatient Detox which is equivalent to inpatient WM, is available in fee-for-service Medi-Cal. The current admission criteria for inpatient WM services require patients to have acute symptoms of withdrawal before receiving services. This may present a challenge for individuals seeking access to services. During withdrawal, symptoms may become so intolerable that it draws a person to the conclusion to use drugs again to make the sense of discomfort stop. Stakeholders indicated these restrictive criteria set a high bar and can lead to unnecessary suffering and medical risk for individuals in need of inpatient WM.

5.9 Inpatient Services

Takeaway

The availability of inpatient beds varies by county, with insufficient capacity for children and youth and people living with complex physical conditions. There is significant pressure on inpatient beds, reflecting the importance of stronger crisis services, housing options and other community-based supports.

Inpatient care is the most intensive level of treatment for individuals experiencing mental health and substance use disorders. It offers 24-hour care in a highly structured, supervised program at a facility staffed by behavioral health professionals. Inpatient mental health and SUD services can be provided in a distinct unit in a general hospital or a freestanding facility that is solely for the purpose of providing inpatient care. Freestanding facilities that solely provide inpatient behavioral health treatment services may be licensed as acute psychiatric hospitals or psychiatric health facilities. The goal of inpatient treatment is to provide an environment for medical stabilization, support, treatment for psychiatric and substance use disorders, and medical supervision.

Availability of Inpatient Services

What data are available, and what do the data say?

Based on licensure and certification data from DHCS, most counties in California have inpatient psychiatric facilities that accept Medi-Cal enrollees. California counties without inpatient facilities contract with out-of-county facilities to provide their residents with these services as needed. Information provided through the county survey and data from other sources provide a general sense of the existence and need for inpatient psychiatric care. Table E-3 in the Appendix documents the number of inpatient psychiatric facilities and bed capacity by county. For instance:

- There are 24 counties that have no inpatient facilities (see Figure 14).
- There are 86 psychiatric units within general acute care hospitals, 31 freestanding psychiatric acute care hospitals, and 29 psychiatric health facilities across 34 counties in the state.
- Psychiatric acute care hospitals tend to be much larger than psychiatric health facilities. Psychiatric acute care hospitals have an average of nearly 75 beds per facility compared to about 18 beds per facility in psychiatric health facilities
- Few inpatient facilities accept individuals who have complex physical health and mental health needs—for example, traumatic brain injury, cognitive decline, or dementia—according to survey responses.

Similar to the process used to measure availability of mobile crisis services, the Crisis Resource Need Calculator was utilized to determine the need for additional inpatient psychiatric bed capacity. This analysis indicated that, overall, California has insufficient inpatient psychiatric bed capacity. The need for inpatient psychiatric beds is significant in some counties. Twenty-four counties do not have any inpatient psychiatric beds. Of the 34 counties that have inpatient psychiatric bed capacity, 41 percent need additional capacity according to the Crisis Resources Need Calculator. The projected need for additional capacity ranges from one-third to more than double the current inpatient capacity. The most acute need is in counties with large populations (e.g., Fresno) and counties with more moderate population sizes (e.g., Kern and Santa Barbara). Figure 14 displays the number of acute inpatient treatment beds in each county and also shows counties that do and do not need additional inpatient treatment capacity according to the Crisis Resource Need Calculator. This calculator is a starting point for understanding the adequacy and availability of psychiatric bed capacity as inpatient facilities may refuse to admit individuals living with particularly significant mental health needs, as well as those deemed to have problematic behaviors or histories.

"There is a shortage of inpatient psychiatric beds for youth, and they often sit in ED rooms longer without any behavioral health treatment while awaiting placement. The COVID-19 pandemic is starting to cause a shortage of sufficient workforce, its long-term effects are still unknown. Staff face burnout and leave the workforce. It is also difficult to hire staff to work outside traditional business hours when youth SMHS is most needed from after school to bedtime. It is challenging to attract and retain psychiatrists who specialize in working with children. Children's System of Care (CSOC) needs to offer nontraditional benefits to our child psychiatrists in order to retain them. We have limited ability to provide specialized treatment (such as for the commercial sexual exploitation of children, eating disorders, etc.) due to a lack of funding to provide specialized one-time and ongoing staff training needed. CSOC is unable to expand services to all schools within our county due to the inability to hire a sufficient additional workforce. Our salaries are not as competitive as some surrounding counties. Services at all schools are required due to an increased need for on-site services related to the COVID-19 pandemic. Additionally, we have limited funds to update our facility and modernize it, allowing for service expansion."

– County Behavioral Health Director

Although many individual counties have an adequate number of acute inpatient beds available according to the Crisis Resource Need Calculator, there are still some gaps at the regional level. For example, counties in the Northern Counties region have a total of 116 acute inpatient beds available but would still need an additional 20 beds across these counties to meet regional demand, according to the calculator.[137] Similarly, the Santa Cruz, San Benito, Monterey County region has a total of 46 beds available but would need an additional 12 beds to adequately serve the regional population. Please see Table 11 in Appendix B for the breakdown of available beds by region.

What did the survey and focus groups say?

Almost all counties reported a need for additional inpatient treatment beds for adults and children/youth. According to survey respondents:

- More than half of the counties (38) reported needing additional acute inpatient hospital services (e.g., psychiatric acute care hospitals or acute care psychiatric units) for adults.
- Seventy percent (42 respondents) identified an urgent need for this service for children and youth. These results are generally consistent with results from the Crisis Resource Need Calculator regarding counties that need additional inpatient treatment capacity. For example, 46 counties identified a need for additional inpatient treatment beds for adults or youth in the county survey. Out of these 46 counties, the Crisis Resource Need Calculator projected a need for additional inpatient treatment capacity in 32 (70 percent) of them.[138]

Survey respondents identified additional impacts stemming from the lack of available inpatient psychiatric units. For instance, there is often competition between counties for contracted services and inpatient providers, with some remote or sparsely populated counties unable to regularly negotiate contracts for needed services. The shortage of inpatient psychiatric beds for youth often results in children being boarded in EDs—sitting in EDs for excessive periods of time while awaiting placement. Information from the California Hospital Association identified several facilities that had ED boarding times in excess of a week.

In addition, focus group participants flagged the need for additional inpatient psychiatric treatment, especially for children and youth. Fewer psychiatric facilities across the state treat children and youth compared with the number of facilities that treat adults.

---

[137] Regions defined according to Covered California regions are available here: https://www.coveredca.com/pdfs/2021_QHP_QDP_%20Region_Map_11022020.pdf.

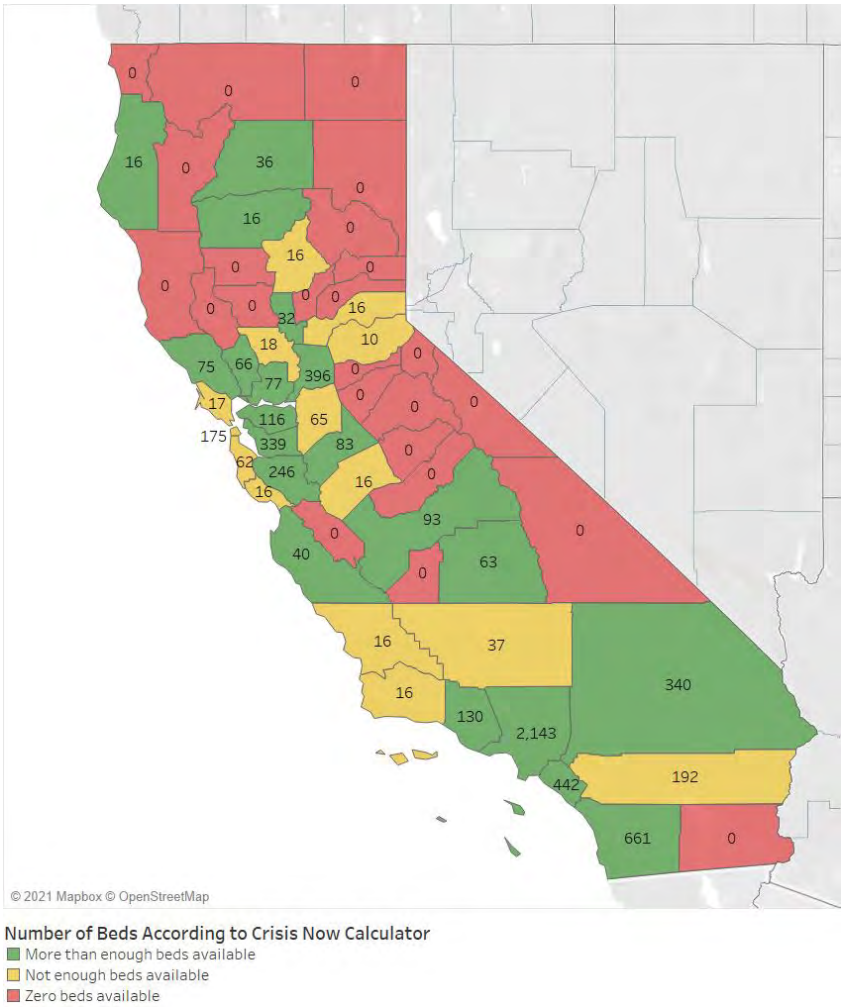
[138] The Crisis Resource Need Calculator was developed by Recovery International for the National Association of State Mental Health Program Directors and uses data from a cross-state analysis to determine projected utilization of crisis services and other behavioral health services. Available at www.crisisnow.com.

Focus group participants echoed the findings of the survey, including concerns about ED boarding and long lengths of stay for individuals with complex needs (e.g., poorly controlled diabetes, wound dressing changes or dental issues). Insufficient inpatient capacity often results in individuals being discharged to the community too quickly and then readmitted to inpatient care, presenting at an ED, or being incarcerated. Other focus group participants indicated that the lack of upstream services (e.g., crisis and intensive community-based services) intensifies the need for inpatient care. Lastly, it can be difficult to find placements for and providers willing to accept individuals with complex needs, including those with co-occurring SUD or dementia or those with criminal records.

An additional challenge is that any facility with more than 16 beds is considered an IMD, which CMS excludes from Medicaid reimbursement. Therefore, hospitalizations in these facilities generally cost counties twice as much since there is no federal match.

Figure 14. **Number of Acute Mental Health Inpatient Treatment Beds and Estimates of Need for Additional Capacity[139]**

Counties shaded in green have more than enough beds according to the Crisis Resource Need Calculator. Counties shaded in yellow have beds available but do not have enough beds according to the calculator. Counties shaded in red do not have any beds available. Labels on counties reflect the current number of acute inpatient beds licensed by the state. Note that some counties may have suspended beds that are not actively available—temporarily due to staffing, or permanently—so this map may overestimate capacity.



[139] Number of acute mental health inpatient treatment beds identified from DHCS licensure data accessed in October 2021. Coloring on map based on analysis of Crisis Resource Calculator. Note that the Crisis Resource Calculator is intended to provide a general sense of where additional resources may be needed and cannot definitively identify whether an area has sufficient treatment capacity.

VI. Populations of Focus

This section discusses the behavioral health needs and corresponding services for children and youth, individuals who are justice-involved, and AI/AN. These populations rose to high importance through a review of data, analysis of surveys and input of focus groups. In addition, DHCS is prioritizing these populations as part of our commitment to health equity, since disparities and poor health outcomes for people of color are particularly prominent for children and youth (especially for children in foster care), for individuals in the justice system, and for AI/AN.

In parallel, DHCS continues to work towards a robust system of care for all Medi-Cal enrollees, with several initiatives underway to expand the continuum of care for all (see pages 18 – 21).

6.1 Children and Youth

The mental health and well-being of California's children and youth are a rising concern. Even before the pandemic, there was a long-term increase in youth suicides and hospitalizations for self-harm.[140] Suicide is the most devastating outcome of rising behavioral health concerns, and many of California's children and youth experience behavioral health conditions that place them at elevated risk.[141]

> "If you know the adult system, that does not mean you know the youth system."
>
> *– Medical Professional Association Focus Group*

The COVID-19 pandemic has added more strain to the mental well-being of children and youth due to missed school, loss of contact with peers and frayed community connections. Many children, especially those in low-income families, faced greater economic uncertainty and, in some instances, the illness or even death of parents and grandparents. Nationally, one in every four high school students reported having worse emotional and cognitive health in 2020; one in five parents of children aged 5-12 said that their children's emotional health was diminished.[142] During 2020, the proportion of mental health–related ED visits among adolescents (12-17 years old) increased 31

---

[140] California Youth Suicide Rate 2011-2019, KidsData. Accessed October 26, 2021. Available at https://www.kidsdata.org/topic/213/suicide-rate/table#fmt=2772&loc=2&tf=134,125,122,120,93,86,81&sortColumnId=0&sortType=asc.

[141] California Health Care Almanac, Mental Health in California: For Too Many, Care Not There, California Health Care Foundation, March 2018. Available at https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf.

[142] Rabah Kamal, et al., Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic. Kaiser Family Foundation, 2021. Available at https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/.

percent and suspected suicide attempt ED visits for girls increased 51 percent compared to 2019.[143]

In addition, adverse childhood experiences (ACEs) such as poverty, food insecurity, homelessness and toxic stress may place children and youth on a life path that has higher rates of mental illness, addiction, and other chronic medical conditions. ACEs are much higher for low-income children because of the hardships associated with scarce resources, but they can affect any child anywhere. In California, the rates of children and youth under 18 experiencing two or more ACEs varies from a low of 11.5 percent in Marin County (a wealthy urban county) to 23.5 percent in Shasta County (a less wealthy rural county).[144]

California's children and youth at risk for or living with behavioral health conditions are not a homogenous group. Some have modest issues or risks and may benefit from preventive and traditional outpatient services provided by agencies, schools, and individual practitioners. Other children and youth have more complex behavioral health needs. Children and youth living with SED, adolescents living with SUD, as well as children and youth involved in child welfare, intellectual/developmental disability systems and juvenile justice require different services and approaches not only to address their behavioral health conditions but also to coordinate services across multiple child-serving systems.

In Medi-Cal, children and youth now can receive treatment for behavioral health services prior to a formal diagnosis and access services through any of the Medi-Cal delivery systems, including the FFS system, MCPs and county- and tribal entity–led behavioral health plans, regardless of their level of care or care needs. Medi-Cal enrollees under age 21 are entitled to all medically necessary services, including mental health and SUD services, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Based on significant stakeholder input, DHCS is actively implementing several policy and program improvements to clarify the responsibilities of each delivery system, reinforce its no-wrong-door approach for individuals accessing care and ensure seamless access to medically necessary services for children and youth living with or at risk for behavioral health conditions. As part of this effort, DHCS is working with stakeholders to develop standardized screening and transition tools that are specific to individuals under the age of 21 for use by county behavioral health plans and MCPs

---

[143] Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. doi:http://dx.doi.org/10.15585/mmwr.mm7024e1.

[144] Children with Adverse Experiences (Parent Reported) by Number 2016-2019, KidsData. Accessed September 8, 2021. Available at https://www.kidsdata.org/topic/1927/aces-nsch-county/table#fmt=2449&loc=2,127,1657,331,1761,171,2168,345,357,324,369,362,360,2076,364,356,217,354,1663,339,2169,365,343,367,344,366,368,265,349,361,4,273,59,370,326,341,338,350,2145,359,363,340&tf=139&ch=1256,1454,1456.

across the state. These tools will be used to support children and youth living with behavioral health needs ultimately are referred to, and seamlessly transition to, the most appropriate Medi-Cal delivery system based on their needs, regardless of where and when they initiated behavioral health treatment.

Given the heightened concern about California's children and youth, this section reviews the issues and opportunities associated with the following services for this population of focus:

- Traditional outpatient behavioral health services offered through facilities (e.g., Community Mental Health Centers outpatient clinics) and individual licensed practitioners.
- School-linked behavioral health services, including preventive and treatment services.
- Child and adolescent psychiatrists.
- Treatment for SUD for adolescents and young adults.
- Services for first-episode psychosis (FEP) and anorexia nervosa, two of the less common but also harder-to-treat behavioral health conditions that affect youth.

Emerging and Existing Initiatives to Improve the Behavioral Health of California's Children and Youth

In recent years, the California legislature and Newsom Administration have adopted a number of high-profile initiatives to support children's mental health and well-being.

The Children and Youth Behavioral Health Initiative, which is intended to transform California's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported and served for emerging and existing behavioral health needs. Key components include:

- Creation of a virtual behavioral health services platform for youth.
- New funding for behavioral health services in schools and in school-linked settings.
- Development and expansion of evidence-based behavioral health programs.
- Establishment of a Behavioral Health Continuum Infrastructure Program (BHCIP), with grants funding new facilities and expansion of existing facilities.
- Launch of a public education and social change campaign on children's and youth's behavioral health.
- Investments in the behavioral health workforce, including a multiyear plan for a statewide school behavioral health coach and counselor system.
- Expanded education and training for pediatric and primary care providers.
- Empowering youth and incorporating youth voice through a variety of strategies including to review progress and provide quality improvement guidance.
- Comprehensive independent evaluation.

ACEs and developmental screening in Medi-Cal.[145] DHCS provides for enhanced reimbursement for ACEs screening, developmental screenings and well-child visits. Originally, funding was slated to expire on December 31, 2021; however, the 21-22 budget eliminated the planned suspension of the payments.

New family and community-based services. Beginning in January 2022, Medi-Cal will cover dyadic services for families with children, doula services and services provided by community health workers.

Implementation of the Title IV-E Prevention Program. California has adopted a five-year plan to implement the program established by the Family First Prevention Services Act. The plan seeks to implement prevention services (to prevent child welfare involvement and promote family stability) as well as to expand services for children requiring residential treatment and to ensure each child and family is provided a trauma-informed prevention plan rooted in evidence-based practices.[146]

System of Care (AB 2083). AB 2083 (Chapter 815, Statutes of 2018) requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. The MOU is designed to help build communication and shared responsibility across local agencies to avert the need for state-level intervention. The System of Care also includes:

- The establishment of a Children and Youth System of Care State Technical Assistance Team consisting of representatives from California Department of Social Services, Department of Health Care Services, Department of Developmental Services, and the California Department of Education.
- The establishment of process to request technical assistance from the State Technical Assistance Team.
- The identification of gaps in placement types and services.
- The development of a multiyear plan for increasing capacity in placements and services. *(In development)*

Outpatient Mental Health Services

As noted above, outpatient services are the cornerstone of efforts to identify and prevent the development of more serious behavioral health conditions. Some outpatient providers, however, only have the capacity to treat adults. Based on the SAMHSA Behavioral Health Treatment Services Locator and county survey results, the disparity in outpatient services in California appears to be particularly large for children and youth.

---

[145] Along with supplemental payments for developmental screening and ACEs, Proposition 56 funds are used to increase the base rate payment for well-child visits and for value-based payments to providers for serving at-risk members (including children with SUD or SMI or experiencing homelessness).

[146] Family First Prevention Services Act. More information about California's five-year implementation plan is available here: https://www.cdss.ca.gov/inforesources/ffpsa.

- Approximately 32 percent of outpatient mental health treatment facilities in California listed on the SAMHSA Behavioral Health Treatment Services Locator do not indicate that they accept children or youth.
- While most counties have at least one treatment facility that serves children and youth, some do not. Five counties (Glenn, Kings, Modoc, Mono and Tehama) do not have any outpatient mental health treatment facilities that accept children or youth, according to the SAMHSA Behavioral Health Treatment Services Locator, which does not include individual practitioners. Fortunately, each of these counties has at least three SMHS-contracted behavioral health providers according to DHCS network adequacy data.
- Thirty percent of counties report an urgent need for non-specialty treatment services, such as individual and group counseling, for children and youth.
- One-fourth of counties report that they face an issue with identifying providers who are willing to treat youth involved in the justice system.

School-Linked Mental Health Services

Research shows that students are more likely to seek counseling when services are available in schools.[147] However, students may also be hesitant to access mental health services at school due to stigma and privacy concerns.[148] Comprehensive, culturally responsive school-linked mental health services can help address inequities in access and help reduce the stigma associated with receiving mental health services. Schools also have a unique opportunity to offer preventive services and education that build resilience and the ability to cope with difficult emotions, potentially staving off the development of more significant conditions for some.

[147] Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools, SAMHSA, July 1, 2019. Available at https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

[148] Kaiser Permanente, Combating Mental Health Stigma in the Community, August 6, 2019. Available at https://lookinside.kaiserpermanente.org/combating-mental-health-stigma-in-the-community/.

"There is a need to provide services in locations convenient for youth, like schools. They are more likely to access services if it's convenient for them."

– County Representative

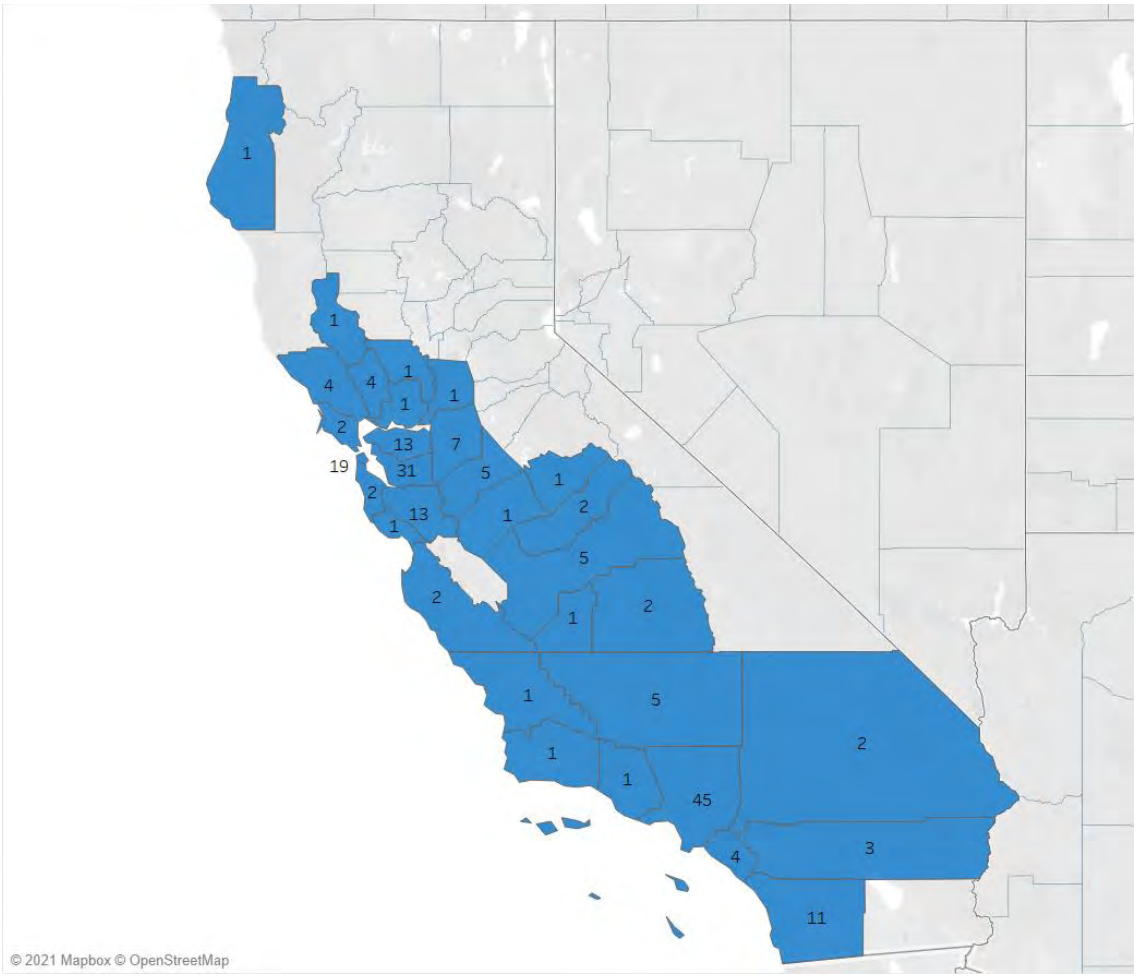
For this assessment, data from the California School-Based Health Alliance were used to identify school-linked health programs with a mental health component. Please note that these data only capture school-based health programs with mental health components that are tracked by the School Based Health Alliance. DHCS recognizes there are additional models of county-supported school-linked mental health services that are available throughout the state, but are not captured in these data, including innovative county-operated programs. These initiatives also offer important help to children and youth; it will be critical in the future to determine how best to catalogue and understand the extent to which they are offered throughout California.

Data from the School Based Health Alliance indicate:

- Most counties—32, or approximately 55 percent—have school-linked health programs with a mental health component.
- Approximately 70 percent of school-linked health programs tracked by the California School-Based Health Alliance provide mental health treatment services.[149]
- An additional three counties have school-linked health programs, but they do not have a separate mental health component.
- Counties with large population centers (San Francisco, Alameda, Contra Costa, Los Angeles, and San Diego) were significantly more likely to have at least some school-based mental health programs.

[149] About School Health Programs, California School-Based Health Alliance. Accessed September 8, 2021. Available at https://www.schoolhealthcenters.org/school-based-health/programs.

Figure 15. **Counties with School-Linked Health Programs That Provide Mental Health Treatment Services**[150]



Among stakeholders, there was deep interest in the new school-linked behavioral health initiatives and excitement about the powerful role they could play. With the COVID-19 pandemic illustrating the critical role of school and community for children and youth, stakeholders repeatedly raised the need for outpatient and intensive outpatient services that can be delivered in schools, via telehealth or through intensive in-home services that allow children to remain with their families.

Stakeholders highlighted the importance of using some of the new funding to provide children with skills and resources before they develop significant issues. Currently, school-linked clinics can offer individual counseling for students with a diagnosis via the local education agency Medi-Cal billing option. However, it is much harder to offer support groups to the general population without a specific mental health diagnosis, such as for students coping with grief, LGBTQ+ concerns, or school and social

[150] Data provided by the California School-Based Health Alliance via personal correspondence in July 2021.

pressures. Stakeholders also noted that students without a diagnosis would benefit from mental health services, as is likely to become more common with the recent policy changes announced by DHCS allowing access to early intervention services and behavioral health treatment prior to diagnosis. In addition, stakeholders indicated that schools are not well equipped to offer SUD services. Due to workforce and other issues, many schools lack the SUD practitioners who could offer SUD counseling.

School-Linked Mental Health Services Success Story

Several "pace car" school-linked initiatives were identified through the survey and focus groups. For instance, Santa Barbara County uses funds from the Youth Opioid Response grant and the cannabis grant to provide targeted outreach to schools. Stanislaus County plans to use the Youth Opioid Response grant to place SUD treatment professionals in educational settings and increase outreach to physicians to incentivize increased access to MAT prescribing in the primary care setting.

Child Psychiatrists

There are approximately 8,300 practicing child and adolescent psychiatrists in the United States. Ratios of child and adolescent psychiatrists range by state from one to 60 per 100,000 children (below the age of 18), with a median of 11 child and adolescent psychiatrists per 100,000 children.[151] In California, there are 13 child and adolescent psychiatrists per 100,000 children below age 18.[152] Some psychiatrists often require direct payment and may choose not to participate in either commercial or Medi-Cal provider networks, leading to access challenges, especially for low-income children.

For the county-specific analysis, the number of child and adolescent psychiatrists in each county was identified using licensure data provided by the Medical Board of California in July 2021. These data were analyzed to identify the number of active board-certified child and adolescent psychiatrists operating in each county in the state. These data, combined with the county survey results, indicate most counties have at least one child psychiatrist, although almost all of California's counties reported shortages. For instance:

- According to the American Academy of Child and Adolescent Psychiatrists, 39 of California's 58 counties were identified as having a high or severe shortage of

[151] Workforce Maps by State, American Academy of Child and Adolescent Psychiatry. Accessed September 8, 2021. Available at https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.

[152] Ibid.

child and adolescent psychiatrists.[153]

- According to data provided by the California Medical Board, 22 counties had no child or adolescent psychiatrists as of July 2021.
- More than 70 percent of counties—42 of 58—report a lack of psychiatrists who specialize in working with children.
- Los Angeles County has significantly more child psychiatrists than any other county, with nearly one-third of all the child psychiatrists in the state and more than double the number of child psychiatrists of any other county. While Los Angeles County has many more psychiatrists than any other county, it does not rank at the top in terms of the number of psychiatrists per 100,000 individuals below the age of 18. San Francisco and Marin Counties had 52.4 and 48.7 respectively, child psychiatrists per 100,000 individuals below age 18, relative to only 14.2 per 100,000 in Los Angeles County.

SUD Services for Adolescents

The vast majority of adults—approximately 90 percent—with SUD started using a substance before age 18.[154] The earlier a person begins using alcohol or drugs, the more likely they are to develop SUD that persists into adulthood. Individuals who begin drinking before age 14 are seven times more likely to develop alcohol dependence than those who begin drinking at age 21.[155] SUD services are not yet widely available for adolescents and young adults. For instance, the county survey found:

- The majority of California counties lack available residential beds specifically for youth (75 percent, 45 respondents).
- Forty-one out of 56 respondents (68 percent) lack providers with the training and experience to meet the specific needs of youth living with SUD.
- There is limited provider availability to treat co-occurring mental health and SUD needs of adolescents (58 percent, 35 respondents).
- Funding was identified by 40 out of 56 respondents (71 percent) as a reason for why they have not expanded SUD services for adolescents.

"The absence of SUD services in my world is so absolute and complete I don't know where to begin to discuss gaps."

[153] Ibid.

[154] NIDA. Introduction. National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction. August 3, 2021.

[155] Hingson RW, Heeren T, Winter MR. Age at Drinking Onset and Alcohol Dependence: Age at Onset, Duration, and Severity. Arch Pediatr Adolesc Med. 2006;160(7):739-746. doi:10.1001/archpedi.160.7.739.

– School-Based Behavioral Health Provider

Insufficient SUD services for adolescents and young adults across the continuum of care was echoed in most focus groups. Participants reported:

- Insufficient available intensive and clinically managed low-intensity residential beds for youth; as a result, teens sometimes must be placed in facilities with adults.
  - School-based counseling programs are limited and have shrunk in recent years.
  - School-based mental health professionals do not have adequate training to address SUD.
  - Some of the evidence-based practices for treating SUD that are increasingly common for adults—such as MAT—still remain largely unavailable to adolescents.
  - A lack of inpatient WM beds (levels 3.7 and 4.0) for youth living with SUD.

Innovation for Adolescents with SUD

There are "pockets" of innovation for adolescents with SUD. Orange County has developed a peer mentoring program to support youth in their transition from out-of-county providers back home to in-county outpatient services. The Peer Connector Program connects individuals via phone with trained mentors with lived experience; mentors are matched according to their common experiences and/or backgrounds and services are available in English and Spanish.

First-Episode Psychosis Programs

According to the National Institute of Mental Health, about 100,000 adolescents and young adults in the U.S. experience FEP each year.[156] Interventions for young adults experiencing FEP are team-based, recovery-oriented approaches to care that commonly include psychotherapy, medication management, family education and support, case management, supported employment and supported education. Increasingly, FEP programs offer primary care coordination, peer support services and supportive housing services in addition to the traditional core components of the model. Young adults participating in FEP programs experience significantly greater symptom

[156] National Institute of Mental Health, Fact Sheet: First Episode Psychosis. Available at https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.

reductions, fewer hospitalization episodes, and better school and work participation compared with those in usual treatment.[157]

Over the past decade, the number of counties with programs for young adults experiencing FEP has increased. As of 2021, 41 counties (71 percent) offer 52 programs that are serving individuals living with FEP.[158] These programs are underwritten using federal (SAMHSA set-aside funds), state and local funds. FEP programs often rely on philanthropic contributions or other funding sources, limiting the ability to grow and sustain much-needed programs. In addition, stakeholders recognized that there is interest in bringing FEP services to all counties in the state. Participants said that making FEP treatment programs available in rural counties should be a high priority. In addition, experts pointed out the importance of overseeing and monitoring the quality of FEP programs. While there are program standards, there currently is not an organized statewide approach for measuring program fidelity.

Innovation for Young Adults Living with FEP

The UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics), founded in 2004, are located within the University of California Davis Health System's Department of Psychiatry & Behavioral Sciences. UC Davis is nationally recognized as a leading provider of outpatient team-based coordinated specialty care for early psychosis. The programs serve transitional-age youth across the spectrum of early psychosis, including threshold affective and nonaffective psychosis ("early psychosis" or EP), as well as individuals who are at clinical high risk for psychosis.

The EDAPT Clinic serves individuals ages 12-40 who have commercial insurance and come from across the Central Valley of California. With the support of Sacramento County MHSA prevention and early intervention funding, EDAPT was expanded in 2011 to create the SacEDAPT Clinic, which serves residents of Sacramento County ages 12-30 who have Medi-Cal or are uninsured. Their family-centered model provides community outreach to support early identification; state-of-the-art assessments; individual, family and group psychotherapy; medication management; supported education/employment; case management; substance use management; and peer and family support and advocacy.

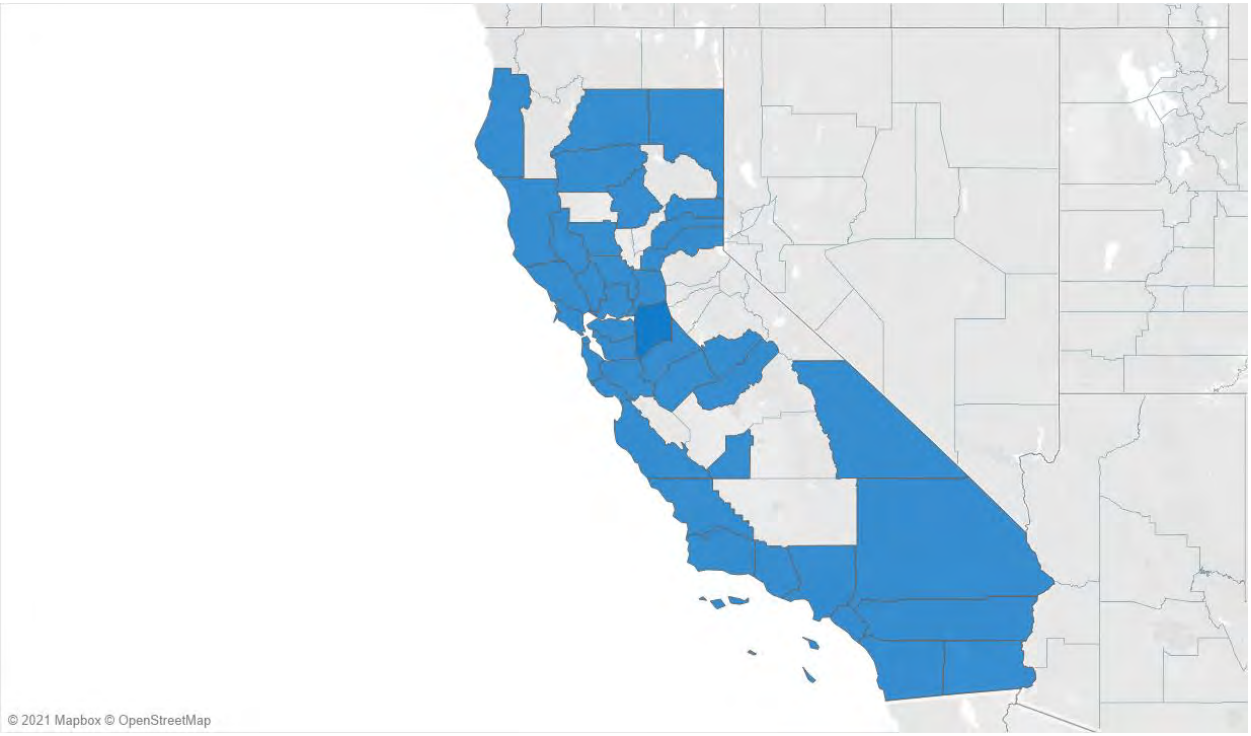
---

[157] Srihari VH, Tek C, Kucukgoncu S, Phutane VH, Breitborde NJK, Pollard J, et al. (2015). First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial. *Psychiatric Services,* Feb. 2, 2015. doi:0.1176/appi.ps.201400236. 66(7), 705-712.

[158] Early Psychosis Program Directory, Stanford Medicine. Available at https://med.stanford.edu/peppnet/interactivedirectory.html.

Outcomes data show reductions in hospitalization rates and symptom severity as well as improvements in overall functioning after 12 months of care. UC Davis has supported the development of programs in nearby areas, including Solano, Napa, Sonoma, and Yolo Counties. With the support of multiple counties, the Mental Health Services Oversight and Accountability Commission and DHCS, UC Davis is leading the EPI-CAL Network, which seeks to provide statewide training and technical assistance as well as outcomes evaluation support to California's early psychosis programs.

Figure 16. **Counties with First-Episode Psychosis Programs Available**[159]



Eating Disorders

Eating disorders, especially among children, youth and young adults, present significant behavioral and medical issues. For instance, individuals living with anorexia nervosa have high mortality rates and higher costs of care than do individuals living with other behavioral health conditions.[160] Discussions with professionals who treat people experiencing eating disorders identified challenges in commercial and Medi-Cal coverage for treating these patients. Over the past several years, there have been additional efforts in selected areas of the state to address these disorders, including:

[159] Data provided by Stanford Medicine Psychosis-Risk and Early Psychosis Program Network via personal correspondence in October 2021.

[160] van Hoeken D, Hoek HW. Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Curr Opin Psychiatry*. 2020;33(6):521-527. doi:10.1097/YCO.0000000000000641.

- Identifying eating disorders earlier and providing consultation to medical and behavioral health staff on effective strategies and practices to address these disorders.
- Establishing training on family-based treatment for eating disorders in certain areas of the state.
- Providing ongoing consultation on a weekly or monthly basis for practitioners who treat individuals living with an eating disorder.

Despite these efforts, focus group participants identified barriers that have historically limited access to treatment of eating disorders. For example, some Medi-Cal plans offer single-case agreements (SCAs) for individuals experiencing an eating disorder. These SCAs are necessary but administratively burdensome for providers and MCPs, and families may not know this is an available treatment option for their loved ones. In addition, focus group participants indicated a dearth of professionals who can identify and treat children, youth and young adults living with eating disorders. National data indicate that close to one in ten people in the United States (9 percent) will have an eating disorder over the course of their lifetimes.[161]

6.2 Populations Who Are Justice-involved

In California, 36,000 individuals are released from prison and a million individuals enter and leave jails each year.[162] Nearly all of these individuals are eligible for Medi-Cal.[163] Individuals who are justice-involved often experience high rates of behavioral health issues and, in fact, often are arrested and incarcerated due to behaviors arising from those issues (e.g., erratic behavior due to psychosis, possession of illicit drugs). Among incarcerated individuals in California, approximately 66 percent of inmates were identified as having a high or moderate need for SUD treatment.[164] In addition, the proportion of incarcerated people in California jails or prisons with an active mental health case has increased over the past decade.[165] Individuals who are justice-involved have a significantly higher likelihood of ED visits, hospitalizations, and overdose- and

---

[161] Report: Economic Costs of Eating Disorders, Harvard School of Public Health, can be found at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/.

[162] "From Corrections to Community: Reentry Health Care," California Health Care Foundation, 2018. Available at https://www.chcf.org/project/corrections-community-reentry-health-care/.

[163] Ibid.

[164] "Improving In-Prison Rehabilitation Programs," Legislative Analyst's Office, 2017. Available at https://lao.ca.gov/Publications/Report/3720.

[165] "The Prevalence of Mental Illness in California Jails Is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019," California Health Policy Strategies, 2020. Available at https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

SUD-related death. And for people recently released from prison, overdose is the leading cause of death.[166]

The incarceration of people living with mental health and substance use disorders intersects with systemic inequities in the way the criminal justice system treats people of color. Black and Latino individuals are not more likely to misuse alcohol or drugs than are white individuals, but they are more likely to be incarcerated for related behaviors. For instance:

- Approximately 29 percent of male prisoners in California are Black (as compared to 5.6 percent of California's adult male population); nationally, 5 percent of illicit drug users are Black, yet they represent 29 percent of those arrested and 33 percent of those incarcerated for drug offenses.[167,168]
- For Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of other races.[169]
- There is also a large discrepancy in the incarceration rate of the AI/AN population relative to the general population; however, due to data collection challenges, AI/AN populations are generally lumped into the "Other" category, making it difficult to report on their incarceration rate.[170]

---

[166] Binswanger, IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release From Prison — A High Risk of Death for Former Inmates, *New England Journal of Medicine*, January 2007.

[167] "Criminal Justice Factsheet," NAACP. Accessed September 8, 2021. Available at https://naacp.org/resources/criminal-justice-fact-sheet.

[168] "California's Prison Population," Public Policy Institute of California, 2017. Available at https://www.ppic.org/publication/californias-prison-.

[169] Ibid.

[170] Daniel R, "Since you asked: What data exists about Native American people in the criminal justice system," Prison Policy Initiative, April 22, 2020. Available at https://www.prisonpolicy.org/blog/2020/04/22/native/.

Incompetent to Stand Trial Backlog

The number of Californians deemed incompetent to stand trial (IST) on the basis of their mental illness for felony charges has increased significantly in recent years.[171] A significant number of individuals—1,722 as of December 2021--who have not been convicted of crimes and are determined to be IST are waiting in jails—on average for several months--for state hospital beds to become available to restore individuals to competency. Once competency is restored individuals return from the state hospital to jail for their court case to be adjudicated. Counties are responsible for treating people facing misdemeanor charges who are deemed to be IST.[172]

The state has taken a number of steps in recent years to address the IST backlog and invest in diversion and community-based restoration programs for individuals living with serious mental illness (SMI) who become justice-involved. CalHHS and the Department of State Hospitals (DSH) have convened an IST Solutions Workgroup to identify actionable solutions to address the growing number of individuals living with SMI who are deemed IST on felony charges.[173] The Workgroup has recently submitted recommendations for short-term, medium-term, and long-term solutions, and the state has appropriated $75 million for DSH to begin implementation of these recommendations beginning in the 2021-22 budget. Examples of recommendations include implementing the CalAIM justice in-reach and re-entry proposal, expanding pre-booking diversion services, and expanding diversion programs with adequate housing supports, including enriched residential programs. In addition, the state's enacted 2021-2022 budget also includes funding for DSH to implement or expand a number of initiatives including:

- Expand community- and jail-based competency restoration funding.
- Contract for sub-acute bed capacity to expand treatment options to serve the increasing number of felony IST patient referrals to the department[174]
- Reevaluate individuals deemed IST on a felony charge waiting in jail 60 days or more pending placement to a California Department of State Hospitals (DSH) treatment program

[171] "Behavioral Health: Community Care Demonstration Project," Legislative Analyst's Office, February 19, 2021. Available at https://lao.ca.gov/Publications/Report/4382.

[172] Ibid.

[173] Incompetent to Stand Trial (IST) Solutions Workgroup. CalHHS. More information available at https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/.

[174] 2021-22 Budget Summary for California Department of Health and Human Services. Available at https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf.

- Expand the current IST/Pre-Trial Felony Mental Health Diversion to current and new counties.

Various approaches and services can effectively address behavioral health issues to divert individuals from entering the justice system, identify and plan for such services during the reentry process, and facilitate and engage individuals with these services as they reenter the community. These services and approaches include:

- Collaborative courts combining judicial supervision with rehabilitative services to support recovery, reduce recidivism and improve outcomes among individuals living with SUD or mental health conditions.[175]
- Pre-release services and reentry planning such as enrolling individuals in Medi-Cal coverage prior to release, offering services and medications to stabilize individuals' physical and behavioral health conditions while incarcerated, and establishing a coordinated plan for their community-based care prior to release to support the reentry transition.
- Community-based reentry programs that connect individuals to community supports and treatment resources upon their release from criminal justice institutions.
- Law Enforcement Assisted Diversion programs, which establish treatment-based alternatives to criminal sanctions for individuals living with mental health, substance use and co-occurring disorders.

To address these issues, California has developed local and statewide initiatives for individuals who are justice-involved with behavioral health issues. Many of these programs aim to prevent unnecessary incarceration for individuals living with behavioral health conditions or to connect such individuals with treatment resources after release from jail or prison. Several initiatives focus efforts on ensuring Medi-Cal benefits upon release from prisons and, increasingly, jails. These existing initiatives include:

- Since 2015, state prisons are required to use a standardized process for gathering and processing pre-release applications to ensure that individuals who are justice-involved are enrolled in Medi-Cal before their return to the community. By January 1, 2023, all counties are mandated to implement pre-release Medi-Cal application processes in county jails and youth correctional facilities.[176]
- As mandated by the federal SUPPORT Act and recent CMS guidance, California requires[177] counties to suspend—rather than terminate—the Medi-Cal eligibility

[175] Collaborative courts supporting individuals with behavioral health conditions were identified using data provided by the Judicial Council of California.

[176] CA Legislature. SB 1469.727 WIC. 2006. Available at http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1451-1500/sb_1469_cfa_20060501_142757_sen_comm.html.

[177] CA Legislature. SB 1147. 2008. Available at http://leginfo.ca.gov/pub/07-08/bill/sen/sb_1101-1150/sb_1147_cfa_20080311_130324_sen_comm.html; see also CA Penal Code § 4011.11.

of individuals under age 21 when they become an inmate in a public institution.[178]

- DHCS requires jails and county juvenile facilities to implement a process to facilitate referrals to county specialty mental health services, the DMC-ODS and/or Medi-Cal MCPs for inmates who received behavioral health services while incarcerated, to allow for the continuation of behavioral health treatment.[179] At least 20 counties have existing processes for Medi-Cal enrollment prior to reentry.
- Managed care plans are required to offer intensive, community-based care management for individuals transitioning to the community through the new statewide Enhanced Care Management and Community Supports benefit.
- DHCS is also leveraging multiple federal funding streams to support the delivery of behavioral health services for individuals who are incarcerated, including, but not limited to, funding to expand MAT in county jails and drug courts, MAT training and technical assistance for the California Department of Corrections and Rehabilitation (CDCR), and Community Mental Health Services Block Grant funding.
- While more can be done in this area, California is making strides in strengthening pre-release efforts, diversion programs and reentry activities, including:
    - Currently, 17 counties offer Whole Person Care (WPC) pilots dedicated to serving individuals reentering the community post-incarceration and have designed programs to directly engage local jails and/or probation departments.[180] These programs will be transitioned into Enhanced Care Management/Community Supports programs in CalAIM.
    - A significant percentage of counties developed and implemented adult drug courts (46 counties) and adult mental health courts (38 counties).
    - Almost all counties (92 percent, 55 respondents) report collaborating with jail or prison facilities to facilitate pre-release planning for incarcerated individuals reentering the community.
    - Most counties operate at least one pre-release reentry program and many counties have several. There are nearly 840 operational pre-release reentry programs serving nearly 13,000 individuals who are justice-involved at any given time.

---

[178] State Medicaid Director Letter re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), CMS, January 19, 2021. Available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf.

[179] Brief Overview of the Department of Health Care Services (DHCS)' California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population, CCJBH, September 2021. Available at https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2021/09/CalAIM-Proposals-Relevant-to-Justice-System-Partners_September-2021.ADA_.pdf?label=Brief%20Overview%20of%20CalAIM%20Proposals&from=https://www.cdcr.ca.gov/ccjbh/publications/.

[180] Counties with justice-involved WPC pilots were identified through a review of WPC contracts and confirmed by targeted interviews and surveys conducted by DHCS and Manatt in May 2021.

As of November 2021, the month of this report's publication, the state is also pursuing authorization of pre-release services to improve care for individuals who are justice-involved through the CalAIM Section 1115 Demonstration waiver.[181] Through its 1115 waiver request, California seeks to test the expectation that providing health care services to individuals for the 90 days prior to release will prevent avoidable use of health care services while improving health outcomes post-incarceration. Service provision in the pre-release period is designed to engage eligible individuals who are justice-involved and prepare them for return to the community and to mitigate gaps in services and medication. If approved by the federal government, covered services for eligible individuals will include in-reach care management/care coordination; in-reach physical and behavioral health clinical consultation services provided via telehealth or in person, as needed, via community-based providers; limited laboratory/ X-rays; and MAT and psychotropic medications. Services will also be provided within jails and prisons for post-release, including a 30-day supply of medications and durable medical equipment.

Pre-Trial Diversion for Individuals Determined Incompetent to Stand Trial

Enacted in 2018, **AB 1810** created a pre-trial diversion pathway for individuals with certain mental health diagnoses charged with a felony or misdemeanor and are determined to be unlikely to pose a significant safety risk if treated in the community.[182] The law allows the court to grant diversion if a mental health treatment program agrees to accept responsibility for the treatment of the defendant. The diversion period can be up to two years and charges are dismissed upon the successful completion of the diversion program.

The 2018-19 State Budget included $100 million one-time over three years and the Budget Act of 2021 allocated an additional $47.6 million dollars one-time to support an expansion of the **California Department of State Hospitals Diversion Program**. The funds will be used for county pre-trial mental health diversion programs for individuals living with serious mental illness who are deemed incompetent to stand trial.[183] Currently, 24 counties have implemented diversion programs and these programs may expand to increase diversion opportunities and additional counties may implement new diversion programs with the funding allocated in the Budget Act of 2021. Funding for this program is not on-going.

---

[181] California Section 1115 Waiver Demonstration Application, June 30, 2021. Available at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Section-1115-Renewal-Application.pdf.

[182] A.B.1810 Chapter 34. June 2018. Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1810.

[183] DSH Diversion Program, California Department of State Hospitals. Available at https://www.dsh.ca.gov/Treatment/DSH_Diversion_Program.html.

Behavioral Health Services for Individuals Who Are Justice-involved

Many initiatives for individuals who are justice-involved are locally or county led, with limited geographic reach. Quantitative and qualitative information collected through this assessment indicated that more can be done to support mental health and SUD services statewide to adequately support individuals who are justice-involved during pre-sentencing, while incarcerated and after release. A foundational problem is that many providers simply will not work with clients with a history of incarceration, particularly if they have been convicted of crimes that could represent a threat to other patients or staff (e.g., assault, sex crimes, arson). This perpetuates health disparities as individuals who are justice-involved are disproportionately people of color who have considerable health care needs but who are often left without care and needed medications upon release.

Thirty-seven of California's counties are participating in the Stepping Up initiative, a collaborative effort between agency decision-makers and diverse stakeholders to develop action plans to reduce the number of people living with mental illnesses in jails.

This results in challenges across the continuum of care for individuals who are justice-involved with behavioral health issues, especially if they require assistance with housing. For instance:

- Sixty-eight percent of counties (40 respondents) reported a significant need for services across the continuum of care for populations who are justice-involved, including an urgent need for mental health residential services.
- Thirty-five counties (58 percent) reported a need for SUD residential services for populations who are justice-involved.
- Forty-two percent of counties (25 respondents) need acute inpatient hospital beds and WM services for individuals who are justice-involved.
- Ninety-three percent of counties (56 respondents) identified an urgent need for housing for individuals who are justice-involved.
- Approximately 58 percent of counties (35 respondents) reported providers are unwilling to accept individuals with felony convictions/forensic backgrounds, and 68 percent (41 respondents) reported providers are unwilling to accept individuals with a history of sex offense convictions.
- Fifty-five percent (33 respondents) reported that they lack staff and training to meet the needs of populations who are justice-involved in their counties.
- According to the California Courts Judicial Council, 48 counties operate juvenile drug courts and 19 counties operate adult drug courts.

"We struggle significantly to place incarcerated people into treatment beds—no one will take people out of jail. We need access to jail-based treatment or facilities willing to take jail inmates."

– County Behavioral Health Director

Focus group participants also explained that because probation systems differ between counties, there currently are inconsistent pathways to connect individuals who are justice-involved with community-based services. In addition, stakeholders shared that there are few, if any, navigational supports for families of incarcerated individuals. These issues are compounded by stigma and discrimination. One county reported, "Many programs take longer to interview patients who are in jail, and there is significant stigma against jailed patients. There is often the assumption that these patients are more dangerous and violent than are patients coming from other places. Programs also think that they have a right to view patients' criminal histories if they are incarcerated at the time of referral."

"There should be no difference in the information required for referral for jail patients, as this perpetuates discrimination. Many programs lack training in working with the criminal justice population and the criminal justice and legal systems in which their clients are involved."

– County Behavioral Health Director

Some counties have developed an array of innovative programs to better serve individuals who are justice-involved. Orange County has developed an approach that includes collaborative release planning, linkages to community resources and treatment (including MAT), and services for youth in juvenile hall. San Diego County requires that individuals released on probation have a "warm handoff" to community services, allowing individuals to receive treatment or housing services immediately upon release.

As discussed in Section 5.7 above, some counties also employ crisis intervention teams (CITs) that are designed to address the needs of individuals living with behavioral health conditions who enter the judicial system during a crisis state. Counties' investments in alternative models of crisis response, such as CITs, are intended to help mitigate unnecessary contact with law enforcement and to divert people in crisis to treatment services instead of jails. Data from the University of Memphis Crisis Intervention Team

Resource Center indicate that CITs are operational in 24 counties across the state[184]; in most cases, the CITs are small and may not be adequately resourced to fully implement the CIT model with fidelity.

6.3 AI/AN Communities

There are 109 federally recognized American Indian tribes in California[185] and 78 entities petitioning for federal recognition.[186] California is home to more AI/AN communities than any other state,[187] and these communities face high rates of behavioral health issues with little or no access to prevention or treatment services across both rural and urban communities. The prevalence and intensity of behavioral health conditions and the lack of access to services are driven by historical trauma as well as related social, policy and economic conditions that have limited access to health care and housing resources and resulted in poverty, unemployment and lower educational attainment.[188] Specifically:

- Nationally, among AI/AN individuals, 19 percent report experiencing mental illness in the past 12 months.[189]
- In California, opioid overdose deaths in the AI/AN population are almost double that of white communities and 500 percent higher than in Latino communities.[190]
- According to the most recent evaluation of the DMC-ODS, overdose death rates from psychostimulants are also higher for the AI/AN population (20.5 per 100,000) than for any other racial/ethnic group.[191]
- AI/AN youth and adolescents nation-wide face significantly higher rates of depression, suicide, and SUD than other young adult populations, but they have

---

[184] University of Memphis Crisis Intervention Team Resource Center. Available: http://www.cit.memphis.edu/aboutCIT.php.

[185] "California Tribal Communities," California Courts: The Judicial Branch of California, 2021. Available at https://www.courts.ca.gov/3066.htm.

[186] "Tribal Governments," Los Angeles City/County Native American Indian Commission, 2021. Available at https://lanaic.lacounty.gov/resources/.

[187] Ibid.

[188] "Tribal Affairs," SAMHSA, October 2021. Available at https://www.samhsa.gov/tribal-affairs.

[189] "Native And Indigenous Communities And Mental Health," Mental Health America, Accessed September 8, 2021. Available at https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health.

[190] "California's Tribal ODS & Tribal Medication Assisted Treatment (MAT) Expansion Project Update," DHCS, October 2019. Available at https://www.dhcs.ca.gov/Documents/5_California%27s_Tribal_ODS_and_MAT_Expansion_Project_Update.pdf.

[191] "Drug Medi-Cal Organized Delivery System FY 2020 Evaluation Report," DHCS, July 2021. Available at https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf.

limited access to youth-focused treatment services and facilities.[192]
- While there are limited data on ACEs among AI/AN youth and adolescents, research generally shows up to 74 percent of AI/AN youth experience at least one traumatic event during childhood.[193]

DHCS recognizes the devastating outcomes among AI/AN individuals and is working with AI/AN communities through the Tribal MAT Project (TMAT) to address the OUD prevention, treatment and recovery needs of California's Tribal and Urban American Indian communities.[194] Specifically, TMAT and TMAT 2.0 are focused on sharing knowledge among Tribal and Urban Indian communities, health programs and community-based partners on OUD prevention, treatment and recovery in California Indian Country.[195] More information on the specific gaps in the behavioral health continuum for AI/AN individuals and communities is provided below.

Challenges and Opportunities in Behavioral Health Services for AI/AN Individuals and Communities

As noted, there are significant gaps in the behavioral health care continuum for both youth and adults in AI/AN communities in California, attributable to systemic discrimination against AI/AN individuals and communities. In this context, it is important to understand the gaps as well as to work in partnership with AI/AN communities to identify culturally appropriate responses and interventions. For instance, focus group participants emphasized the following:

- The importance of culturally responsive and trauma-informed care that recognizes the historical trauma experienced by AI/AN individuals and the deep distrust of health care and government institutions attributable to forced assimilation campaigns.
- The integration of traditional AI/AN practices into behavioral health services, which might include sharing AI/AN blessings and other traditional forms of healing practices, such as sweat lodges and talking circles.
- A significant lack of residential services for AI/AN youth, as well as for adults, who require stabilization for mental health conditions.
- Recognition of the unique needs of the isolated and rural communities in which some AI/AN individuals reside, necessitating greater use of telehealth,

---

[192] "Native American Youth Depression and Suicide," Child Welfare Information Gateway, Department of Health and Human Services. Accessed September 8, 2021. Available at https://www.childwelfare.gov/topics/systemwide/diverse-populations/americanindian/mentalhealth/depression/.

[193] Bereiter J, "ACES and Why They Matter in Healthcare," Indian Health Service, 2017. Available at https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/slides/traumainformedcare/aces0617.pdf.

[194] "Tribal MAT Project," California MAT Expansion Project. Accessed September 8, 2021. Available at http://www.californiamat.org/matproject/tribal-mat-program/.

[195] Ibid.

community-driven solutions, and a willingness to support transportation to services that may be hours away.
- The importance of accounting for the complexity and intensity of need among AI/AN individuals, which may require more extended and expansive treatment to allow for stabilization and treatment of multilayered historical and family-based trauma.
- A strong focus on prevention and early intervention systems specific to AI/AN communities to prevent the need for higher levels of care, focusing on AI/AN-led initiatives that include participation and leadership from AI/AN youth.

In addition to the information gathered through the focus groups, DHCS recently worked with the University of Southern California Keck School of Medicine to complete a needs assessment that focused on OUD and AI/AN communities.[196] This needs assessment found:

- Family substance use is pervasive, necessitating multigenerational treatment strategies.
- While there has been a decrease in opioid prescriptions resulting from increased prescription oversight, AI/AN youth are found to have greater access to a variety of substances than in the past.
- Community and individual stressors are risk factors for opioid use, while historical and intergenerational trauma remain significant drivers of both mental health issues and substance use among AI/AN populations.
- Barriers to treatment include individual stigma and shame in seeking services and structural factors including cost, lack of or insufficient insurance coverage, unstable housing, fragmented service delivery, and a lack of residential treatment facilities for SUD.
- There is a lack of youth OUD prevention programs in AI/AN communities in California.

The OUD needs assessment recommended various program and policy changes DHCS should consider addressing OUD, including better access to MAT. These recommendations include:[197]

- Removing prior authorization requirements and limits on insurance coverage.
- Providing financial incentives to providers to become MAT certified.
- Charging a fee on opioid sales, to be deposited into a recovery fund.
- Adopting policies supporting longer provider-patient interactions.
- Expanding access to Tribal Opioid Response Grants among Urban Indian Health Programs.

---

[196] Soto C, "Tribal MAT Statewide Needs Assessment & Recommendations," University of Southern California Keck School of Medicine, 2019. Available at https://www.uclaisap.org/slides/psattc/cod/2019/Day%202/02_Workshop_Y_Soto.pdf.

[197] Ibid.

Finally, there are coordination challenges between counties, the federal Indian Health Service (IHS) and DHCS. Stakeholders shared that AI/AN communities with behavioral health needs are faced with a patchwork of service providers, with some county-based services covered by Medi-Cal and other services provided by IHS. This fragmentation adds to an already challenging landscape for AI/AN individuals who experience behavioral health conditions.

VII. Highest-Priority Challenges and Opportunities

Stakeholders identified significant concerns across the board regarding the continuum of behavioral health care in California, but a handful of issues emerged as urgent priorities. Many of these already are a focus of DHCS' behavioral health agenda, offering an important opportunity to address the highest-priority challenges confronting California's behavioral health system. These challenges and opportunities may be incorporated into DHCS's more immediate efforts to reform Med-Cal to better address adults living with SMI, children living with SED, individuals living with SUD and individuals who are involved in the justice system. As a point-in-time study completed in the midst of implementation of numerous large-scale changes, the Aadministration hopes to see changes in these outcomes in coming years as a result of recent significant investments.

California needs a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

California needs a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

The assessment at the center of this report highlights the importance of a comprehensive, coordinated effort to develop a continuum of crisis services that leverages and builds on the many initiatives already underway, including implementation of the 988 hotline by July 16, 2022; the Behavioral Health Continuum Infrastructure Program (see Section 2 for more details); and the CalHOPE 24/7 warm lines and chat support; and the new enhanced federal funding for a Medi-Cal mobile crisis benefit (pending budget approval).

While a key piece of any crisis initiative should include who responds to crisis calls—ideally, peers and behavioral health professionals who are experts in de-escalation—it also needs to address what happens to people before and after such crises. Any crisis system should start with identifying ways to avert the escalation of mental health and substance use issues, including offering support through peer warm lines before stress turns into a crisis. If a crisis response team is necessary, it is important to have alternatives to hospitalization when appropriate or incarceration, including crisis stabilization units, crisis residential services, crisis respite services (including peer respite) and sobering centers. In the absence of crisis response teams, these same

services should be available to law enforcement and other first responders as alternative destinations.

Most important, the assessment illustrates the importance of viewing crisis services as part of the broader behavioral health continuum, ensuring people receive services at the least expensive, least restrictive level of care (preventing unnecessary use of limited institutional resources such as EDs and hospitals, and helping to reduce the criminalization of mental health and substance use issues). Crisis services should be sufficiently funded by all payers, including Medicaid and commercial insurance, to ensure they can maintain 24/7 availability and respond in a timely manner to all individuals in crisis, regardless of insurance status. While there will be regional variation in capacity and resources for delivering crisis services, warm lines and crisis call centers should perform comparably across the state. The many initiatives already underway in California are working toward this vision.

Community-based living options are essential for people living with serious mental illness and/or a substance use disorder.

Bed capacity and long waits in the ED and inpatient psychiatric hospitals are the most apparent challenges in California's behavioral health care system. The assessment highlights the importance of responding to these urgent needs and developing a strategy for finding ways to assist people to live independent and meaningful lives in their communities. In line with DHCS' broader vision for CalAIM, this requires a fundamental shift toward considering Whole Person Care (WPC) that is rooted in the priorities of the people served by the behavioral health care system. The approach should be person centered, allowing the individual to define where they want to live, to connect with others, to become employed and to participate in meaningful activities that facilitate community integration.

For behavioral health care system reform, this imperative translates into the importance of addressing the basic issue of affordable housing for individuals who are likely to have little or inconsistent income. Affordable housing was repeatedly raised as the most important barrier to supporting individuals in living in the community. More broadly, it points to the promise of social rehabilitation models—both for shorter-term residential treatment and housing programs (e.g., ARFs)--that offer people community-based services in home-like environments that meets their needs, including life skills and activities, and look beyond their medical conditions to the key ingredients for a meaningful life and the opportunity to remain in the community.

More treatment options are vital for children and youth living with significant mental health and substance use disorders.

Stakeholders across the board highlighted the dearth of services for youth experiencing substance use disorders and the importance of finding ways to help prevent risky behaviors. The most glaring gap in services is for young people who require substance use treatment; 75 percent of counties (45) reported a lack of residential beds for youth patients, and 68 percent (41) reported they did not have enough providers with training and experience to meet youth patients' needs. As a result, children and youth SUD treatment options, including residential care, are sometimes mixed in with adult treatment options, or in some instances, youth are sent out of state to receive care.

At the same time, there was little interest in building out residential beds for youth without making sure they are used as rarely as possible. This requires viable community-based alternatives for treatment. So much of how children and youth succeed is linked to their ability to remain in school and their relationship with parents or other caretakers. Therefore, it is particularly problematic to have them sent far away from their communities and families for treatment. The assessment highlights the importance of increasing access to outpatient and intensive outpatient services for youth that can be delivered locally in or linked to schools, via telehealth or through intensive in-home services. The assessment also identified the need for prevention and early intervention for substance use or misuse that could be provided by schools and other community-based organizations.

Fortunately, California is making unprecedented investments in behavioral health services for children and youth (see Emerging and Existing Initiatives to Improve the Behavioral Health of California's Children and Youth in Section 6.1), including, most notably, through the Children and Youth Behavioral Health Initiative. This creates the opportunity to invest in prevention, such as by reducing risky behaviors, as well as to address the treatment gaps identified in the assessment.

Prevention and early intervention are critical for children and youth, especially those who are at high risk.

While gaps in care are evident throughout the behavioral health care continuum for children and youth, the biggest chasm is a lack of services and interventions that could prevent children from developing significant and long-term behavioral health issues. Children who experience adverse childhood experiences (ACEs) are more likely to exhibit negative behaviors and more likely to develop risky behaviors. Traditional payer approaches often do not recognize or pay for prevention or early intervention activities to address these behaviors and other issues that confront children and youth. The lack of resources has resulted in few staff having the necessary training and competencies to effectively identify and address behavioral health issues early in children and youth. While the Children and Youth Behavioral Health Initiative and recent investments in screening for and addressing ACEs will provide some support for prevention activities, there are a host of other issues that children and youth experience. Trauma, gender

identification issues and grief, as identified in the assessment, are some of the areas that would benefit from a well-organized and funded approach.

Schools can play an important role in these preventive and early intervention activities. They offer a safe, welcoming, and inclusive place where all students can thrive, regardless of circumstance or location. School-based health centers as well as county operated school-linked services may be in the best position to develop the capacity to spread and sustain efforts that ensure children have timely access to these activities and interventions. Financially supporting school-based and linked programs, such as is planned in the Children and Youth Behavioral Health initiative, will give educators the support and resources they need to be successful. School communities that engage in the development and support of all school staff can create a culture that builds resilience for all students.

Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.

A consistent theme in the assessment is the importance of culturally responsive services across the continuum of care that meet the needs of people of varied genders, sexual orientations, races, and ethnicities. This requires using California's various workforce initiatives to ensure that there is a strong focus on recruiting and retaining a diverse set of providers such as is the focus with many of the workforce programs through the Department of Health Care Access and Information. Many stakeholders also noted that California's new option for counties to offer peer support services in Medi-Cal may make it more likely that people will be able to see providers who share some of their life experiences, such as language and cultural background. In addition, targeted initiatives are needed for marginalized populations akin to the work already underway in AI/AN communities to expand medication for addiction treatment (MAT) through the Tribal MAT project.

California may be able to draw from its California Reducing Disparities Project (CRDP), a statewide policy initiative focusing on reducing mental health disparities among historically unserved, underserved, and inappropriately served communities, to inform its approach for the broader behavioral health system. Phase I of the project focused on development of a strategic plan for addressing mental health disparities along with population-specific assessments and recommendation reports for five priority populations -- Black, Asian and Pacific Islander, Latino, American Indian/Alaska Native and LGBTQ+. Now in Phase II, CRDP is in the process of implementing and evaluating 35 community-defined evidence practices (CDEPs) delivered by CBOs that provide culturally and linguistically competent prevention and early intervention mental health services to priority populations.

More can be done to encourage evidence-based practices are used consistently and with fidelity throughout California's behavioral health system.

As the body of research on effective treatment for mental health and substance use disorder conditions continues to expand, the assessment highlights the importance of embracing and making full use of those initiatives and treatment options that are known to be effective. Evidence-based practices can greatly improve lives if implemented broadly and with fidelity, and that is why the Children and Youth Behavioral Health Initiative included a significant investment for this purpose. The specific evidence-based practices highlighted in this assessment include use of contingency management for stimulant use disorders and greater availability of fidelity-based practices such as supported employment, supportive housing, Assertive Community Treatment teams, first-episode psychosis initiatives and specialized eating disorder protocols. Even beyond these specific initiatives and programs, the behavioral health field continues to evolve and produce more research on effective ways for providers to deliver therapy and other behavioral health supports. For example, the research continues to grow on the value of CBT, DBT, contingency management and motivational interviewing.

While sustainable funding for these practices is important, supporting providers to provide services with fidelity is equally so. California has had success expanding the use of MAT in recent years, offering an example of how a combination of state and county requirements, provider education, ongoing support and funding can assist in disseminating evidence-based practices. According to the Addiction Free California Dashboard, the rate of buprenorphine prescribing in California increased over 70% from December 2009 to December 2017.[198] Other states have had considerable success setting up Centers of Excellence (COEs) that work with providers to help them understand and use evidence-based practices, such as New York's Center for Culturally Competent Care, Ohio's Child and Adolescent Behavioral Health Center of Excellence, and Pennsylvania's Centers of Excellence for MAT. With its leading academic institutions, California is particularly well positioned to leverage and work with such institutions to support providers in deploying evidence-based practices with fidelity. A California approach to developing COEs should consider existing practice change efforts and regional models given the size and diversity of the State.

In addition to expanding coverage and access to EBPs across the state, DHCS also recognizes the importance of sustaining community defined practices for behavioral health interventions. Under this model, community-based practitioners develop interventions that are geared toward a specific community or population and are often culturally grounded.

[198] "Data Dashboard," Addiction Free CA. Available at https://addictionfreeca.org/data-dashboard.

More effectively addressing the behavioral health issues—and related housing, economic and physical health issues—of individuals who are justice-involved is critical.

Stakeholders consistently raised the critical importance of improving mental health and substance use disorder services for individuals who are justice-involved, starting by reducing the arrest and incarceration of people because they are in crisis due to those conditions. Despite the current reality that vast numbers of people in California's jails and prisons are experiencing a mental health and/or substance use disorder, it was universally agreed that jails and prisons generate more trauma and stress and are not the right place for individuals living with behavioral health conditions unless they engage in criminal activity that leaves no other option.

Practical implications include the importance of implementing a comprehensive crisis response system, per the discussion above, that reduces the unnecessary involvement of law enforcement and incarceration of people who are having a mental health or substance use–driven crisis; pursuing the new Medi-Cal initiative to offer selected pre-release services to individuals living with certain behavioral health conditions; offering training and support to providers to encourage more of them to work with individuals who are justice-involved; engaging peers who have experienced incarceration to offer services to people leaving jail or prison; and ensuring that CalAIM's WPC approach reflects the unique challenges confronting individuals who are justice-involved, such as additional barriers to housing, employment and treatment.

VIII. Implications Across the Continuum of Care

Along with the highest-priority issues and opportunities described above, numerous additional actions and initiatives may help California strengthen its behavioral health care system. This section reviews some of the ideas and strategies that were identified by stakeholders, focus group participants, survey responses and additional data organized by the continuum of care outlined in Figure 1b. For each service area or challenge, there is generally a need to expand capacity, consider policy changes and address workforce issues contributing to the situation. For more details on strategies and efforts underway to strengthen the behavioral health workforce in California, readers may want to review some of the more in-depth analyses on this topic, including materials from the California Future Health Workforce Commission and the Department of Health Care Access and Information.[199]

[199] More information about the recommendations from the California Future Health Workforce Commission is available at https://futurehealthworkforce.org/about/.

8.1 Preventive, Wellness and Outpatient Considerations

A strong theme from the assessment is the importance of expanding preventive and outpatient behavioral health services, particularly for children and youth, including integrating services to address substance use and misuse into school-based settings. Prevention and early intervention are needed to stave off or ameliorate emerging behavioral health conditions, reduce the impact on EDs and inpatient facilities, and support California's commitment to seeing care delivered in the least restrictive settings possible.

The assessment also identified a host of policy changes that could reduce barriers and increase access to preventive and outpatient services. These policy changes may provide new and/or more focused direction to several key initiatives DHCS is shaping, including revisions to the SUD 1115 and SMI/SED Medicaid demonstrations waivers and proposed value-based purchasing proposals. The State will work with other state agencies and stakeholders to review current policies as needed to increase access to these services.

Overall, the assessment reinforced the importance of strengthening and expanding the behavioral health care workforce for early intervention (especially in schools and through pediatric offices serving children prior to elementary school), wellness and traditional outpatient services. Stakeholders recommended programs that seek to encourage the existing workforce to remain in the field, increase their expertise, and enhance their efficiency and bandwidth. Stakeholders also encouraged efforts to diversify the types of practitioners and settings that can offer outpatient behavioral health services.

Policy opportunities suggested by stakeholders include (1) incentivizing providers to adopt a no-reject policy for outpatient and other behavioral health services for individuals who are justice-involved and (2) developing a model of on-call and telehealth mentoring from psychiatrists for pediatric providers and perinatal providers to help with psychotropic prescribing for children, their parents and pregnant/postpartum women, similar to programs in Massachusetts and other states.

8.2 Crisis Services Considerations

The assessment reinforced the importance of DHCS' existing and proposed crisis service initiatives, such as the plan to use the new federal option to expand mobile crisis services for Medi-Cal enrollees (pending budget approval) and grants to counties for planning and implementation of crisis services. Other findings identified potential new services or renewed approaches for ensuring a full continuum of crisis services.

DHCS will continue to work with other state agencies and stakeholders to examine access to crisis services. One issue identified by stakeholders was to review and identify regulatory barriers preventing the delivery of integrated crisis care and SUD treatment, including ensuring that crisis services offer access to MAT for those individuals who have both OUD and a mental health issue.

The assessment identified opportunities to enhance the workforce of crisis providers, such as including peer support service providers and trained law enforcement personnel

operating in partnership with behavioral health providers, when necessary for an intervention. In addition, focus group respondents identified the need for training and technical assistance on the new federal mobile crisis option in Medi-Cal, pending budget approval (e.g., trauma-informed care, de-escalation strategies and harm reduction training), as well as training call center and mobile crisis staff on issues related to substance use disorders.

8.3 Community, Peer and Recovery Support Considerations

The assessment identified opportunities to improve various community, peer and recovery supports for children, youth and adults, including building additional capacity for the peer workforce and leveraging work already underway to provide coordinated specialty care services to youth and young adults who experience an initial episode of psychosis. Additional workforce strategies identified by stakeholders include creating a process for recruiting and certifying youth peer supports, SUD recovery coaches and a family peer support workforce. Efforts to increase access to and the quality of various community, peer and recovery supports will have workforce implications.

The focus group participants identified the need to expand the capacity and ensure consistent standards for community-based, peer and recovery services, which will be addressed in July 2022, as DHCS implements its new peer support certification standards. Other potential strategies to ensure the quality of peer-delivered services would not need regulatory changes but could benefit from processes to review and monitor programs to ensure they meet existing standards. For instance, strategies to review programs that address first-episode psychosis could promote alignment with existing strategies from the California Mental Health Services Oversight and Accountability Commission. Other policies may focus on strategies to include supported employment and supported education in the Medi-Cal program.

8.4 Intensive Outpatient and Treatment Services Considerations

The assessment identified several potential gaps in intensive services (community- and facility-based) where additional capacity was recommended. Data regarding potential gaps in inpatient psychiatric care identified by the California Hospital Association and supported by outputs using the Crisis Resource Need Calculator showed variability in existing inpatient bed capacity. The assessment also identified the lack of “upstream” services (e.g., crisis services) that could be helpful in diverting individuals from EDs and potential admission to these facilities. Additionally, the assessment suggested additional capacity to divert individuals from incarceration. It also highlighted the current bottlenecks in services that are necessary to transition individuals out of these facilities in a timely manner.

Stakeholders also identified the need to develop additional capacity for existing services or, in some instances, new services (e.g., ASAM Level 4.0-WM), and recommended that DHCS educate managed care organizations and hospitals regarding the current Voluntary Inpatient Detoxification benefit (inpatient withdrawal management) to ensure broader availability of services. Stakeholders also identified the need for additional clinical programs and providers to address eating disorders and clarifying the mutual responsibilities of managed care plans and mental health plans.

Stakeholders identified the need for policy changes to address gaps in intensive outpatient and treatment services. Suggestions include leveraging the proposed SMI/SED 1115 Demonstration program to allow Medi-Cal coverage of high-fidelity ACT teams and forensic ACT teams, to support programs to divert individuals from arrest and incarceration into treatment, and/or expand treatment options for eating disorders, and (2) developing standards and admission criteria for inpatient withdrawal management (also known as voluntary inpatient detox), consistent with current ASAM criteria.

8.5 Selected SUD Services Considerations

Overall, there were many findings that were specific to enhancing services for individuals living with SUD. These included findings regarding specific services for adults living with SUD and findings related to services and approaches for specific substances or combinations of substances (e.g., methamphetamine, fentanyl), MAT for OUD, and unevenness of access to various ASAM Level 3.0 residential levels of care. For adolescents, the service gaps were more pronounced. Quantitative and qualitative data from county surveys and focus group members identified a lack of treatment services across all SUD levels of care. While the 2015 1115 SUD DMC-ODS waiver provided a major driver in expanding access to and the quality of SUD services across the state, little noticeable improvement occurred for adolescents with SUD. DHCS will be addressing some of these issues for adults and adolescents in the renewal of the SUD 1115 DMC-ODS waiver. In addition, SUD program enhancements were included in California's request for federal funding opportunities available through the American Rescue Plan Act (ARPA). The department's Tribal MAT program has supported AI/AN populations over the past several years, and findings from the assessment supported continued enhancements of MAT and other SUD services for this population.

The assessment identified various policy barriers that hindered access to treatment. Some of these barriers would require statutory changes to address, such as acting on new federal guidance to allow OUD medications to be dispensed through mobile narcotic treatment vans, to offer access to methadone in regions with no NTP access. Others could be addressed through regulatory changes, such as amending licensing and certification standards to increase oversight authority of treatment programs to ensure clients with OUD are offered MAT, either on-site or through referral. Other barriers will be addressed through CalAIM updates to the DMC-ODS program and the new pilot of contingency management for stimulant use disorder. These efforts will require that DHCS continue to work with stakeholders on a range of strategies planned for calendar year 2022 and beyond to implement these updates.

The assessment findings provided direction for various strategies to address the workforce. While DHCS recognizes that recruitment and retention efforts will be imperative across behavioral health and other social service areas, more targeted strategies may be necessary to enhance the capacity and competencies of the workforce serving individuals living with SUD. These strategies may focus on implementation efforts that result from capacity and policy changes specific to SUD services. Similar to these efforts, considerations for workforce development will be

driven by changes to the SUD 1115 DMC-ODS waiver, implementation efforts for addressing stimulant use disorder and other planned initiatives.

IX. Conclusion

In summary, DHCS collected data from multiple sources, including quantitative analysis and qualitative input from focus groups and surveys, aiming to document the state of behavioral health capacity in California, with a particular focus on Medi-Cal. DHCS has many major behavioral health initiatives underway to address issues surfacing in this report, The assessment will also help inform future work, including guidance for implementation of the Behavioral Health Continuum Infrastructure Program (BHCIP) and California's proposal for the SMI/SED Demonstration 1115 Waiver. Key findings include:

- It is critical to have a comprehensive approach to behavioral health services that emphasizes community-based treatment, diverts individuals from costly inpatient services and involvement with law enforcement and connects people to ongoing services, including housing and housing supports.
- More community based treatment options are essential for people living with serious mental illness and/or a substance use disorder, there is a profound need for more community-based living options to promote community inclusion.
- More treatment options are vital for children and youth living with significant mental health and substance use disorders.
- Prevention and early intervention provided through schools and other community-based organizations are critical for children and youth, especially those who are at high risk.
- Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.
- A large and diverse health workforce can support the expansion and sustainability of mental health and SUD services, including efforts to recruit and train peers support staff and recovery coaches.
- More can be done to encourage evidence-based practices are used consistently and with fidelity throughout California's behavioral health system.
- More effectively addressing the behavioral health issues—and related housing, economic and physical health issues—of individuals who are justice-involved is critical.

In the months and years ahead, DHCS will continue to review and update these findings to inform its process for implementing existing initiatives and developing new ones. This assessment is a substantial start and intended to serve as one source of information that DHCS can consult in its work. DHCS recommends more in depth work to understand and analyze the current state of play with respect to the role of commercial insurers in providing behavioral health services; the role of MHSA funding; the use of realignment funds and other issues. As it continues its work, DHCS looks forward to ongoing consultation with the people living with behavioral health conditions, their families and caretakers, counties, providers, plans and other stakeholders that share the commitment to improving California's behavioral health system.

Appendix A – List of Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACEs	adverse childhood experiences
ACF	Administration for Children and Families
ACT	Assertive Community Treatment
AI/AN	American Indian/Alaska Native
AMI	any mental illness
AOT	assisted outpatient treatment
ARPA	American Rescue Plan Act of 2021
ASAM	American Society of Addiction Medicine
BHCIP	Behavioral Health Continuum Infrastructure Program
BSCC	Board of State and Community Corrections
CalAIM	California Advancing and Innovating Medi-Cal
CBHSQ	Center for Behavioral Health Statistics and Quality
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CHIP	Children's Health Insurance Program
CDCR	California Department of Corrections and Rehabilitation
CIT	crisis intervention team
CMS	Centers for Medicare & Medicaid Services
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble Screening Tool
CRTPs	Crisis Residential Treatment Programs
CSOC	Children’s System of Care
CSUs	crisis stabilization units
DBT	Dialectical Behavior Therapy
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EDs	emergency departments
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment benefit
ERISA	Employee Retirement Income and Security Act of 1974

Acronym	Definition
FEP	first-episode psychosis
FFS	fee-for-service
FPL	federal poverty Level
FQHCs	Federally Qualified Health Centers
FSP	Full-Service Partnership
FURS	Family Urgent Response System
HPSAs	health professional shortage areas
IHS	Indian Health Service
ILOS	In-lieu-of services
IMDs	Institutions for Mental Disease
IOPs	Intensive Outpatient Programs
LOS	lengths of stay
MAT	medications for addiction treatment (also known as medication-assisted treatment)
MCOs	managed care organizations
MCPs	managed care plans
MHPAEA	Mental Health Parity and Addiction Equity Act
MHRCs	mental health rehabilitation centers
MHSA	Mental Health Services Act
NASMHPD	National Association of State Mental Health Program Directors
NIMBY	“Not in my backyard”
NPs	nurse practitioners
NSDUH	National Survey of Drug Use and Health
NTPs	Narcotic Treatment Programs
OTPs	Opioid Treatment Programs
OUD	opioid use disorder
PAs	physician assistants
PHF	psychiatric health Facility
PHPs	Partial Hospitalization Programs
PRTFs	Psychiatric Residential Treatment Facilities
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment

Acronym	Definition
SCAs	single-case agreements
SED	serious emotional disturbance
SMHS	Specialty Mental Health Services
SMI	serious mental illness
SNF	Skilled Nursing Facilities
SSI	Supplemental Security Income
STRTPs	Short-term Residential Therapeutic Programs
SUD	Substance Use Disorder
TMAT	Tribal MAT Project
WIC	Welfare and Institutions Code
WM	Withdrawal management
WPC	Whole Person Care

Appendix B – Data

Table 1. **Rates of Behavioral Health Conditions Among Adults Aged 18+ from the 2019 National Survey of Drug Use and Health**

	Any Mental Illness	Serious Mental Illness (SMI)	Illicit Drug Use Disorder	Alcohol Use Disorder	Any Substance Use Disorder (SUD)
Age Group					
Aged 18-25	29.4%	8.6%	7.5%	9.3%	14.1%
Aged 26-49	19.2%	6.8%	3.7%	7.0%	9.6%
Aged 50+	14.1%	2.9%	1.0%	3.4%	4.1%
Gender					
Male	16.3%	3.9%	3.7%	7.3%	10.0%
Female	24.5%	6.5%	2.3%	4.0%	5.6%
Race/Ethnicity					
Not Hispanic	21.1%	5.3%	3.0%	5.7%	7.8%
White	22.2%	5.7%	2.9%	6.0%	8.1%
Black	17.3%	4.0%	3.3%	5.1%	7.6%
American Indian/Alaska Native (AI/AN)	18.7%	6.7%	4.5%	6.8%	10.2%
Native Hawaiian/Pacific Islander	16.6%	2.6%	2.9%	5.7%	8.3%
Asian	14.4%	3.1%	1.7%	3.6%	4.6%
Two or more	31.7%	9.3%	5.9%	7.6%	11.9%
Hispanic	18.0%	4.9%	2.9%	5.1%	7.0%
Employment Status					
Full-time employed	19.2%	4.6%	2.7%	6.7%	8.6%
Part-time employed	25.0%	6.8%	3.8%	5.7%	8.1%
Unemployed	27.7%	8.4%	9.9%	9.5%	16.1%

	Any Mental Illness	Serious Mental Illness (SMI)	Illicit Drug Use Disorder	Alcohol Use Disorder	Any Substance Use Disorder (SUD)
Other	20.1%	5.2%	2.2%	3.6%	5.3%
Region					
Northeast	19.7%	4.7%	2.9%	5.2%	7.2%
Midwest	22.1%	5.6%	3.0%	6.2%	8.2%
South	19.2%	5.0%	2.4%	5.0%	6.7%
West	22.1%	5.7%	3.9%	6.5%	9.2%
Metro Area					
Large metro	20.2%	4.8%	3.1%	5.8%	7.9%
Small metro	20.9%	5.7%	2.9%	5.6%	7.6%
Nonmetro	21.2%	5.9%	2.6%	5.1%	7.0%
Income Level					
Less than 100% federal poverty level (FPL)	26.7%	8.9%	5.3%	6.1%	9.8%
100%-199% FPL	23.7%	6.8%	3.3%	5.3%	7.8%
200% or more FPL	18.5%	4.3%	2.4%	5.6%	7.2%
Educational Attainment					
< High school	18.3%	4.3%	3.3%	5.4%	7.7%
High school graduate	19.3%	5.1%	3.5%	5.2%	7.9%
Some college	23.7%	7.0%	3.7%	6.1%	8.7%
College graduate	19.5%	4.1%	1.7%	5.4%	6.8%
Health Insurance Coverage					
Private	18.6%	4.3%	2.1%	5.4%	7.0%
Medicaid/CHIP	31.2%	10.1%	5.9%	6.3%	10.9%

	Any Mental Illness	Serious Mental Illness (SMI)	Illicit Drug Use Disorder	Alcohol Use Disorder	Any Substance Use Disorder (SUD)
Other	16.8%	3.8%	1.3%	3.3%	4.0%
No coverage	21.8%	6.0%	5.7%	7.6%	11.3%

Sources:

SAMHSA NSDUHD Adult SMI Data Tables 2018-19

SAMHSA NSDUHD Adult SUD Data Tables 2018-19

Caveats: These results are pulled directly from the results of the 2019 National Survey of Drug Use and Health. These results are based on survey responses, which may be prone to underreporting. Additional details about the NSDUH and inherent limitations can be found on the NSDUH website.

Table 2. **Rates of SMI, SED and SUD by County Among Medi-Cal Enrollees in 2019**

County	SED Rate	SMI Rate	SUD Rate Aged 18+	SUD Rate Aged 12-17
Alameda	2.8%	5.9%	3.3%	1.4%
Alpine	*	8.3%	*	0.5%
Amador	3.1%	10.4%	4.6%	0.0%
Butte	5.1%	9.1%	6.3%	*
Calaveras	4.7%	10.0%	3.5%	0.9%
Colusa	1.7%	6.5%	2.1%	0.8%
Contra Costa	3.1%	6.5%	3.5%	*
Del Norte	7.8%	10.2%	4.9%	0.6%
El Dorado	3.9%	8.5%	5.6%	1.7%
Fresno	2.5%	5.6%	3.1%	1.3%
Glenn	3.8%	7.3%	4.2%	0.8%
Humboldt	4.7%	8.8%	6.7%	0.8%
Imperial	2.3%	6.1%	3.2%	0.9%
Inyo	3.2%	7.4%	4.5%	1.6%
Kern	2.5%	5.9%	3.4%	1.8%
Kings	2.2%	6.6%	3.9%	0.6%
Lake	3.5%	9.9%	7.2%	1.4%
Lassen	3.4%	10.3%	4.8%	1.5%
Los Angeles	3.0%	5.7%	2.3%	1.5%
Madera	2.6%	5.0%	2.4%	0.7%
Marin	3.9%	8.3%	4.5%	0.9%
Mariposa	6.0%	10.4%	4.6%	1.1%
Mendocino	5.8%	9.1%	6.1%	2.4%

County	SED Rate	SMI Rate	SUD Rate Aged 18+	SUD Rate Aged 12-17
Merced	2.1%	5.9%	3.3%	2.1%
Modoc	3.9%	9.8%	6.0%	0.8%
Mono	0.8%	5.0%	2.4%	*
Monterey	2.2%	5.3%	3.6%	*
Napa	3.4%	7.3%	3.7%	1.3%
Nevada	4.7%	9.9%	6.6%	0.9%
Orange	2.4%	5.2%	2.6%	1.2%
Placer	2.3%	8.3%	4.6%	0.9%
Plumas	6.0%	12.1%	3.9%	0.7%
Riverside	2.6%	7.1%	3.9%	*
Sacramento	2.5%	7.1%	3.7%	1.0%
San Benito	2.5%	4.9%	2.6%	0.4%
San Bernardino	2.9%	6.9%	3.5%	0.9%
San Diego	2.4%	8.2%	4.1%	0.7%
San Francisco	2.4%	7.0%	5.0%	1.2%
San Joaquin	1.9%	5.4%	4.2%	0.5%
San Luis Obispo	3.7%	9.7%	7.5%	0.5%
San Mateo	2.5%	5.7%	2.8%	1.5%
Santa Barbara	2.7%	6.7%	4.7%	0.9%
Santa Clara	3.0%	4.9%	2.5%	1.2%
Santa Cruz	3.2%	8.7%	5.4%	1.2%
Shasta	5.5%	11.8%	8.0%	1.0%
Sierra	*	4.1%	3.3%	1.1%
Siskiyou	6.0%	10.3%	4.8%	0.0%
Solano	3.1%	6.7%	4.0%	1.5%
Sonoma	3.4%	8.3%	5.3%	0.5%
Stanislaus	2.3%	6.0%	4.1%	1.0%
Sutter	2.6%	5.6%	3.4%	0.7%
Tehama	3.4%	9.8%	4.6%	0.6%
Trinity	5.5%	7.4%	5.0%	0.4%
Tulare	2.8%	5.4%	2.8%	*
Tuolumne	4.5%	11.4%	6.1%	1.1%
Ventura	2.6%	6.6%	3.8%	1.2%
Yolo	3.1%	7.7%	4.1%	1.2%
Yuba	2.7%	8.2%	5.9%	0.7%
UNKNOWN	2.6%	5.0%	1.5%	0.3%

Source: Analysis of Medi-Cal administrative claims data.

* Rates for these counties are censored due to small sample size.

Caveats: These results are based on analyses of California Medicaid administrative claims data. Diagnosis code– and utilization-based proxy measures were developed to

estimate rates of SED, SMI and SUD among the Medi-Cal population by county. A complete description of these proxy measures and their inherent limitations can be found in Appendix C, below. In general, these proxy measures are likely to underestimate the true prevalence of these conditions because they fail to capture individuals who do not actively engage with the health care system. Further, proxy measures based on diagnosis codes do not capture the full nuance of DSM-consistent diagnoses related to these conditions.

Table 3. **Rates of Behavioral Health Conditions Among Individuals Aged 12-17 from the 2019 National Survey of Drug Use and Health**

	Major Depressive Episode	Major Depressive Episode with Impairment	Illicit Drug Use Disorder	Alcohol Use Disorder	Any SUD
Age Group					
Aged 12-13	10.5%	6.8%	0.8%	0.2%	0.9%
Aged 14-15	16.4%	11.9%	3.9%	1.4%	4.8%
Aged 16-17	20.1%	14.5%	6.1%	3.4%	7.9%
Gender					
Male	8.8%	6.0%	3.4%	1.3%	4.0%
Female	23.0%	16.5%	3.8%	2.1%	5.0%
Race/Ethnicity					
Not Hispanic	15.2%	11.0%	3.4%	1.7%	4.3%
White	15.9%	11.4%	3.5%	2.2%	4.7%
Black	11.4%	8.0%	3.5%	0.3%	3.7%
AI/AN	12.2%	11.5%	7.2%	3.2%	8.9%
Asian	15.1%	11.3%	1.3%	0.2%	1.3%
Two or more	20.9%	14.9%	4.3%	1.4%	5.1%
Hispanic	17.3%	11.7%	4.2%	1.7%	5.0%
Region					
Northeast	13.8%	9.5%	3.7%	1.8%	4.4%
Midwest	16.4%	11.8%	3.5%	1.9%	4.7%
South	15.1%	10.9%	3.0%	1.3%	3.7%
West	17.5%	22.9%	4.6%	1.9%	5.6%
Metro Area					
Large metro	15.9%	11.3%	3.9%	1.6%	4.6%
Small metro	16.0%	11.4%	3.5%	1.6%	4.6%
Nonmetro	14.6%	9.9%	2.6%	2.1%	4.0%
Income Status					
Less than 100% FPL	14.0%	10.0%	3.9%	1.4%	4.7%

	Major Depressive Episode	Major Depressive Episode with Impairment	Illicit Drug Use Disorder	Alcohol Use Disorder	Any SUD
100%-199% FPL	16.0%	11.5%	4.3%	1.6%	5.0%
200% or more FPL	16.2%	11.4%	3.2%	1.8%	4.2%
Health Insurance Coverage					
Private	16.0%	10.9%	3.1%	1.7%	4.1%
Medicaid/CHIP	15.3%	11.2%	4.2%	1.7%	5.0%
Other	15.9%	13.2%	4.1%	1.8%	5.3%
No coverage	16.3%	10.5%	4.2%	1.4%	5.0%

Sources:

SAMHSA NSDUHD Child/Youth Mental Health Data Tables 2018-19

SAMHSA NSDUHD Child/Youth SUD Data Tables 2018-19

Caveats: These results are pulled directly from the results of the 2019 National Survey of Drug Use and Health. These results are based on survey responses, which may be prone to underreporting. Additional details about the NSDUH and inherent limitations can be found on the NSDUH website.

Table 4. **Facilities Providing Outpatient Mental Health or SUD Treatment and Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plans, by County**

County	Community Mental Health Clinics	Federally Qualified Health Centers (FQHCs)	Other Outpatient Mental Health Treatment Facilities	Number of Outpatient SUD Treatment Facilities	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents
Alameda	6	3	20	29	532	3.2
Alpine	0	0	1	1	4	38.5
Amador	0	0	1	1	14	3.6
Butte	1	0	4	8	124	5.5

County	Community Mental Health Clinics	Federally Qualified Health Centers (FQHCs)	Other Outpatient Mental Health Treatment Facilities	Number of Outpatient SUD Treatment Facilities	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents
Calaveras	0	0	1	1	21	4.6
Colusa	1	0	0	1	8	3.7
Contra Costa	3	1	10	21	681	6.0
Del Norte	0	0	3	2	11	4.0
El Dorado	1	0	2	4	70	3.7
Fresno	0	0	13	22	473	4.8
Glenn	0	0	0	3	22	7.9
Humboldt	0	1	4	7	88	6.5
Imperial	0	0	1	4	42	2.3
Inyo	1	0	0	2	9	5.0
Kern	0	1	11	21	339	3.8
Kings	0	0	0	3	50	3.3
Lake	0	1	0	4	25	3.9
Lassen	0	0	1	2	5	1.6
Los Angeles	38	10	128	195	4,490	4.5
Madera	0	0	3	2	53	3.4
Marin	2	0	6	13	107	4.1
Mariposa	0	0	1	1	22	12.6
Mendocino	0	2	3	6	56	6.4
Merced	0	0	5	4	146	5.4
Modoc	0	0	0	2	8	9.0
Mono	0	0	0	1	5	3.5
Monterey	0	1	7	12	253	5.8
Napa	0	0	4	3	49	3.5
Nevada	1	0	2	4	63	6.3

County	Community Mental Health Clinics	Federally Qualified Health Centers (FQHCs)	Other Outpatient Mental Health Treatment Facilities	Number of Outpatient SUD Treatment Facilities	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents
Orange	0	5	40	73	831	2.6
Placer	0	0	5	8	125	3.2
Plumas	0	0	1	0	16	8.6
Riverside	1	1	17	37	652	2.7
Sacramento	3	3	19	18	336	2.2
San Benito	0	0	1	1	18	3.0
San Bernardino	3	5	20	30	812	3.8
San Diego	1	8	32	78	812	2.4
San Francisco	5	2	14	17	613	7.0
San Joaquin	1	0	3	11	164	2.2
San Luis Obispo	4	0	1	4	181	6.4
San Mateo	0	1	6	8	195	2.5
Santa Barbara	0	1	9	17	195	4.4
Santa Clara	1	2	22	22	599	3.1
Santa Cruz	0	0	2	6	119	4.3
Shasta	1	0	4	8	93	5.2
Sierra	0	0	2	2	3	9.9
Siskiyou	0	0	2	3	16	3.7
Solano	1	0	6	6	165	3.7
Sonoma	2	0	7	8	106	2.1
Stanislaus	0	1	3	10	189	3.5
Sutter	1	2	3	2	74	4.3
Tehama	0	0	0	2	25	3.9

County	Community Mental Health Clinics	Federally Qualified Health Centers (FQHCs)	Other Outpatient Mental Health Treatment Facilities	Number of Outpatient SUD Treatment Facilities	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan	Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents
Trinity	2	0	0	1	11	8.7
Tulare	0	0	4	8	170	3.7
Tuolumne	0	0	1	2	15	2.8
Ventura	0	0	14	15	312	3.7
Yolo	1	0	4	6	75	3.5
Yuba	0	1	1	3	*	3.2
Total	**81**	**52**	**474**	785	14,692	3.7

*Note: Yuba County submits workforce data jointly with Sutter County.

Sources: Data on CMHCs, FQHCs and outpatient mental health/SUD treatment facilities were extracted from the SAMHSA Behavioral Health Treatment Services Locator. Data on the number of non-psychiatrist behavioral health providers licensed with county SMHS plans were provided by DHCS.

Caveats: The numbers of outpatient mental health and SUD facilities documented in this table were identified using the SAMHSA Behavioral Health Treatment Services Locator. There likely are additional facilities providing outpatient mental health and SUD treatment services that are not documented in the SAMHSA treatment locator. The SAMHSA Behavioral Health Treatment Services Locator covers facilities funded by the state, facilities administered by the U.S. Department of Veterans Affairs, and/or private for-profit and nonprofit facilities that are licensed by the state or a national treatment accreditation organization such as The Joint Commission or the National Committee for Quality Assurance. However, the locator generally does not provide information on individuals in private practice or a small group practice unless they are licensed or certified as a clinic. Data on the number of non-psychiatrist behavioral health providers licensed with county SMHS plans were extracted from network adequacy data provided by DHCS. These counts only reflect the number of Medi-Cal-enrolled behavioral health providers licensed with county SMHS plans. Additional behavioral health providers in the state that are not licensed with county SMHS plans are not captured here.

Table 5. **Facilities Providing Selected Intensive Treatment Services for Mental Health or SUD According to the SAMHSA Behavioral Health Treatment Services Locator**

County	Partial Hospitalization for Mental Health	Partial Hospitalization for SUD	Intensive Outpatient Services for SUD
Alameda	1	6	19
Alpine	0	0	1
Amador	0	0	0
Butte	0	0	5
Calaveras	0	0	0
Colusa	0	0	0
Contra Costa	2	1	15
Del Norte	0	0	1
El Dorado	0	1	3
Fresno	0	2	10
Glenn	0	0	2
Humboldt	0	1	3
Imperial	0	0	2
Inyo	0	0	2
Kern	0	2	15
Kings	0	0	0
Lake	0	0	2
Lassen	0	0	0
Los Angeles	12	49	117
Madera	0	0	2
Marin	0	3	12
Mariposa	0	0	0
Mendocino	0	0	3
Merced	0	0	3
Modoc	0	0	1
Mono	0	0	1
Monterey	0	6	9
Napa	0	0	2
Nevada	0	1	3
Orange	5	51	61
Placer	0	1	6
Plumas	0	0	0
Riverside	1	16	25
Sacramento	0	5	7
San Benito	0	0	0
San Bernardino	0	10	19
San Diego	8	20	51

County	Partial Hospitalization for Mental Health	Partial Hospitalization for SUD	Intensive Outpatient Services for SUD
San Francisco	0	1	5
San Joaquin	0	1	2
San Luis Obispo	0	2	3
San Mateo	0	1	6
Santa Barbara	1	2	11
Santa Clara	1	7	10
Santa Cruz	0	1	3
Shasta	0	0	3
Sierra	0	0	0
Siskiyou	0	0	1
Solano	0	2	3
Sonoma	0	1	4
Stanislaus	0	4	7
Sutter	0	0	2
Tehama	0	0	1
Trinity	0	0	0
Tulare	0	2	4
Tuolumne	0	0	1
Ventura	2	5	11
Yolo	0	0	3
Yuba	0	1	2
Total	33	205	484

Source: Data were extracted from the SAMHSA Behavioral Health Treatment Services Locator.

Caveats: These results are based on analysis of the SAMHSA Behavioral Health Treatment Services Locator. These results only capture facilities included in the treatment services locator that have flags indicating that the facilities provide partial hospitalization or intensive outpatient services for the treatment of mental health or SUD. As mentioned above, the SAMHSA Behavioral Health Treatment Services Locator may not capture all facilities providing outpatient mental health and SUD treatment services in the state. It is also possible that the treatment locator is missing relevant indicator variables for some facilities that are in fact providing partial hospitalization or intensive outpatient services.

Table 6. **Narcotic Treatment Programs and DEA-Waivered Buprenorphine Prescribers by County**

Counties	NTP Facilities	Total DEA-waivered buprenorphine patient capacity	Buprenorphine Patient Capacity per 100,000 Residents
Alameda	8	17,230	1,101
Alpine	0		
Amador	1	1,535	4,077
Butte	1	3,040	1,367
Calaveras	0	220	486
Colusa	0	60	281
Contra Costa	4	14,965	1,382
Del Norte	0	310	1,107
El Dorado	1	3,030	1,661
Fresno	5	5,380	567
Glenn	0	130	465
Humboldt	1	3,910	2,902
Imperial	2	2,095	1,191
Inyo	0	580	3,163
Kern	5	5,845	683
Kings	0	1,875	1,241
Lake	0	1,075	1,673
Lassen	0	320	965
Los Angeles	44	88,615	890
Madera	0	580	381
Marin	1	5,205	2,034
Mariposa	0	365	2,036
Mendocino	0	2,140	2,445
Merced	1	1,150	440
Modoc	0	30	323
Mono	0	270	1,912
Monterey	2	6,210	1,467
Napa	0	2,540	1,835
Nevada	1	1,570	1,592
Orange	5	30,215	981
Placer	1	4,450	1,233
Plumas	0	150	774
Riverside	5	15,190	671
Sacramento	6	24,685	1,697
San Benito	4	465	816
San Bernardino	10	15,065	725
San Diego	13	35,615	1,120

Counties	NTP Facilities	Total DEA-waivered buprenorphine patient capacity	Buprenorphine Patient Capacity per 100,000 Residents
San Francisco	7	29,565	3,554
San Joaquin	1	4,805	683
San Luis Obispo	1	4,165	1,518
San Mateo	2	8,530	1,154
Santa Barbara	4	5,540	1,284
Santa Clara	2	18,930	1,028
Santa Cruz	1	4,285	1,606
Shasta	0	4,495	2,522
Sierra	0	275	8,929
Siskiyou	0	600	1,359
Solano	2	5,330	1,258
Sonoma	2	8,600	1,754
Stanislaus	3	3,175	605
Sutter	0	510	537
Tehama	0	180	285
Trinity	0	100	748
Tulare	3	2,560	570
Tuolumne	0	1,055	1,930
Ventura	5	8,310	998
Yolo	1	1,090	530
Yuba	2	585	798

Sources: Data on licensed NTPs are available via DHCS

Data on DEA-waivered buprenorphine prescriber capacity from the US DEA.

Caveats: The US DEA collects data on all DEA-waivered buprenorphine prescribers, including the total patient capacity that an individual is permitted to treat with buprenorphine. Summaries of these data may be found on the Addiction Free California data dashboard produced as part of the California MAT expansion project. These data were provided by the Addiction Free California website administrators for the purpose of this assessment. These data capture the total potential buprenorphine case load by county rather than the number of patients who are actively receiving buprenorphine. Previous research suggests that many buprenorphine prescribers do not treat their full potential caseload of patients, and some providers do not prescribe buprenorphine at all despite having a DEA-waiver

Table 7. **Residential SUD Treatment Facilities by County**

County	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7
Alameda	9	4	9	0
Alpine	0	0	0	0
Amador	0	0	0	0
Butte	0	0	0	0
Calaveras	0	0	0	0
Colusa	0	0	0	0
Contra Costa	12	2	4	0
Del Norte	0	0	0	0
El Dorado	3	0	0	0
Fresno	4	0	3	0
Glenn	0	0	0	0
Humboldt	0	1	1	0
Imperial	0	0	0	0
Inyo	0	0	0	0
Kern	5	0	5	0
Kings	0	0	0	0
Lake	2	0	1	0
Lassen	0	0	0	0
Los Angeles	78	18	65	1
Madera	0	0	0	0
Marin	3	0	3	0
Mariposa	0	0	0	0
Mendocino	1	0	0	0
Merced	2	0	0	0
Modoc	0	0	0	0
Mono	0	0	0	0
Monterey	4	0	4	0
Napa	1	0	1	0
Nevada	2	0	2	0
Orange	8	1	5	0
Placer	1	0	1	0
Plumas	0	0	0	0
Riverside	11	2	19	0
Sacramento	9	0	6	0
San Benito	1	0	1	0
San Bernardino	8	0	8	0
San Diego	27	2	19	0

County	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7
San Francisco	7	3	3	0
San Joaquin	1	0	1	0
San Luis Obispo	1	0	0	0
San Mateo	9	0	7	0
Santa Barbara	6	0	2	0
Santa Clara	6	3	5	0
Santa Cruz	5	0	2	0
Shasta	5	0	4	0
Sierra	0	0	0	0
Siskiyou	0	0	0	0
Solano	4	0	0	0
Sonoma	0	0	0	0
Stanislaus	4	0	3	0
Sutter	1	0	1	0
Tehama	0	0	0	0
Trinity	0	0	0	0
Tulare	5	0	4	0
Tuolumne	0	0	0	0
Ventura	1	0	1	0
Yolo	1	0	1	0
Yuba	1	0	1	0
Total	**256**	**36**	**191**	**1**

Source: Data were extracted from DMC-ODS provider reports provided by DHCS.

Caveats: These data are based on DMC-ODS provider reports. These reports document the different types of services provided by DMC-ODS-licensed facilities. These reports do not capture facilities that are not licensed by DMC-ODS. Additional SUD treatment facilities in the state that are providing ASAM-consistent residential treatment services may not be documented here.

Table 8. **Social Rehabilitation Programs by County**

County	Social Rehabilitation Programs licensed by DSS	Number of Available Beds Among Social Rehabilitation Programs Affiliated with California Association of Social Rehabilitation Agencies		
		Crisis Residential Treatment	Long Term Residential Treatment	Transitional Residential Treatment
Alameda	8	0	0	0
Butte	2	0	0	0
Contra Costa	5	0	0	0
Fresno	4	0	0	0
Humboldt	1	0	0	0
Imperial	1	0	0	0
Kern	2	0	0	0
Los Angeles	34	24	0	0
Marin	1	10	42	0
Merced	1	0	0	0
Monterey	3	28	0	1
Napa	2	8	0	1
Nevada	1	0	0	0
Orange	39	0	0	0
Placer	1	0	0	0
Riverside	6	0	0	0
Sacramento	9	45	0	0
San Bernardino	12	0	0	0
San Diego	15	0	0	0
San Francisco	17	48	0	13
San Joaquin	5	0	0	0
San Luis Obispo	1	0	0	1
San Mateo	5	16	0	2
Santa Barbara	4	0	0	0
Santa Clara	9	62	45	0
Santa Cruz	3	0	0	0
Shasta	2	0	0	0
Solano	2	0	0	0
Sonoma	6	20	0	1
Ventura	7	0	0	0
Yolo	2	0	0	0

Source: Social rehabilitation Licensure data were obtained from the California Department for Social Services. Data on the number of beds available among social rehabilitation programs affiliated with California Association of Social Rehabilitation Agencies were obtained via personal correspondence in November 2021

Caveats: California licenses transitional and long-term residential settings and crisis residential treatment programs as social rehabilitation programs and does not differentiate among the different settings. Data provided by California Association of Social Rehabilitation Agencies may not include complete information from all member organizations.

Table 9. **Mobile Crisis Teams Available by County in 2021**

County	Number of Mobile Crisis Teams
Alameda	5
Alpine	0
Amador	1
Butte	2
Calaveras	2
Colusa	1
Contra Costa	4.5
Del Norte	0
El Dorado	2
Fresno	1
Glenn	1
Humboldt	2
Imperial	1
Inyo	1
Kern	13
Kings	1
Lake	7
Lassen	0
Los Angeles	171
Madera	1
Marin	1
Mariposa	1
Mendocino	1

County	Number of Mobile Crisis Teams
Merced	2
Modoc	0
Mono	0
Monterey	2
Napa	0
Nevada	2
Orange	25
Placer	3
Plumas	0
Riverside	12
Sacramento	8
San Benito	1
San Bernardino	18
San Diego	2
San Francisco	3
San Joaquin	4
San Luis Obispo	2
San Mateo	1
Santa Barbara	3
Santa Clara	10
Santa Cruz	7
Shasta	2
Sierra	0
Siskiyou	0
Solano	4
Sonoma	3
Stanislaus	0
Sutter	0
Tehama	0
Trinity	0
Tulare	2
Tuolumne	3

County	Number of Mobile Crisis Teams
Ventura	1
Yolo	4
Yuba	0
Total	343.5

Source: Data were obtained from a survey of county behavioral health directors.

Caveats: These results are based on surveys conducted with county behavioral health directors. Directors were asked to report the number of mobile crisis response teams operational in their county. Counties have varying definitions of what constitutes a mobile crisis response team. These teams may vary in size and scope (e.g., some may only serve selected populations or may only operate during limited days/times). It is also unclear how many individuals each team is able to serve.

Table 10. **Facilities Providing Ambulatory or Residential Withdrawal Management by County**

Counties	Ambulatory Withdrawal Management	ASAM Level 3.2-WM	ASAM Level 3.7-WM	ASAM Level 4.0-WM
Alameda	0	1	0	0
Alpine	0	0	0	0
Amador	0	0	0	0
Butte	0	0	0	0
Calaveras	0	0	0	0
Colusa	0	0	0	0
Contra Costa	1	5	0	0
Del Norte	0	0	0	0
El Dorado	0	0	0	0
Fresno	1	2	0	0
Glenn	0	0	0	0
Humboldt	0	1	0	0
Imperial	1	0	0	0
Inyo	0	0	0	0
Kern	1	2	0	0
Kings	0	0	0	0
Lake	0	0	0	0

Counties	Ambulatory Withdrawal Management	ASAM Level 3.2-WM	ASAM Level 3.7-WM	ASAM Level 4.0-WM
Lassen	0	0	0	0
Los Angeles	36	41	3	3
Madera	0	0	0	0
Marin	1	1	0	0
Mariposa	0	0	0	0
Mendocino	0	1	0	0
Merced	1	0	0	0
Modoc	0	0	0	0
Mono	0	0	0	0
Monterey	0	3	0	0
Napa	0	1	0	0
Nevada	0	2	0	0
Orange	7	4	0	0
Placer	0	2	0	0
Plumas	0	0	0	0
Riverside	6	6	0	0
Sacramento	1	3	0	0
San Benito	0	1	0	0
San Bernardino	1	3	0	0
San Diego	8	5	0	0
San Francisco	0	4	0	0
San Joaquin	0	1	0	0
San Luis Obispo	2	0	0	0
San Mateo	1	0	0	0
Santa Barbara	0	4	0	0
Santa Clara	0	3	0	0
Santa Cruz	0	1	0	0
Shasta	0	1	0	0
Sierra	0	0	0	0
Siskiyou	0	1	0	0
Solano	0	2	0	0
Sonoma	0	0	0	0

Counties	Ambulatory Withdrawal Management	ASAM Level 3.2-WM	ASAM Level 3.7-WM	ASAM Level 4.0-WM
Stanislaus	0	2	0	0
Sutter	0	1	0	0
Tehama	0	0	0	0
Trinity	0	0	0	0
Tulare	0	3	0	0
Tuolumne	0	0	0	0
Ventura	1	1	0	0
Yolo	0	0	0	0
Yuba	0	1	0	0
Total	**69**	**108**	**3**	**3**

Sources: Facilities providing ambulatory withdrawal management were identified using DHCS alcohol and drug program certification data, and facilities providing residential withdrawal management were identified using DMC-ODS provider reports from DHCS.

Caveats: Facilities providing residential withdrawal management services were identified using DMC-ODS provider reports provided by DHCS. As mentioned above, these reports only include facilities that are licensed by DMC-ODS. There may be additional facilities in the state providing ASAM-consistent withdrawal management services that are not licensed by DMC-ODS.

Table 11. **Availability of Inpatient Psychiatric Beds by Covered California Region**

Covered California Region	Total Beds Available for Region	Net Bed Surplus/Gap per Region According to Crisis Now Resource Calculator
Northern Counties	116	-20
North Bay Area	235	75
Greater Sacramento	440	127
San Francisco County	175	-85
Contra Costa County	116	3
Alameda County	339	160
Santa Clara County	246	6
San Mateo County	62	-51
Santa Cruz, San Benito, and Monterey Counties	56	-12
Central Valley	227	35
Fresno, Kings and Madera Counties	93	-12
Central Coast	162	14
Eastern Counties	0	-11
Kern County	37	-57
Los Angeles County	2,143	854
Inland Empire	532	63
Orange County	442	3
San Diego County	661	166

Sources: Data on inpatient beds were obtained from DHCS licensure data. Net bed surplus/gap per region is based on an analysis of Crisis Now Resource Calculator results. Information on Covered California regions is available at 2021_QHP_QDP_Region_Map_11022020.pdf (coveredca.com).

Caveats: The number of inpatient psychiatric beds in each county was assessed using DHCS licensure data. Some licensed facilities may have beds that are suspended, which are not captured in these licensure data. The net bed surplus/gap per region was assessed based on an analysis of data from the Crisis Now Resource Calculator. This calculator estimates the number of beds that are needed to serve the population in a given region. This calculator does not take into account regional variation in rates of mental health conditions or availability of other downstream providers, both of which may affect local need for inpatient psychiatric beds.

Appendix C – Approach and Methodology

This assessment was prepared by the California Department of Health Care Services (DHCS) with the assistance of Manatt Health Strategies and Dr. Anton Nigusse Bland. It is based on a mixed-methods design, relying on both quantitative and qualitative data sources. With respect to quantitative data, the assessment primarily relied on secondary data and existing reports available from the state as well as external data sources (e.g., the National Survey of Drug Use and Health (NSDUH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatment Services Locator (henceforth, "the Treatment Locator"). Qualitative data were gathered through a survey, interviews and stakeholder focus groups between July and September 2021.

Establishing the Framework for a Core Continuum of Care

The key principles and core continuum of care used in this assessment were developed based on source documents from federal agencies and national organizations and associations that describe the array of services and other attributes (policies, quality of care and principles) that should exist in a comprehensive and robust behavioral health care system. These include:

- SAMHSA's Description of a Good and Modern Addictions and Mental Health Service System[200]
- DHCS' 2012 California Mental Health and Substance Use System Needs Assessment[201]
- Various federal guidance regarding behavioral health services from CMS, SAMHSA, and the National Institute of Mental Health[202,203,204]
- American Society of Addiction Medicine (ASAM) levels of care description[205]
- Administration for Children and Families Title IV-E Prevention Services Clearinghouse[206]

---

[200] Description of a Good and Modern Addictions and Mental Health Service System, SAMHSA, April 2011. Available at https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

[201] Available at https://www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf.

[202] Behavioral Health Services, Medicaid.gov. Available at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[203] National Guidelines for Behavioral Health Crisis Care, SAMHSA. Available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[204] Available at https://www.nimh.nih.gov/health.

[205] Available at https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/.

[206] Available at https://www.acf.hhs.gov/opre/project/title-iv-e-prevention-services-clearinghouse-2018-2023.

These materials do not provide an exhaustive list of all behavioral health services that could be included in a continuum of care. However, federal and state agencies have relied on these documents to identify what services should be available for people living with mental health and SUD needs, regardless of payer source. Similar needs assessments conducted in other states and jurisdictions have relied on these sources to benchmark what core services "are" available versus what "should be" available. California-specific information gathered through the qualitative data sources was used to adapt the continuum of services to California's unique environment. For example, the continuum includes services and provider types that are specific to California (e.g., the Crisis Residential Treatment Program). While the continuum of care is designed to help guide the assessment, it includes some services for which data are not yet available.

Quantitative Data Collection

The assessment used quantitative data to capture the prevalence of behavioral health conditions in California as well as to take stock of the availability of behavioral health treatment services in each county. Data from the NSDUH and Medi-Cal (the state's Medicaid program) administrative claims data were used to quantify the prevalence of behavioral health conditions in each county in California. Licensure and certification data, the Treatment Locator, and other secondary reports from state agencies and stakeholder groups were used to identify the availability of different behavioral health treatment resources in each county. In general, data on the availability of treatment resources were analyzed by assessing the absence or presence of treatment programs in each county. In some cases, availability was quantified by calculating the number of treatment facilities (or slots/beds) per capita in each county. In many instances, county-level data were not readily available.

Additional information on the data sources and how they were used to inform the assessment is provided below:

- *The NSDUH.* SAMHSA administers the NSDUH to estimate the prevalence of mental health conditions, SUD, and other health-related behaviors. NSDUH survey data were used in this assessment to compare the prevalence of behavioral health conditions in California with national rates. These data were also used to examine demographic characteristics associated with behavioral health conditions at the national level. The NSDUH data used for this assessment are available in public-facing reports available on the NSDUH website.
- *Medi-Cal Administrative Claims Data.* Medi-Cal administrative claims data from calendar year 2019 were used to quantify the number of Medicaid enrollees with SMI, SED and SUD in each county in California. While the NSDUH produces a statewide estimate for the total number of individuals living with SMI and SUD, it does not provide this information at the county level. The assessment uses claims data to supplement prevalence data from the NSDUH in order to understand county-level variations in the prevalence of behavioral health conditions. While these data are only inclusive of Medi-Cal enrollees, they still provide useful insight regarding the wide variation in rates of behavioral health conditions in different regions of the state.
    - *Calculating Rates of SMI, SED and SUD Using Administrative Claims Data*. Proxy measures were used to assess rates of SMI, SED and SUD using

Medi-Cal administrative claims data. These proxy measures were generally based on combinations of ICD-10 diagnosis codes as well as utilization of inpatient psychiatric services. Adults aged 18+ were identified as having SMI if they had at least one inpatient or outpatient claim with a primary ICD-10 diagnosis code corresponding to schizophrenia, bipolar disorder, or major depression. Individuals were also classified as having SMI if they had at least one inpatient claim with a revenue code corresponding to inpatient psychiatric treatment. Slightly different criteria were used to identify individuals aged less than 18 with SED. Individuals were classified as having SED if they had at least one claim with a primary ICD-10 diagnosis code corresponding to schizophrenia, bipolar disorder, posttraumatic stress disorder, obsessive compulsive disorder or eating disorders. Individuals were also considered as having SED if they had at least one inpatient claim with a revenue code corresponding to inpatient psychiatric treatment. Finally, individuals were identified as having SUD if they had at least one claim with a primary ICD-10 diagnosis code corresponding to alcohol use disorder, opioid use disorder, stimulant use disorder or other substance use disorders.

  - *Limitations of proxy measures used to calculate rates of SMI, SED and SUD using administrative claims data*. The proxy measures described above are prone to several noteworthy limitations. For one, there are many cases where these proxy measures may only identify individuals as having SMI/SED/SUD if they are actively receiving treatment for one of these conditions. An individual must have some interaction with the health care system in order for a Medicaid claim with an ICD-10 diagnosis code to be generated. In many cases, this interaction often implies receipt of a treatment or service related to the primary diagnosis code. With this in mind, diagnosis-based proxy measures may underestimate the true prevalence of a condition by only capturing individuals who have interactions with the health care system related to that condition. Conversely, these diagnosis-based proxy measures may also overestimate the population prevalence of these conditions. For example, the NSDUH defines individuals living with SMI as those who have diagnosable mental health conditions of “sufficient duration to meet diagnosis criteria in the DSM-IV.” ICD-10 codes related to bipolar disorder, schizophrenia, etc., do not necessarily imply DSM-IV-consistent diagnoses. In many cases, the threshold for receiving a DSM-IV-consistent diagnosis is higher than the threshold for receiving an ICD-10 diagnosis code. ICD-10 diagnosis codes also do not allow us to assess duration, so individuals with ICD-10 diagnosis codes related to SMI may not have mental health conditions for a sufficient-enough duration to meet the DSM-IV threshold for an SMI.

- *Licensure and Certification Data*. This assessment employed an array of licensure and certification data from DHCS, the Department of Social Services, the Department of Public Health, the Department of State Hospitals, the Office of Statewide Health Planning and Development, and the Medical Board of California to quantify the availability of behavioral health treatment resources in each county in California. Specifically, these data were used to identify psychiatrists and other behavioral health practitioners as well as treatment facilities providing crisis services,

inpatient mental health treatment, SUD treatment and withdrawal management (WM). The majority of these licensure and certification data are available through public reports published on the California Health and Human Services Open Data Portal.

- *SAMHSA Treatment Locator.* The Treatment Locator is a tool developed by SAMHSA to assist individuals with identifying available mental health and SUD treatment resources. The Treatment Locator is compiled from responses to SAMHSA's National Survey of Substance Abuse Treatment Services and the National Mental Health Services Survey. These data include information on facilities that provide behavioral health treatment and are funded by a state agency. These data also include information on private and non-profit facilities that are licensed by a state or national agency to provide behavioral treatment services. These data were used to identify the availability of treatment resources that are not easily identifiable using licensure and certification data from the state. Specifically, the Treatment Locator was used to quantify the following types of facilities at the county level:
    - Community Mental Health Centers
    - Federally Qualified Health Centers
    - Facilities providing outpatient mental health treatment
    - Facilities providing intensive outpatient treatment or partial hospitalization services
    - Facilities providing Assertive Community Treatment
- Data from the Treatment Locator may be downloaded for free from the SAMHSA website. While the Treatment Locator data are very valuable, they are not without limitations. In particular, it should be noted that this tool may not include all behavioral health providers. For example, the tool may not include unlicensed treatment facilities or license-exempt facilities. The locator also generally does not provide information on individuals in private practice or a small group practice unless they are licensed or certified as a clinic. Although the Treatment Locator is not a comprehensive database of every behavioral health treatment provider, it provides useful information regarding the general availability of outpatient treatment services at the county level. For example, the SAMHSA Treatment Locator includes information on availability of DEA-waivered buprenorphine prescribers that is generally consistent with data provided directly from the DEA. The Treatment Locator data indicate that there are two counties in California that do not have any DEA-waivered buprenorphine prescribers available. Comparatively, data from the US DEA suggest that there is only one county that does not have any buprenorphine prescribers available. Additional information regarding the treatment facilities that are included in the Treatment Locator may be found on the SAMHSA webpage.
- *Other Secondary Reports.* This assessment also relied on a variety of other secondary reports and data that were developed by California state agencies and other stakeholder groups. For example, the availability of school-based health services in each county was quantified using data collected by the California School-Based Health Alliance. Behavioral health treatment services for the populations who are justice-involved were generally identified using reports

shared by the California Department of Corrections and Rehabilitation as well as information found online. SUD treatment facilities providing residential or inpatient SUD treatment or withdrawal management were identified using Drug Medi-Cal Organized Delivery System (DMC-ODS) provider reports shared by DHCS. Data on average length of stay for inpatient psychiatric admissions were provided by the California Hospital Association. Other instances where data were gleaned from miscellaneous sources are referenced throughout the report.

Qualitative Data Collection

The assessment used qualitative data to identify gaps in the availability of behavioral health treatment services as well as to understand needs and priorities from counties' and other stakeholders' perspectives. Qualitative data were collected through:

- *A Survey of County Behavioral Health Directors*. Developed in collaboration with DHCS and the County Behavioral Health Directors Association of California, the survey sought to understand the perspectives of county behavioral health directors on the current continuum of care and their priorities for change. All 58 counties and the two city jurisdictions that operate behavioral health departments responded to the survey, as completion is a prerequisite to the receipt of future infrastructure grant funding.
- *Stakeholder Focus Groups and Interviews.* The authors facilitated seven focus groups to gather input on gaps in the continuum of care for mental health and SUD services as well as to learn more about success stories and innovative solutions that the state may consider for spread and sustainability. Focus groups were conducted with representatives from community behavioral health agencies; peer support advocacy groups; social rehabilitation agencies; alcohol and drug program executives; medical associations, including psychiatric and psychiatrist associations; urban and rural tribal behavioral health organizations; children and youth advocates and providers; individuals with lived experience; and community mental health advocates. The authors also facilitated 14 interviews to gather key insights from stakeholders and behavioral health experts in California about current gaps in the continuum of care as well as available data to inform the assessment.

The qualitative data were a critical supplement to the quantitative data collected, given the quantitative data's limitations. Manatt analyzed information collected through the survey as well as through stakeholder focus groups and interviews to inform the themes and recommendations in this report. Specifically, Manatt drew from these sources case studies to illustrate the report's themes, examples of innovations within and across counties, and quotes from individuals with both lived experience and important insights based on their roles as behavioral health directors, program administrators, state officials, providers, caregivers and individuals.

Assessment Limitations

Certain gaps and limitations affected this assessment. As discussed above, the broad nature of the assessment as well as the short time frame for its preparation prevented DHCS from examining every aspect of the continuum of care. Other limitations included the following:

- There were challenges in assessing the prevalence of behavioral health conditions and the need for services among California's population due to lack of consistent data collection and availability, particularly among those individuals who are involved in the criminal justice system, individuals experiencing homelessness and AI/AN individuals.
- The assessment was not able to methodically evaluate access to and utilization of behavioral health services, except with respect to some of the claims data available on Medi-Cal enrollees.
- The assessment does not evaluate the integration of physical and mental health services across the state.
- The assessment does not examine the quality of behavioral health services and facilities; this was deemed out of scope given both the data and time limitations.
- While the assessment attempted to engage a wide range of stakeholders through the survey, interviews, and focus groups, DHCS acknowledges that stakeholder engagement could not be as comprehensive as desired due to the truncated timeframe for the report's development.

Appendix D – Assessing the Need

To assess the adequacy of California's current behavioral health care system, it is important to understand the prevalence of mental health and substance use disorders in the state. How many children and adults in California face such issues? How much does prevalence vary across counties and by characteristics such as race and ethnicity? There is not a perfect data source that captures the true population prevalence of mental health conditions or substance use disorders. Many data sources calculate rates of these conditions using self-reported surveys, which may be prone to underreporting. Other data sources rely on administrative claims data that fail to capture individuals who are not actively using health care services.

For the purposes of this assessment, rates of mental health conditions and substance use disorders were primarily assessed using data from the National Survey of Drug Use and Health (NSDUH). Administered by SAMHSA, the NSDUH can be used to estimate the prevalence of mental health conditions, SUDs, and other health-related behaviors.[207] It can provide state-level information but not county-specific data. To provide some county-specific data, this assessment also draws from Medi-Cal administrative claims data and other California-specific sources of information.

Overall, as described in detail below, these data suggest that:

- Close to one in 20 California adults (4.5 percent) has SMI, and more than twice as many have SUD (9.2 percent).
- California has a marginally higher rate of SUD and lower rate of SMI compared with the overall U.S. population aged 18+.
- Rates of SMI nationally tend to be higher among AI/AN individuals and individuals who report being of two or more races.
- In California, rates of SMI and SUD are highest among individuals aged 18-25.
- Rates of SED among Black and Latino children in California are higher relative to other racial/ethnic groups, and SED rates among children are higher among lower-income groups.[208]
- Among individuals who are justice-involved in California and nationwide, rates of SMI and SUD are markedly higher relative to the general population. For example, reports from the California Department of Corrections and Rehabilitation (CDCR) suggest that 6.4 percent and 80 percent of individuals in prison in California have SMI or SUD, respectively, compared with only 4.5 percent and 9.2 percent among the general population, respectively.

---

[207] NSDUH. About the Survey. Accessed September 8, 2021. https://nsduhweb.rti.org/respweb/about_nsduh.html.

[208] "Mental Health in California. For Too Many, Care Not There. California Health Care Foundation, 2018. Available at https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf.

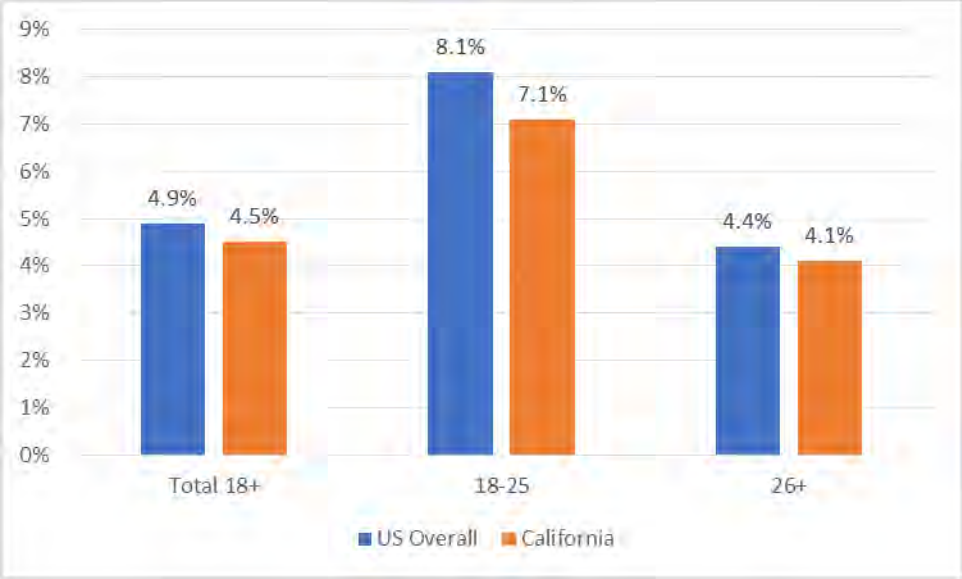
SMI Among Adults

The estimated percentage of adults living with SMI in the United States has increased steadily in recent years, from 3.7 percent in 2008 to 5.2 percent in 2019.[209] In Appendix B, Table 1 displays nationwide rates of SMI among adults aged 18+ stratified by various demographic characteristics of interest. The NSDUH results suggest that the rate of SMI from 2018 to 2019 in California was marginally lower (4.5 percent) than the overall rate among the U.S. adult population (4.9 percent) for that period.[210]

[209] Lipari RN. "Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health." Published online 2019:114.

[210] https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

Figure D-1. **Percentage of Individuals Aged 18+ with SMI in California Relative to U.S. Overall from 2018 and 2019 from Pooled NSDUH Data[211]**



According to the NSDUH, the rate of SMI among Medicaid enrollees nationally (8.1 percent) is substantially higher than the rate among individuals with any other type of insurance and is also higher than the rate among individuals who are uninsured.[212]

California Medicaid administrative claims data also provided a picture of the number of Medi-Cal enrollees who had SMI in 2019. Proxy measures based on ICD-10 diagnosis codes and utilization of inpatient psychiatric services were used to estimate the rate of SMI among adult Medi-Cal enrollees aged 18+. Additional information on these proxy measures can be found in Appendix C. This analysis suggests that 6.3 percent of adult Medi-Cal enrollees had SMI in 2019. This rate differs from those reported by the NSDUH above because those rates are based on proxy measures calculated using administrative claims data. Limitations associated with these proxy measures are further described in Appendix C. At the county level, rates of SMI among Medi-Cal enrollees ranged from a high of 12.1 percent in Plumas County to a low of 4.1 percent in Sierra County. Figure D-2 below displays the percentages of adult Medi-Cal enrollees with SMI in each county in 2019. These data are also displayed in Appendix B, Table 2.

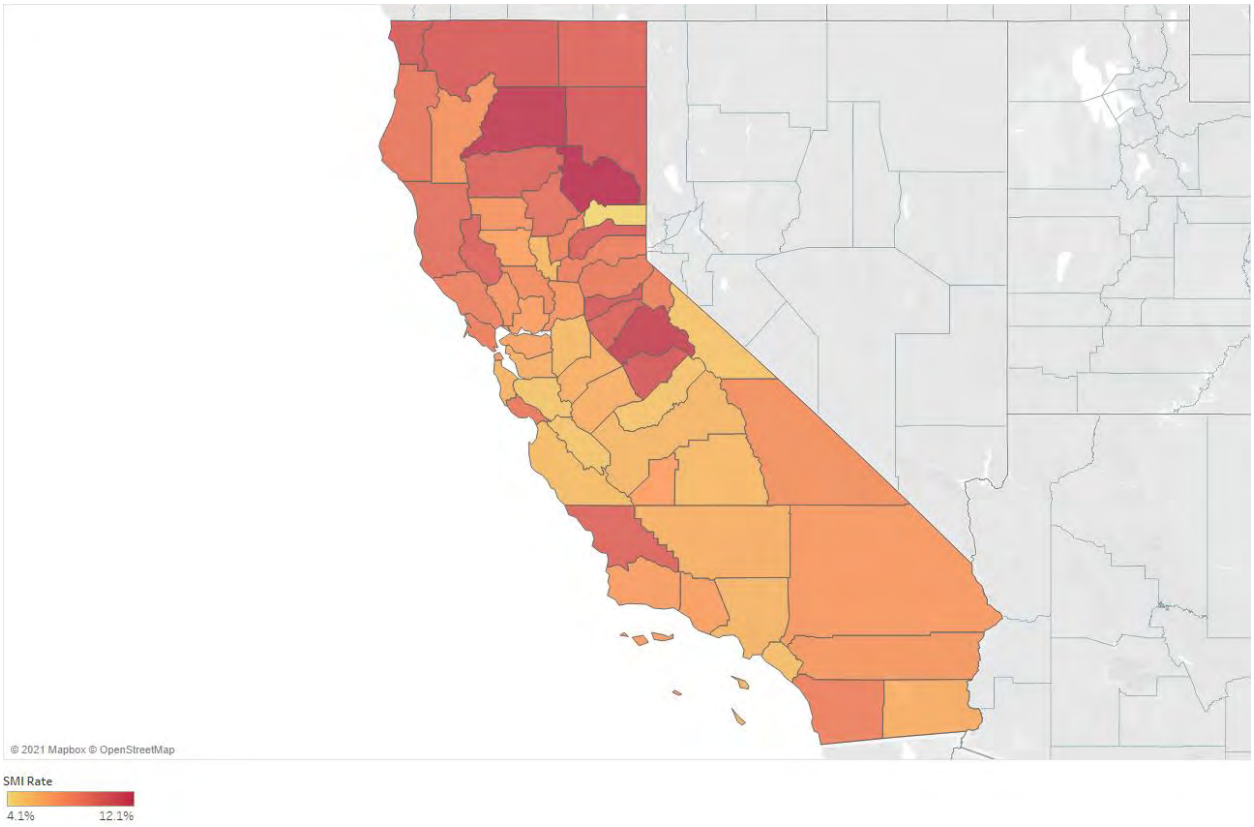
Adults living with SMI often receive treatment via county-contracted specialty mental health plans. DHCS produces publicly available reports that document the number of

[211] Ibid.

[212] Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. Accessed September 8, 2021. https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

Medi-Cal enrollees receiving specialty mental health services.[213] These data indicate that approximately 3.8 percent of adult Medi-Cal enrollees received a specialty mental health service in 2019. The discrepancy between the number of individuals receiving specialty mental health services (3.8 percent) and the number of Medi-Cal enrollees identified as having SMI using proxy measures (6.5 percent) implies that many enrollees with SMI fail to receive Medi-Cal SMHS services.

Figure D-2. **Percentage of Adult Medi-Cal Enrollees Identified as Having SMI Using California Medicaid Claims Data–Based Proxy Measures in 2019**



SUD Among Adults

In Appendix B, Table 1 also displays NSDUH data estimating nationwide rates of alcohol use disorder and SUD among adults aged 18+ stratified by demographic characteristics of interest. Rates of SUD tended to be higher among males, AI/AN individuals, individuals who are unemployed and individuals who are uninsured.[214] The NSDUH estimates suggest that the rate of SUD among adults in California (9.2 percent) is marginally higher than the rate among the overall U.S. population (7.7 percent).[215]

---

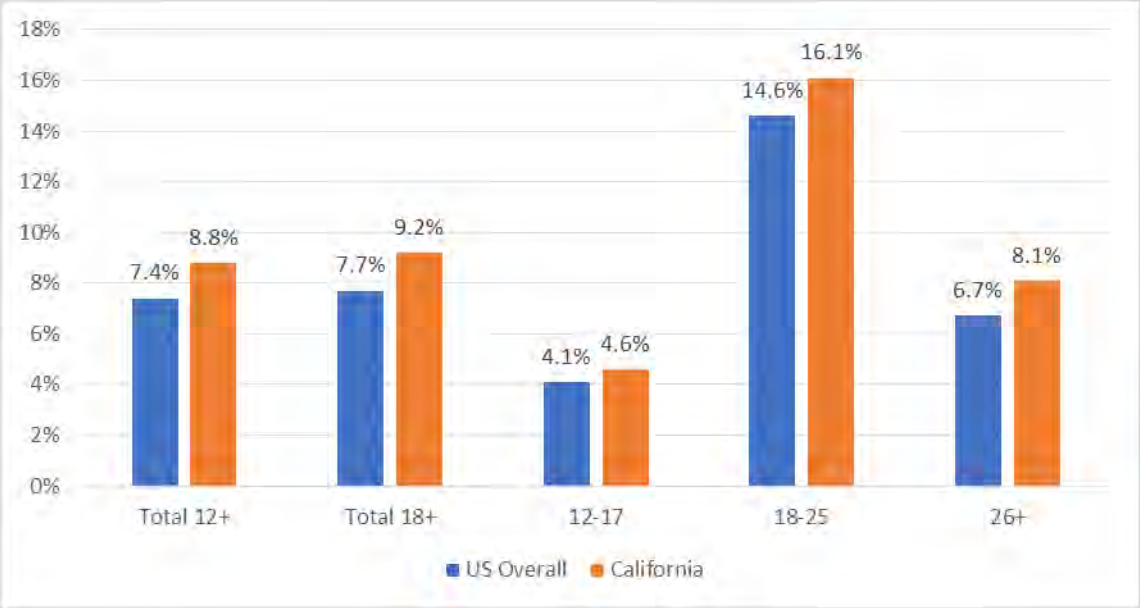
[213] Adult Population Performance Dashboard, CHHS Open Data. Available at https://data.chhs.ca.gov/dataset/adult-population-performance-dashboard.

[214] Ibid.

[215] Ibid.

In addition to capturing the prevalence of SUD, older versions of the NSDUH also estimated the percentage of individuals who received treatment. These data suggest that from 2010 to 2014, on average, only 7 percent of adults in California with alcohol use disorder and 12 percent of adults living with illicit drug use disorder received treatment.[216,217] Although dated, these data suggest that a significant proportion of the overall population with SUD likely fail to receive treatment.

Figure D-3. **Percentage of Individuals Aged 12+ with SUD in California Relative to U.S. Overall from 2018 and 2019 Pooled NSDUH Data[218]**



Analyses of Medicaid claims data revealed that 3.3 percent of Medi-Cal enrollees aged 18+ had an SUD diagnosis in 2019. This rate is lower than rates reported by the NSDUH above because it is based on diagnosis code–based proxy measures calculated using administrative claims data. Despite the fact that there are effective evidence-based treatments for some SUDs, only about one in five people who currently need treatment for this condition actually receive it.[219] Additional details on these proxy measures and their inherent limitations can be found in Appendix C. These proxy measures likely underreport the true prevalence of SUD because they fail to capture individuals who do not receive SUD treatment or otherwise interact with the health care system. As documented by NSDUH, the majority of individuals living with SUD have

[216] https://www.chcf.org/wp-content/uploads/2018/09/SubstanceUseDisorderAlmanac2018.pdf.

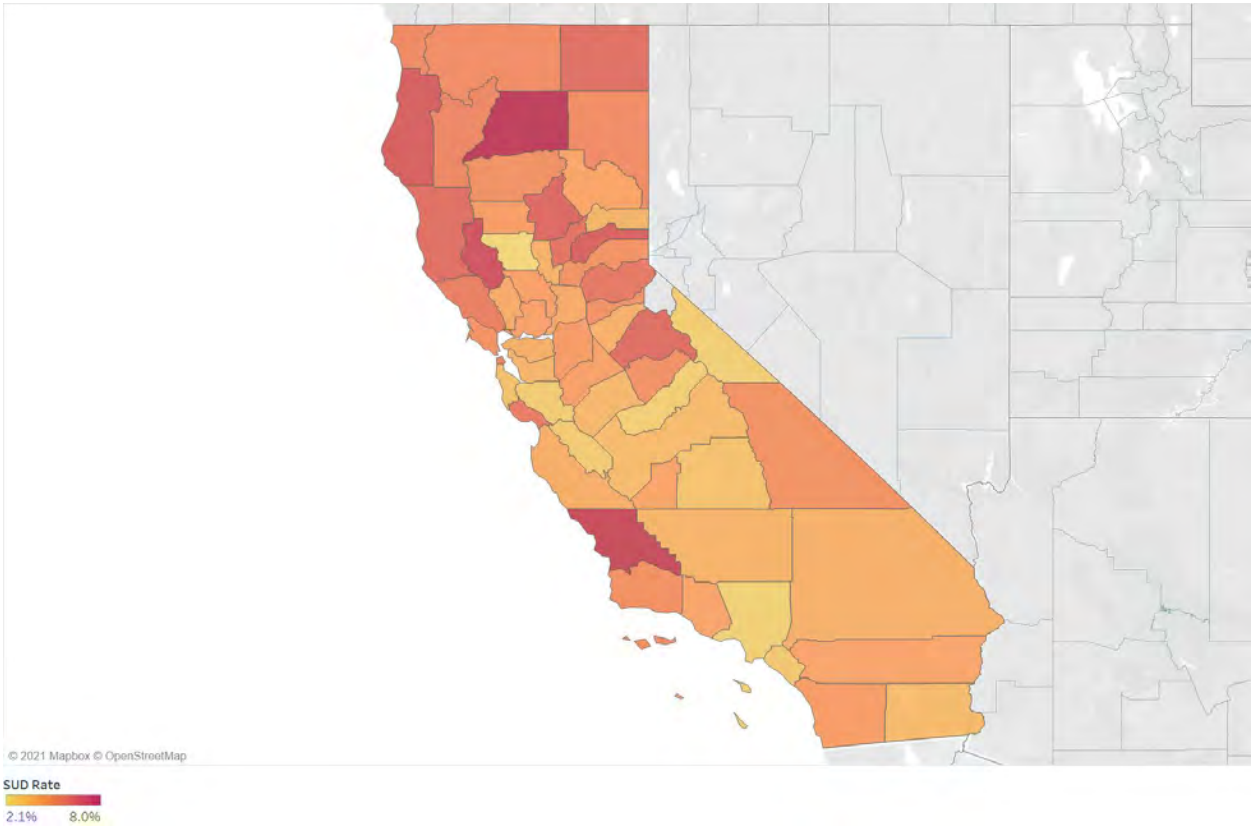
[217] Illicit drug use disorder includes use of marijuana, cocaine, heroin, hallucinogens, inhalants and methamphetamine, and nonmedical use of prescription drugs.

[218] Ibid.

[219] Saloner B, Karthikeyan S. National Changes in 12-Month Substance Abuse Treatment Utilization Among Individuals with 2 Opioid Use Disorders, 2004-2013, JAMA, Oct. 13, 2015.

historically not participated in treatment.[220] Observed county-level rates of SUD among Medi-Cal enrollees ranged from a high of 8.0 percent in Shasta County to a low of 2.1 percent in Colusa County. Figure E-4 below displays the percentage of adult Medi-Cal enrollees with an SUD diagnosis in each county in 2019. These data are also displayed in Appendix B, Table 2.

Figure D-4. **Percentage of Adult Medi-Cal Enrollees Identified as Having SUD Using California Medicaid Claims Data–Based Proxy Measures in 2019**



*Note: Alpine County is excluded due to having a count less than 10.

Data from the California Department of Public Health on opioid-related overdose deaths were also used as a proxy to assess county-level variation in SUD prevalence.[221] These data show wide variation in rates of opioid-related overdose deaths at the county level. In 2020, rates ranged from a low of zero in six counties (Alpine, Mariposa, Modoc, Mono, Sierra, and Trinity) to a high of 43.68 per 100,000 in San Francisco. The age-adjusted opioid-related overdose death rate in San Francisco was over three times higher than the overall rate for the state. These data also suggest there is significant overlap between counties with high rates of SUD among Medi-Cal enrollees and

[220] "California Health Care Almanac," California Health Care Foundation, October 2018. Available at https://www.chcf.org/wp-content/uploads/2018/09/SubstanceUseDisorderAlmanac2018.pdf.

[221] "California Overdose Surveillance Dashboard," California Department of Public Health. Available at https://skylab.cdph.ca.gov/ODdash.

counties with high rates of opioid-related overdose deaths. Five of the top 10 counties in terms of rates of SUD among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall opioid-related overdose death rates in 2020.

SED Among Children/Youth

Federal regulations use the term "serious emotional disturbance" to refer to youth living with psychiatric disorders that cause substantial functional impairment.[222,223] Rates of SED among youth are less well documented than are rates of SMI among adults, and the methodological challenges associated with estimating rates of SED among youth are well established.[224] The NSDUH does not provide estimates for nationwide rates of SED. However, a recent meta-analysis assessing 12 nationwide and regional studies that estimated rates of SED found a pooled prevalence rate of 10.06 percent among the studies examined.[225] A previous study from California estimated that 7.6 percent of children in the state had SED in 2014.[226] The California study estimated higher rates of SED among Black and Latino children relative to other racial/ethnic groups and higher rates among children in lower-income groups.[227]

---

[222] 34 CFR § 300.8 – Child with a disability. Available at https://www.law.cornell.edu/cfr/text/34/300.8.

[223] Williams NJ, Scott L, Aarons GA. Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis. *Psychiatr Serv Wash DC*. 2018;69(1):32-40. doi:10.1176/appi.ps.201700145.

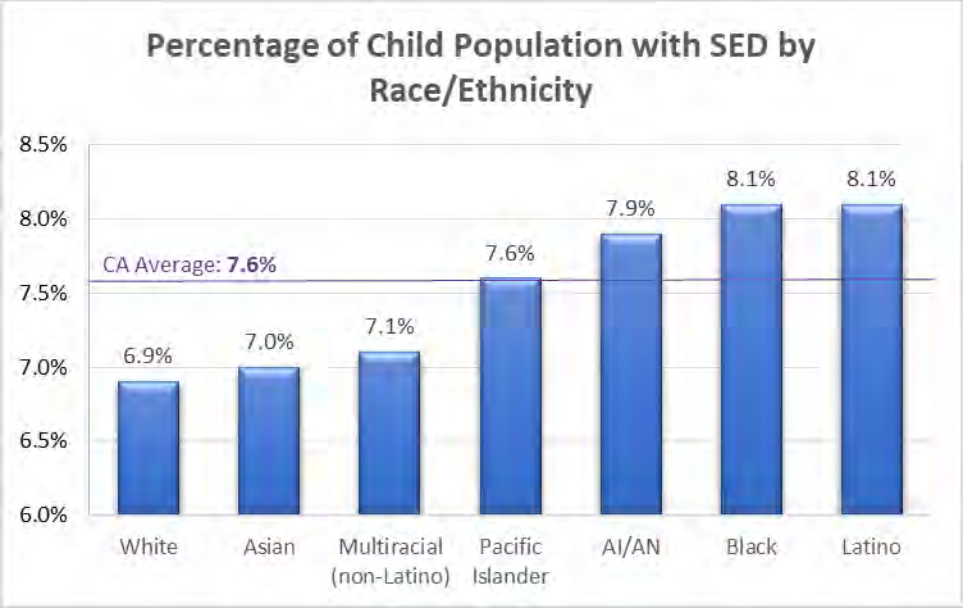
[224] Existing measures and data. "Measuring Serious Emotional Disturbance in Children: Workshop Summary." Committee on National Statistics; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; Board on Health Sciences Policy; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine; 2016. https://www.ncbi.nlm.nih.gov/books/NBK368059/.

[225] Williams NJ, Scott L, Aarons GA. Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis. *Psychiatr Serv Wash DC*. 2018;69(1):32-40. doi:10.1176/appi.ps.201700145.

[226] "Mental Health in California. For Too Many, Care Not There." California Health Care Foundation; 2018. Available at https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf.

[227] Ibid.

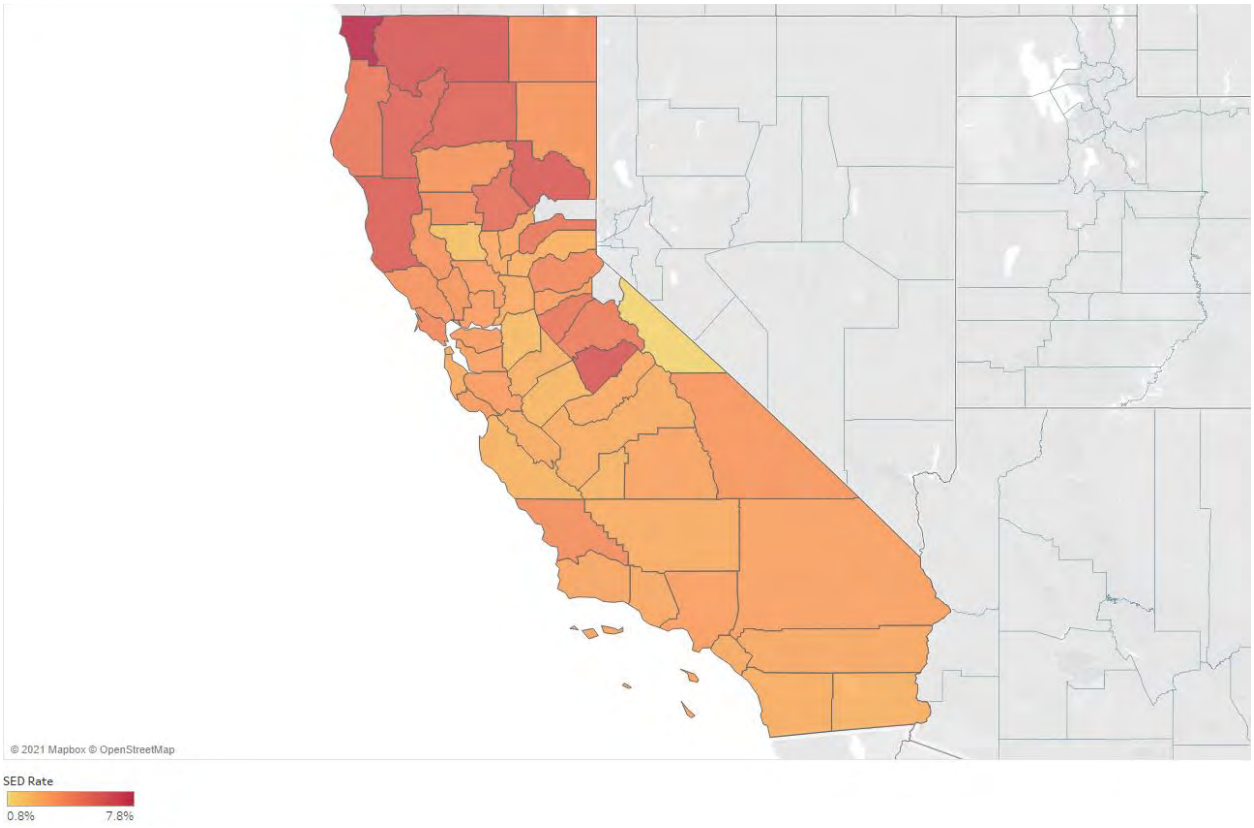
Figure D-5. **Percentage of California Child Population with SED by Race/Ethnicity in 2014**[228]



Analyses of California Medicaid administrative claims data were used to provide additional estimates of the rate of SED among Medi-Cal enrollees. These analyses indicate that 2.8 percent of Medi-Cal enrollees under age 18 had SED in 2019, with rates ranging from a low of 0.8 percent in Mono County to a high of 7.8 percent in Del Norte County. Note that these rates are not directly comparable to rates reported in other sources because they were calculated using proxy measures that do not capture the true population prevalence of SED. Figure E-6 below displays the percentage of Medi-Cal enrollees with SED in each county in 2019. These data are also presented in Appendix B, Table 2. Additional information on how these SED proxy measures were operationalized, as well as their inherent limitations, can be found in Appendix C.

[228] Holzer C, Nguyen H, "Estimation of Need for Mental Health Services." Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

Figure D-6. **Percentage of Medi-Cal Enrollees Identified as Having SED Using California Medicaid Claims Data–Based Proxy Measures in 2019**



Note: Sierra and Alpine Counties are excluded due to having counts less than 10.

Adolescents with SUD

In Appendix B, Table 3 displays results from the NSDUH estimating the nationwide rate of SUD among youth aged 12-17 stratified by various demographic characteristics. Rates of SUD among this population were higher for females and AI/AN individuals. Pooled NSDUH data from 2018 to 2019 suggest that California has a higher rate of SUD (4.55 percent) among individuals aged 12-17 relative to the overall U.S. population (4.08 percent).[229]

Analyses of Medi-Cal claims data found that only 0.8 percent of youth Medi-Cal enrollees (aged 12-17) received an SUD diagnosis during calendar year 2019. This rate is lower than rates reported by the NSDUH above because it is based on proxy measures calculated using administrative claims data. Again, these rates likely underestimate the true prevalence of SUD because they fail to capture individuals who

[229] Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. Accessed September 8, 2021. https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

do not engage with the health care system. Additional detail on these proxy measures and their inherent limitations can be found in Appendix C. County-specific rates of SUD among youth Medi-Cal enrollees ranged from a high of 2.4 percent in Mariposa County to a low of 0 percent in Alpine and Sierra Counties. In Appendix B, Table 2 displays rates of SUD among youth Medi-Cal enrollees in each county in 2019.

Behavioral Health Conditions Among the Justice-involved Population

Rates of behavioral health conditions among the justice-involved population tend to be substantially higher than rates among the overall U.S. population.[230] There is not a comprehensive data source similar to the NSDUH that captures rates of mental health conditions or SUD among individuals in jails and prisons, and previous nationwide estimates vary considerably. Figure D-7 below presents estimates from multiple disparate data sources to compare rates of any mental illness (AMI), SMI and SUD among individuals in prisons and jails relative to the overall U.S. population (e.g., different data sources were used to assess the rate of AMI in jails versus prisons versus the general population).

A previous report by the Bureau of Justice Statistics suggested that up to 14 percent of individuals in federal prisons and 26 percent of individuals in jails reported symptoms consistent with SMI.[231] The Bureau of Justice Statistics has also reported that approximately 58 percent and 63 percent of individuals in prisons and jails, respectively, met the criteria for substance abuse or dependence.[232]

The prevalence of behavioral health conditions in jails and prisons in California specifically may be estimated using proxy measures that are routinely reported by the Board of State and Community Corrections (BSCC) as well as the CDCR. According to the BSCC Jail Profile Survey, the number of individuals in California jails with an active mental health case rose from 19 percent in 2009 to 31 percent in 2019.[233] Over the

---

[230] Lamb HR, Weinberger LE. Persons With Severe Mental Illness in Jails and Prisons: A Review. *Psychiatry Serv*. 1998;49(4):483-492. doi:10.1176/ps.49.4.483. Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics. Accessed September 8, 2021. https://bjs.ojp.gov/library/publications/mental-health-problems-prison-and-jail-inmates.

[231] Bronson J, Berzofsky M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. Bureau of Justice Statistics; 2017. https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf.

[232] Bronson, Jennifer and Jessica Stroop, "Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates," US Department of Justice. Available at https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf.

[233] "California Jail Profile Survey 1995-2020." Available at https://www.openicpsr.org/openicpsr/project/104560/version/V7/view;jsessionid=9028C59D95C1C3DCF30613F070226456.

same period, the percentage of individuals in jail with a psychotropic medication prescription increased from 13 percent in 2009 to 26 percent in 2019.[234]

Notably, the BSCC Jail Profile Survey captures wide variability in these measures across counties (e.g., the percentage of individuals with open mental health cases ranges from 6 percent in Trinity County to 88 percent in Santa Clara County), which suggests that these measures may not reliably capture the true underlying prevalence of mental health conditions. The BSCC Jail Profile Survey does not report proxy measures that can be used to estimate the percentage of individuals living with SUD.

The CDCR uses rates of mental health treatment in prisons as a proxy measure for rates of mental health conditions. According to the Council on Criminal Justice and Behavioral Health's *19th Annual Legislative Report*, approximately 22 percent of prison inmates received treatment consistent with mild-to-moderate mental health conditions, while 6.4 percent received higher levels of care comparable to treatment for SMI.[235] The report does not present statewide data that may be used to estimate rates of SUD among individuals in prisons. However, a previous report from California Correctional Health Care Services estimates that up to 80 percent of individuals in prison in California may have SUD.[236]

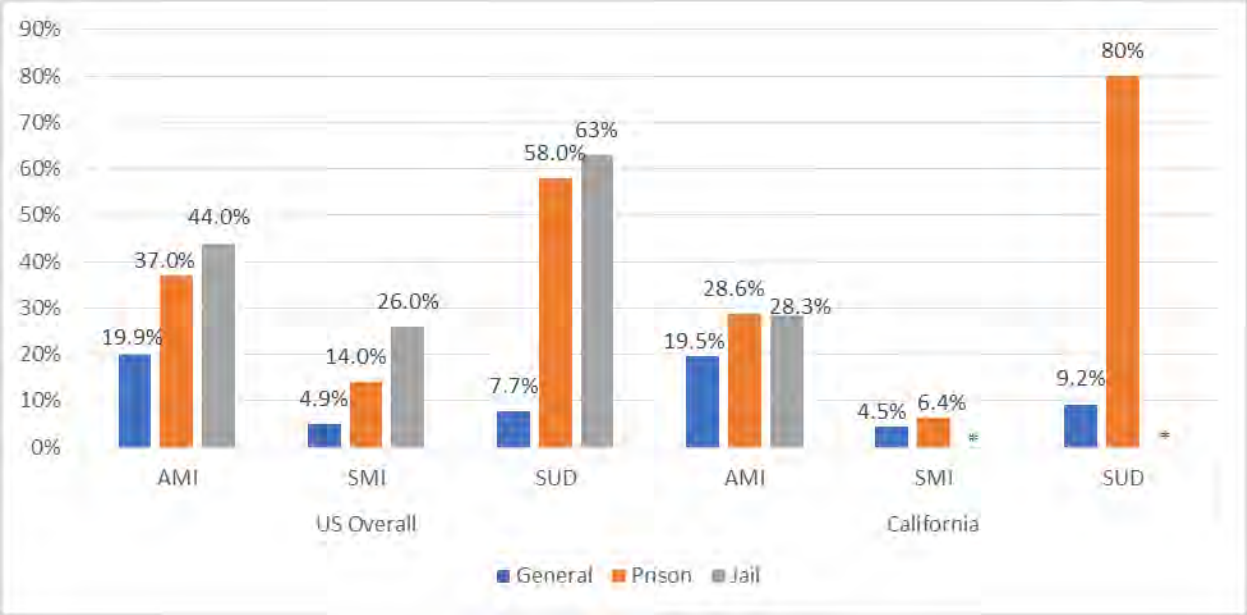
---

[234] "The Prevalence of Mental Illness in California Jails Is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019." California Health Policy Strategies LLC; 2020. https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

[235] 19th Annual Legislative Report. Council on Criminal Justice and Behavioral Health; 2020.

[236] Kelso C. Treatment to Reduce the Burden of Disease and Deaths from Opioid Use Disorder. California Correctional Health Care Services; 2018. https://cchcs.ca.gov/wp-content/uploads/sites/60/Reports/Drug-Treatment-Program.pdf.

Figure D-7. **Rates of AMI, SMI and SUD Among Populations who are justice-involved in California and the U.S. Overall[237]**



*Note: The rate of SMI or SUD in jails could not be determined from available data sources.

[237] Justice-involved prevalence data were available from the CDCR legislative report. https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2021/01/CCJBH-2020-Annual-Report-Final.pdf. AMI, SMI and SUD data were available from the NSDUH. https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf.

Appendix E – Additional Tables with County-Specific Information

Table E-1. **Number of Facilities Providing Assertive Community Treatment by County**

County	Facilities Providing ACT
Alameda	5
Alpine	0
Amador	0
Butte	2
Calaveras	0
Colusa	1
Contra Costa	3
Del Norte	0
El Dorado	1
Fresno	8
Humboldt	2
Imperial	0
Inyo	0
Kern	0
Lake	0
Lassen	0
Los Angeles	28
Madera	3
Marin	3
Mariposa	0
Mendocino	1
Merced	1
Monterey	5
Napa	0
Nevada	2
Orange	12
Placer	1
Plumas	0
Riverside	5
Sacramento	4
San Benito	0
San Bernardino	3
San Diego	12
San Francisco	8
San Joaquin	1
San Luis Obispo	0

County	Facilities Providing ACT
San Mateo	2
Santa Barbara	0
Santa Clara	8
Santa Cruz	0
Shasta	1
Sierra	0
Siskiyou	1
Solano	2
Sonoma	0
Stanislaus	1
Sutter	0
Trinity	0
Tulare	1
Tuolumne	0
Ventura	0
Yolo	1
Yuba	0

Source: SAMHSA Behavioral Health Treatment Services Locator.

Table E-2. **Sobering Centers and Sobering Center Capacity by County**

County	Sobering Centers	Capacity
Alameda	1	17
Alpine	0	0
Amador	0	0
Butte	0	0
Calaveras	0	0
Colusa	0	0
Contra Costa	0	0
Del Norte	0	0
El Dorado	0	0
Fresno	0	0
Glenn	0	0
Humboldt	0	0
Imperial	0	0
Inyo	0	0
Kern	2	16
Kings	0	0
Lake	0	0
Lassen	0	0
Los Angeles	1	50
Madera	0	0
Marin	0	0
Mariposa	0	0
Mendocino	0	0
Merced	0	0
Modoc	0	0
Mono	0	0
Monterey	1	10
Napa	0	0
Nevada	0	0
Orange	0	0
Placer	0	0
Plumas	0	0
Riverside	0	0
Sacramento	0	0
San Benito	0	0
San Bernardino	0	0
San Diego	1	15
San Francisco	1	13
San Joaquin	0	0

County	Sobering Centers	Capacity
San Luis Obispo	0	0
San Mateo	1	14
Santa Barbara	1	10
Santa Clara	1	20
Santa Cruz	0	0
Shasta	1	3
Sierra	0	0
Siskiyou	0	0
Solano	0	0
Sonoma	0	0
Stanislaus	0	0
Sutter	0	0
Tehama	0	0
Trinity	0	0
Tulare	0	0
Tuolumne	0	0
Ventura	0	0
Yolo	0	0
Yuba	0	0

Source: Provided by National Sobering Collaborative via personal correspondence in July 2021.

Table E-3. **Inpatient Psychiatric Units and Bed Capacity by County**

Counties	Psychiatric Units Within General Acute Care Hospitals	Psychiatric Units Within General Acute Care Hospitals (Number of Beds)	Psychiatric Acute Care Hospital Facilities	Psychiatric Acute Care Hospital Facilities (Number of Beds)	Psychiatric Health Facilities	Psychiatric Health Facilities (Number of Beds)
Alameda	3	203	1	96	2	40
Alpine	0	0	0	0	0	0
Amador	0	0	0	0	0	0
Butte	0	0	0	0	1	16
Calaveras	0	0	0	0	0	0
Colusa	0	0	0	0	0	0
Contra Costa	1	43	1	73	0	0
Del Norte	0	0	0	0	0	0
El Dorado	0	0	0	0	1	10
Fresno	1	61	0	0	2	32
Glenn	0	0	0	0	0	0
Humboldt	0	0	0	0	1	16
Imperial	0	0	0	0	0	0
Inyo	0	0	0	0	0	0
Kern	3	21	0	0	1	16
Kings	0	0	0	0	0	0
Lake	0	0	0	0	0	0
Lassen	0	0	0	0	0	0
Los Angeles	28	1,176	10	919	3	48
Madera	0	0	0	0	0	0
Marin	1	17	0	0	0	0
Mariposa	0	0	0	0	0	0

Counties	Psychiatric Units Within General Acute Care Hospitals	Psychiatric Units Within General Acute Care Hospitals (Number of Beds)	Psychiatric Acute Care Hospital Facilities	Psychiatric Acute Care Hospital Facilities (Number of Beds)	Psychiatric Health Facilities	Psychiatric Health Facilities (Number of Beds)
Mendocino	0	0	0	0	0	0
Merced	0	0	0	0	1	16
Modoc	0	0	0	0	0	0
Mono	0	0	0	0	0	0
Monterey	2	40	0	0	0	0
Napa	1	21	1	45	0	0
Nevada	0	0	0	0	0	0
Orange	9	408	1	34	0	0
Placer	0	0	0	0	1	16
Plumas	0	0	0	0	0	0
Riverside	2	114	1	62	1	16
Sacramento	0	0	3	314	3	82
San Benito	0	0	0	0	0	0
San Bernardino	3	145	2	195	0	0
San Diego	13	376	5	285	0	0
San Francisco	4	141	2	34	0	0
San Joaquin	1	2	1	35	1	28
San Luis Obispo	0	0	0	0	1	16
San Mateo	2	62	0	0	0	0
Santa Barbara	0	0	0	0	1	16
Santa Clara	4	126	1	80	2	40
Santa Cruz	0	0	0	0	1	16
Shasta	1	20	0	0	1	16

Counties	Psychiatric Units Within General Acute Care Hospitals	Psychiatric Units Within General Acute Care Hospitals (Number of Beds)	Psychiatric Acute Care Hospital Facilities	Psychiatric Acute Care Hospital Facilities (Number of Beds)	Psychiatric Health Facilities	Psychiatric Health Facilities (Number of Beds)
Sierra	0	0	0	0	0	0
Siskiyou	0	0	0	0	0	0
Solano	0	0	1	61	1	16
Sonoma	3	75	0	0	0	0
Stanislaus	1	67	0	0	1	16
Sutter	0	0	0	0	2	32
Tehama	0	0	0	0	1	16
Trinity	0	0	0	0	0	0
Tulare	1	63	0	0	0	0
Tuolumne	0	0	0	0	0	0
Ventura	1	43	1	87	0	0
Yolo	1	18	0	0	0	0
Yuba	0	0	0	0	0	0

Source: DHCS licensure data.

Table E-4. **Services for Children/Youth and Young Adults by County**

County	Outpatient Programs for Children / youth	Outpatient treatment programs for young adults	Number of Child psychiatrists	Child psychiatrists per 100,000 individuals below age 18	School based health programs with mental health services
Alameda	20	22	36	10.6	31
Alpine	1	1	0	0.0	0
Amador	1	1	2	33.3	0
Butte	2	5	2	4.5	0
Calaveras	1	1	0	0.0	0
Colusa	1	1	0	0.0	0
Contra Costa	10	11	39	15.1	13
Del Norte	2	3	0	0.0	0
El Dorado	3	3	2	5.2	0
Fresno	11	12	13	4.6	5
Glenn	0	0	0	0.0	0
Humboldt	4	5	0	0.0	1
Imperial	1	0	1	1.9	0
Inyo	1	1	0	0.0	0
Kern	7	10	15	5.8	5
Kings	0	0	0	0.0	1
Lake	1	1	0	0.0	1
Lassen	1	1	0	0.0	0
Los Angeles	121	157	305	14.2	45
Madera	3	3	0	0.0	2
Marin	5	6	25	48.7	2
Mariposa	1	1	0	0.0	1
Mendocino	4	3	0	0.0	0
Merced	4	5	1	1.2	1
Modoc	0	0	0	0.0	0
Mono	0	0	0	0.0	0
Monterey	6	7	9	8.0	2
Napa	3	3	7	25.2	4
Nevada	2	3	1	5.9	0
Orange	26	41	78	11.3	4
Placer	3	5	9	10.2	0
Plumas	1	1	0	0.0	0
Riverside	12	13	26	4.2	3
Sacramento	16	22	42	11.6	1

County	Outpatient Programs for Children / youth	Outpatient treatment programs for young adults	Number of Child psychiatrists	Child psychiatrists per 100,000 individuals below age 18	School based health programs with mental health services
San Benito	1	1	0	0.0	0
San Bernardino	23	28	27	4.7	2
San Diego	16	39	125	17.5	11
San Francisco	13	19	62	52.5	19
San Joaquin	2	4	10	4.9	7
San Luis Obispo	3	5	6	12.1	1
San Mateo	6	7	24	15.5	2
Santa Barbara	5	10	8	8.1	1
Santa Clara	19	21	101	24.3	13
Santa Cruz	2	2	8	15.4	1
Shasta	3	5	2	5.2	0
Sierra	2	2	0	0.0	0
Siskiyou	2	2	0	0.0	0
Solano	6	7	7	7.1	1
Sonoma	4	8	16	16.8	4
Stanislaus	2	3	2	1.3	5
Sutter	4	6	1	4.0	0
Tehama	0	0	0	0.0	0
Trinity	2	2	0	0.0	0
Tulare	1	4	4	2.8	2
Tuolumne	1	1	1	10.9	0
Ventura	9	14	15	7.9	1
Yolo	4	5	14	30.6	1
Yuba	1	2	0	0.0	0

Sources- Outpatient programs for children / youth and young adults identified from SAMHSA Behavioral Health Services Treatment Locator. Data on child psychiatrists provided by California Medical Board. Data on school-based health programs with mental health services.

Table E-5. **Housing Units Available by Housing and Urban Development Continuum of Care**

Continuum of Care	Permanent Supportive Housing: Total Year-Round Beds	Other Permanent Housing: Total Year-Round Beds	Transitional Housing: Total Year-Round Beds	Rapid Rehousing: Total Year-Round Beds
San Jose/Santa Clara City and County	3,829	126	559	1,486
San Francisco	5,897	4,154	627	1,187
Oakland, Berkeley/Alameda County	3,545	-	617	633
Sacramento City and County	3,251	91	590	772
Santa Rosa, Petaluma/Sonoma County	823	145	375	630
Richmond/Contra Costa County	1,156	6	194	231
Salinas/Monterey, San Benito Counties	301	-	509	226
Marin County	514	90	180	48
Watsonville/Santa Cruz City and County	658	-	182	420
Mendocino County	363	-	124	41
Turlock, Modesto/Stanislaus County	555	-	248	12
Stockton/San Joaquin County	726	-	360	364
Daly City/San Mateo County	1,218	47	172	367
Visalia/Kings, Tulare Counties	235	65	184	139
Fresno City and County/Madera County	1,338	44	148	767
Roseville, Rocklin/Placer, Nevada Counties	61	-	166	74
Redding/Shasta County	55	-	189	251
Napa City and County	50	-	22	59
Vallejo/Solano County	228	-	109	177
Chico, Paradise/Butte County	176	115	254	21
Merced City and County	163	-	144	46
Davis, Woodland/Yolo County	242	-	51	334
Humboldt County	57	-	85	213

Continuum of Care	Permanent Supportive Housing: Total Year-Round Beds	Other Permanent Housing: Total Year-Round Beds	Transitional Housing: Total Year-Round Beds	Rapid Rehousing: Total Year-Round Beds
Colusa, Glen, Trinity Counties	-	-	58	-
Yuba City/Sutter County	18	4	42	213
El Dorado County	5	-	66	85
Tuolumne, Amador, Calaveras, Mariposa Counties	58	-	51	100
Tehama County	-	-	38	188
Lake County	210	24	38	-
Alpine, Inyo, Mono Counties	-	-	21	7
Nevada County	42	2	12	97
Los Angeles City and County	22,683	2,030	4,111	6,045
San Diego City and County	4,901	939	1,700	1,846
Santa Ana, Anaheim/Orange County	2,496	295	1,017	663
Santa Maria/Santa Barbara County	707	277	163	186
Bakersfield/Kern County	2,308	9	264	602
Long Beach	1,662	240	317	378
Pasadena	434	-	51	25
Riverside City and County	1,744	-	92	318
San Bernardino City and County	1,603	-	186	2,101
Oxnard, San Buenaventura/ Ventura County	693	-	205	683
Glendale	189	-	54	15
Imperial County	321	-	154	157
San Luis Obispo County	357	4	31	404

Source: U.S. Department of Housing and Urban Development.

Table E-6. **Psychiatrists by County**

County	Number of Psychiatrists	Psychiatrists per 100,000
Alameda	350	21.1
Alpine	0	0.0
Amador	6	15.6
Butte	13	5.8
Calaveras	2	4.4
Colusa	0	0.0
Contra Costa	188	16.5
Del Norte	2	7.3
El Dorado	19	10.1
Fresno	93	9.4
Glenn	0	0.0
Humboldt	14	10.3
Imperial	12	6.6
Inyo	1	5.6
Kern	68	7.7
Kings	11	7.3
Lake	3	4.7
Lassen	1	3.2
Los Angeles	1882	18.7
Madera	4	2.6
Marin	177	68.1
Mariposa	1	5.7
Mendocino	8	9.2
Merced	7	2.6
Modoc	0	0.0
Mono	0	0.0
Monterey	63	14.5
Napa	86	61.6
Nevada	15	15.1
Orange	496	15.7
Placer	73	18.9
Plumas	0	0.0
Riverside	192	8.0
Sacramento	322	21.1
San Benito	1	1.7
San Bernardino	249	11.6
San Diego	725	21.9
San Francisco	567	64.8

County	Number of Psychiatrists	Psychiatrists per 100,000
San Joaquin	65	8.8
San Luis Obispo	91	32.3
San Mateo	214	27.9
Santa Barbara	61	13.7
Santa Clara	547	28.4
Santa Cruz	52	19.0
Shasta	12	6.7
Sierra	0	0.0
Siskiyou	4	9.2
Solano	59	13.4
Sonoma	88	17.6
Stanislaus	35	6.4
Sutter	11	11.4
Tehama	0	0.0
Trinity	1	7.9
Tulare	16	3.5
Tuolumne	4	7.4
Ventura	108	12.7
Yolo	52	23.9
Yuba	2	2.6

Source: California Medical Board.

Table E-7. **Mental Health Rehabilitation Centers by County**

Counties	Total Facilities	Total Beds
Alameda	3	154
Alpine	0	0
Amador	0	0
Butte	0	0
Calaveras	0	0
Colusa	0	0
Contra Costa	0	0
Del Norte	0	0
El Dorado	0	0
Fresno	2	81
Glenn	0	0
Humboldt	1	42
Imperial	0	0
Inyo	0	0
Kern	1	55
Kings	0	0
Lake	0	0
Lassen	0	0
Los Angeles	2	196
Madera	0	0
Marin	1	89
Mariposa	0	0
Mendocino	0	0
Merced	1	98
Modoc	0	0
Mono	0	0
Monterey	0	0
Napa	1	54
Nevada	0	0
Orange	1	80
Placer	0	0
Plumas	0	0
Riverside	1	38
Sacramento	1	54
San Benito	0	0
San Bernardino	0	0
San Diego	4	406
San Francisco	2	101
San Joaquin	0	0
San Luis Obispo	0	0

Counties	Total Facilities	Total Beds
San Mateo	1	68
Santa Barbara	0	0
Santa Clara	1	100
Santa Cruz	1	99
Shasta	0	0
Sierra	0	0
Siskiyou	0	0
Solano	1	92
Sonoma	0	0
Stanislaus	0	0
Sutter	1	44
Tehama	0	0
Trinity	0	0
Tulare	0	0
Tuolumne	0	0
Ventura	2	31
Yolo	0	0
Yuba	0	0

Source: DHCS licensure data.

Table E-8. **Availability by County of Short-Term Residential Therapeutic Program (STRTPs) and Community Treatment Facilities (CTFs)**

Counties	STRTP Facilities	STRTP Beds	CTF Facilities	CTF Beds
Alameda	11	86	0	0
Alpine	2	12	0	0
Amador	0	0	0	0
Butte	2	12	0	0
Calaveras	2	68	0	0
Colusa	0	0	0	0
Contra Costa	13	80	0	0
Del Norte	0	0	0	0
El Dorado	7	42	0	0
Fresno	37	239	0	0
Glenn	0	0	0	0
Humboldt	0	0	0	0
Imperial	2	12	0	0
Inyo	0	0	0	0
Kern	26	151	0	0
Kings	1	6	0	0
Lake	0	0	0	0
Lassen	1	10	0	0
Los Angeles	77	947	2	68
Madera	3	38	0	0
Marin	1	67	0	0
Mariposa	2	12	0	0
Mendocino	3	12	0	0
Merced	7	42	0	0
Modoc	0	0	0	0
Mono	0	0	0	0
Monterey	3	18	0	0
Napa	0	0	0	0
Nevada	4	30	0	0
Orange	21	182	0	0
Placer	6	36	0	0
Plumas	0	0	0	0
Riverside	35	396	0	0
Sacramento	21	198	0	0
San Benito	4	24	0	0
San Bernardino	42	471	0	0
San Diego	18	312	0	0
San Francisco	3	64	0	0

Counties	STRTP Facilities	STRTP Beds	CTF Facilities	CTF Beds
San Joaquin	5	52	0	0
San Luis Obispo	2	18	0	0
San Mateo	2	24	0	0
Santa Barbara	5	50	0	0
Santa Clara	5	29	0	0
Santa Cruz	3	18	0	0
Shasta	4	24	0	0
Sierra	0	0	0	0
Siskiyou	0	0	0	0
Solano	3	18	0	0
Sonoma	12	85	0	0
Stanislaus	16	135	0	0
Sutter	0	0	0	0
Tehama	0	0	0	0
Trinity	0	0	0	0
Tulare	3	54	0	0
Tuolumne	0	0	0	0
Ventura	13	114	0	0
Yolo	3	18	0	0
Yuba	0	0	0	0

Source: Licensure data from Department of Social Services.

Table E-9. **Crisis Stabilization Units and Slots by County**

County	CSUs	CSU Slots
Alameda	3	21
Alpine	0	0
Amador	0	0
Butte	0	0
Calaveras	0	0
Colusa	0	0
Contra Costa	1	8
Del Norte	1	25
El Dorado	3	59
Fresno	1	39
Glenn	0	0
Humboldt	1	39
Imperial	1	7
Inyo	1	4
Kern	2	32
Kings	0	0
Lake	2	32
Lassen	0	0
Los Angeles	9	150
Madera	0	0
Marin	10	122
Mariposa	0	0
Mendocino	1	10
Merced	0	0
Modoc	0	0
Mono	2	12
Monterey	0	0
Napa	0	0
Nevada	0	0
Orange	4	51
Placer	1	4
Plumas	0	0
Riverside	1	12
Sacramento	5	81
San Benito	2	37
San Bernardino	0	0
San Diego	2	40
San Francisco	3	58
San Joaquin	2	17

County	CSUs	CSU Slots
San Luis Obispo	1	24
San Mateo	1	4
Santa Barbara	1	14
Santa Clara	2	13
Santa Cruz	2	20
Shasta	1	10
Sierra	0	0
Siskiyou	0	0
Solano	1	16
Sonoma	1	16
Stanislaus	1	12
Sutter	0	0
Tehama	0	0
Trinity	1	5
Tulare	0	0
Tuolumne	0	0
Ventura	0	0
Yolo	0	0
Yuba	2	12

Sources: DHCS licensure data and surveys with county behavioral health directors.

Table E-10. **Jail-Based Competency Treatment Program Capacity, Psychiatric Inpatient Units, and Crisis Intervention Teams**

County	Jail-Based Competency Treatment Program Capacity	Psychiatric Inpatient Units	Crisis Intervention Teams
Alameda	0	0	0
Alpine	0	0	0
Amador	0	0	0
Butte	5	0	1
Calaveras	10	0	0
Colusa	0	0	0
Contra Costa	0	0	1
Del Norte	0	0	0
El Dorado	0	0	1
Fresno	0	0	0
Glenn	0	0	0
Humboldt	6	0	1
Imperial	0	0	0
Inyo	0	0	0
Kern	60	0	1
Kings	5	0	0
Lake	0	0	0
Lassen	0	0	0
Los Angeles	0	0	1
Madera	0	0	0
Marin	0	0	1
Mariposa	6	0	0
Mendocino	6	0	0
Merced	0	0	1
Modoc	0	0	0
Mono	0	0	0
Monterey	10	1	1
Napa	0	0	0
Nevada	0	0	0
Orange	0	0	1
Placer	15	0	1
Plumas	0	0	0
Riverside	25	1 (Women)	1
Sacramento	44	0	0
San Benito	0	0	0

County	Jail-Based Competency Treatment Program Capacity	Psychiatric Inpatient Units	Crisis Intervention Teams
San Bernardino	146	0	1
San Diego	30	0	1
San Francisco	0	0	1
San Joaquin	12	1 (Men) and 1 (Women)	0
San Luis Obispo	5	0	1
San Mateo	0	0	1
Santa Barbara	10	0	1
Santa Clara	0	0	1
Santa Cruz	0	0	0
Shasta	6	0	1
Sierra	0	0	0
Siskiyou	0	0	0
Solano	12	1	0
Sonoma	12	0	1
Stanislaus	18	0	1
Sutter	0	0	0
Tehama	0	0	0
Trinity	0	0	0
Tulare	0	0	0
Tuolumne	0	0	0
Ventura	8	0	1
Yolo	0	0	1
Yuba	0	0	0

Sources: Data on jail-based competency treatment program capacity provided by the California Department of State Hospitals and data on psychiatric inpatient units were provided by CDCR. Data on crisis intervention teams were obtained from the University of Memphis Crisis Intervention Team Resource Center website.

Table E-11. **Pre-Trial Diversion Programs Petitions, Prison Community Reentry Programs and Community Based Restoration Program Capacity by County**

County	Pre-Trial Diversion Program Petitions Received in Q1 2020	Prison Community Reentry Total Programs	Prison Community Reentry Program Total Capacity	Community Based Restoration Program Capacity
Alameda	8	12	207	0
Alpine	1	0	0	0
Amador	0	0	0	0
Butte	51	13	198	0
Calaveras	0	0	0	0
Colusa	0	0	0	0
Contra Costa	0	7	91	0
Del Norte	0	0	0	0
El Dorado	2	4	0	0
Fresno	14	23	896	0
Glenn	0	0	0	0
Humboldt	0	3	28	0
Imperial	0	8	31	0
Inyo	1	0	0	0
Kern	0	26	479	0
Kings	1	4	69	0
Lake	0	3	46	0
Lassen	0	0	0	0
Los Angeles	0	161	3,398	350
Madera	0	0	0	0
Marin	0	0	0	0
Mariposa	0	0	0	0
Mendocino	1	1	0	0
Merced	0	5	55	0
Modoc	0	0	0	0
Mono	4	0	0	0
Monterey	1	13	85	0
Napa	0	6	0	0
Nevada	6	0	0	0
Orange	35	26	388	0
Placer	2	9	69	0
Plumas	0	0	0	0
Riverside	1	106	1,028	0

County	Pre-Trial Diversion Program Petitions Received in Q1 2020	Prison Community Reentry Total Programs	Prison Community Reentry Program Total Capacity	Community Based Restoration Program Capacity
Sacramento	69	35	675	0
San Benito	7	32	651	0
San Bernardino	36	100	1,043	0
San Diego	0	43	978	0
San Francisco	35	9	220	0
San Joaquin	49	18	192	0
San Luis Obispo	0	6	42	0
San Mateo	6	5	130	0
Santa Barbara	8	29	604	0
Santa Clara	66	14	201	0
Santa Cruz	39	8	106	0
Shasta	3	26	148	0
Sierra	0	0	0	0
Siskiyou	8	0	0	0
Solano	0	19	182	0
Sonoma	4	1	6	0
Stanislaus	10	8	93	0
Sutter	0	0	0	0
Tehama	0	3	38	0
Trinity	0	0	0	0
Tulare	15	14	118	0
Tuolumne	0	0	0	0
Ventura	10	87	1	0
Yolo	23	225	1	0
Yuba	3	46	0	0

Sources: Data on pre-trial diversion program petitions in Q1 2020 were provided by the Judicial Council of California. Data on prison community reentry programs were provided by CDCR. Data on community-based restoration program capacity were provided by the California Department of State Hospitals

Table E-12. **Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Inpatient Treatment Beds**

County	Number of Acute Psychiatric Inpatient Beds Available	Number of Acute Psychiatric Inpatient Beds Needed According to Crisis Resource Calculator	Gap Between Beds Available and Beds Needed
Alameda	339	179	160
Alpine	0	0	0
Amador	0	2	-2
Butte	16	22	-6
Calaveras	0	2	-2
Colusa	0	1	-1
Contra Costa	116	113	3
Del Norte	0	1	-1
El Dorado	10	22	-12
Fresno	93	92	1
Glenn	0	3	-3
Humboldt	16	14	2
Imperial	0	10	-10
Inyo	0	1	-1
Kern	37	94	-57
Kings	0	7	-7
Lake	0	3	-3
Lassen	0	1	-1
Los Angeles	2143	1289	854
Madera	0	6	-6
Marin	17	28	-11
Mariposa	0	1	-1
Mendocino	0	5	-5
Merced	16	22	-6
Modoc	0	1	-1
Mono	0	1	-1
Monterey	40	35	5
Napa	66	20	46
Nevada	0	6	-6
Orange	442	439	3
Placer	16	50	-34
Plumas	0	1	-1
Riverside	192	288	-96

County	Number of Acute Psychiatric Inpatient Beds Available	Number of Acute Psychiatric Inpatient Beds Needed According to Crisis Resource Calculator	Gap Between Beds Available and Beds Needed
Sacramento	396	220	176
San Benito	0	3	-3
San Bernardino	340	181	159
San Diego	661	495	166
San Francisco	175	260	-85
San Joaquin	65	70	-5
San Luis Obispo	16	22	-6
San Mateo	62	113	-51
Santa Barbara	16	43	-27
Santa Clara	246	240	6
Santa Cruz	16	30	-14
Shasta	36	33	3
Sierra	0	0	0
Siskiyou	0	3	-3
Solano	77	57	20
Sonoma	75	56	19
Stanislaus	83	47	36
Sutter	32	20	12
Tehama	16	7	9
Trinity	0	1	-1
Tulare	63	52	11
Tuolumne	0	3	-3
Ventura	130	83	47
Yolo	18	21	-3
Yuba	0	7	-7

Source: Data on number of acute inpatient beds from DHCS licensure data. Data on the number of beds needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator

Table E-13. **Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Crisis Stabilization Unit Slots**

County	Number of CSU Slots Available	Number of CSU Slots Needed According to Crisis Resource Calculator	Gap Between CSU Slots Available and CSU Slots Needed
Alameda	21	79	-58
Alpine	0	0	0
Amador	0	2	-2
Butte	0	11	-11
Calaveras	0	2	-2
Colusa	0	1	-1
Contra Costa	8	55	-47
Del Norte	25	1	24
El Dorado	59	9	50
Fresno	39	47	-8
Glenn	0	1	-1
Humboldt	39	6	33
Imperial	7	9	-2
Inyo	4	1	3
Kern	32	42	-10
Kings	0	7	-7
Lake	32	3	29
Lassen	0	1	-1
Los Angeles	150	482	-332
Madera	0	7	-7
Marin	122	12	110
Mariposa	0	1	-1
Mendocino	10	4	6
Merced	0	13	-13
Modoc	0	0	0
Mono	12	1	11
Monterey	0	21	-21
Napa	0	7	-7
Nevada	0	5	-5
Orange	51	151	-100
Placer	4	18	-14
Plumas	0	1	-1
Riverside	12	115	-103
Sacramento	81	73	8
San Benito	37	3	34

County	Number of CSU Slots Available	Number of CSU Slots Needed According to Crisis Resource Calculator	Gap Between CSU Slots Available and CSU Slots Needed
San Bernardino	0	103	-103
San Diego	40	158	-118
San Francisco	58	42	16
San Joaquin	17	35	-18
San Luis Obispo	24	13	11
San Mateo	4	37	-33
Santa Barbara	14	21	-7
Santa Clara	13	92	-79
Santa Cruz	20	13	7
Shasta	10	9	1
Sierra	0	0	0
Siskiyou	0	2	-2
Solano	16	21	-5
Sonoma	16	24	-8
Stanislaus	12	26	-14
Sutter	0	5	-5
Tehama	0	3	-3
Trinity	5	1	4
Tulare	0	22	-22
Tuolumne	0	3	-3
Ventura	0	40	-40
Yolo	0	10	-10
Yuba	12	4	8

Source: Data on number of CSU slots from DHCS licensure data and county survey results. Data on the number of CSU slots needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator

Table E-14. **Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Mobile Crisis Teams Available**

County	Number of Mobile Crisis Teams Available	Number of Mobile Crisis Teams Needed According to Crisis Resource Calculator	Gap Between Number of Mobile Crisis Teams Available and Number Needed
Alameda	5	13	-8
Alpine	0	0	0
Amador	1	0	1
Butte	2	2	0
Calaveras	2	0	2
Colusa	1	0	1
Contra Costa	5	9	-5
Del Norte	0	0	0
El Dorado	2	2	0
Fresno	1	8	-7
Glenn	1	0	1
Humboldt	2	1	1
Imperial	1	1	0
Inyo	1	0	1
Kern	13	7	6
Kings	1	1	0
Lake	7	1	6
Lassen	0	0	0
Los Angeles	171	81	90
Madera	1	1	0
Marin	1	2	-1
Mariposa	1	0	1
Mendocino	1	1	0
Merced	2	2	0
Modoc	0	0	0
Mono	0	0	0
Monterey	2	3	-1
Napa	0	1	-1
Nevada	2	1	1
Orange	25	25	0
Placer	3	3	0
Plumas	0	0	0
Riverside	12	19	-7

County	Number of Mobile Crisis Teams Available	Number of Mobile Crisis Teams Needed According to Crisis Resource Calculator	Gap Between Number of Mobile Crisis Teams Available and Number Needed
Sacramento	8	12	-4
San Benito	1	0	1
San Bernardino	18	17	1
San Diego	2	27	-25
San Francisco	3	7	-4
San Joaquin	4	6	-2
San Luis Obispo	2	2	0
San Mateo	1	6	-5
Santa Barbara	3	4	-1
Santa Clara	10	15	-5
Santa Cruz	7	2	5
Shasta	2	1	1
Sierra	0	0	0
Siskiyou	0	0	0
Solano	4	4	0
Sonoma	3	4	-1
Stanislaus	0	4	-4
Sutter	0	1	-1
Tehama	0	1	-1
Trinity	0	0	0
Tulare	2	4	-2
Tuolumne	3	0	3
Ventura	1	7	-6
Yolo	4	2	2
Yuba	0	1	-1

Source: Data on number of mobile crisis teams available from county survey results. Data on the number of mobile crisis teams needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget

PERSONNEL	No. of Positions	Monthly Salary or Hourly Rate	% of Project Time	Months	Hours	TOTAL
Monthly Salary Positions						
Hourly Positions						
Case Manager (Licensed or BBS Reg PSC)	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Case Manager (Licensed or BBS Reg PSC)	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Registered Nurse	1.0	$ 70.00	100%	12.00	173	$ 145,600.00
Family and Peer Advocate	1.0	$ 24.00	100%	12.00	173	$ 49,920.00
Peer Support Specialist	1.0	$ 24.00	100%	12.00	173	$ 49,920.00
Housing Specialist	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Housing Specialist	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Dual Recovery Specialist	1.0	$ 29.00	100%	12.00	173	$ 60,320.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Night Monitor (Peer)	1.0	$ 25.00	100%	12.00	173	$ 52,000.00
Increases for ACT Staff	1.0	$ 77.50	100%	12.00	173	$ 161,191.68
LVN (ACT Side)	1.0	$ 35.00	100%	12.00	173	$ 72,800.00
					TOTAL STAFF SALARIES	**$ 972,391.68**
Total Staff Benefits (% of Total Staff Salaries)			**Current Percentage =**		**25.00%**	243,097.92
					TOTAL PERSONNEL COSTS	**$ 1,215,489.60**
SUBCONTRACTORS/CONSULTANT COSTS		**Direct Hours**		**Proposed Rate**		
Consultants - Psychiatrist		1040		$ 260		$ 270,400.00
					TOTAL SUBCONTRACTORS/CONSULTANT COSTS	**$ 270,400.00**
OPERATING COSTS						
Building Rent & Leases						$ 33,612.00
Building Repairs/Maintenance						$ 4,321.00
Equipment Rent & Leases						$ 42,843.00
Equipment Repair/Maintenance						$ 50,030.00
Telecommunications						$ 26,388.00
Utilities						$ -
Medical Supplies						$ 3,000.00
Minor Equipment						$ 66,699.00
Equipment Purchases > $5,000						$ -
Office Supplies						$ 12,134.00
Other Supplies						$ 8,266.00
Printing						$ 740.00
Drug Testing Supplies						$ 3,840.00
Travel						$ 32,632.00
Accounting/Auditing/Legal Fees						$ 200.00
Dues and Subscriptions						$ -
Insurance						$ 31,472.00
Staff Development/Training/Education						$ 15,600.00
Tax/License/Fees						$ 13,114.00
Other Business Services						$ 3,360.00
Interpreter Services						$ 500.00
					TOTAL OPERATING COSTS	**$ 348,751.00**
FLEX FUNDS						
Wraparound Funds						$ 6,000.00
Gift Cards						$ -
Pharmaceutical Costs						$ 1,200.00
Client Transportation						$ 1,980.00
Client Housing						$ 765,945.46
Payee Services						$ -
Client Curriculum						$ 1,200.00
					TOTAL FLEX FUNDS	**$ 776,325.46**
					SUBTOTAL ANNUAL DIRECT EXPENSES	**$ 2,610,966.06**
TOTAL INDIRECT COSTS					**14.90%**	$ 389,033.94
					TOTAL GROSS COST FOR 12-months	**$ 3,000,000.00**

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget
0

Contractor:	**Mental Health Systems, Inc.**	**Contract #:**	#REF!	**Amendment #:**	
Budget Period:	**12 Months**	**State Provider Code: 37-**		**D/M-C Provider Code:**	

LINE ITEM: Consultants (Services rendered by persons who are members of a particular profession or possess a special skill and who are not officers or employees of the contractor)	Total Amount **$ 270,400**
(Provide a Brief Description & Justification): Cover the cost of psychiatry services for clients.	

LINE ITEM: Wraparound Funds	Total Amount **$ 6,000**
(Provide a Brief Description & Justification): Includes client provisions such as clothing, transport, birth certificates, employment related needs such as tools to begin a job, & items such as food, furnishings for household setup & maintenance. Also covers costs for supplies & services for client recreational & occupational therapy as well as the rewarding of behaviors as client goals are reached.	

LINE ITEM: Gift Cards	Total Amount **$ -**
(Provide a Brief Description & Justification): N/A	

LINE ITEM: Building Rent or Lease	Total Amount **$ 33,612**
(Provide a Brief Description & Justification): This amount is comprised of building rent or lease + utilities for office space.	

LINE ITEM: Building Repair & Maintenance	Total Amount **$ 4,321**
(Provide a Brief Description/Justification): Minor repairs and maintenance for facility including, but not limited to replacement of locks, minor breakage, internal phone line repairs, and other repairs required for safe operation of the program at the leased facility. This also includes the cleaning of the building and alarm service.	

LINE ITEM: Equipment Rent & Lease (e.g., copiers, fax machines, vehicles, point-of-sale equipment, etc.)	Total Amount **$ 42,843**
(Provide a Brief Description & Justification): Expenses are for rental or leasing of equipment that may be needed at facility including a copier and 4 leased vehicles for client transport.	

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget
0

Contractor:	**Mental Health Systems, Inc.**	**Contract #:**	#REF!	**Amendment #:**	
Budget Period:	**12 Months**	**State Provider Code: 37-**		**D/M-C Provider Code:**	

LINE ITEM: Equipment Repair & Maintenance	Total Amount
	$ 50,030

(Provide a Brief Description & Justification):
Equipment Repairs/Maintenance encompasses the cost of a maintenance contract for the copier, monitoring of internet firewall, and the repair of other equipment not covered by maintenance agreements such as computers, printers, and telephones. Also includes repair and maintenance on the program vehicles.

LINE ITEM: Telecommunications (e.g., internet, telephone, long distance, cell phones, cable or satellite TV, etc.)	Total Amount
	$ 26,388

(Provide a Brief Description & Justification):
Includes expense for installation and recurring costs of telephones, pagers, fax machine, internet services, MS Teams user fees, and LAN phone service. Expenses may be somewhat greater or less for individual months.

LINE ITEM: Utilities (e.g., gas, electricity, water, sewer, burglar alarm, etc.)	Total Amount
	$ -

(Provide a Brief Description & Justification):
N/A

LINE ITEM: Medical Supplies (For Client Use Only)	Total Amount
	$ 3,000

(Provide a Brief Description & Justification):
Consists of purchase of miscellaneous items such as latex gloves, cotton, alcohol swipes, etc.

LINE ITEM: Minor Equipment	Total Amount
	$ 66,699

(Provide a Brief Description & Justification):
Represents minor equipment purchases such as phones, cell phones, calculators, printers, CPU and monitors, fax machines, or furniture for replacement purposes of existing equipment that in the normal course of use is worn out and either cannot be repaired or is not practical to have repaired. Includes the purchase of new equipment and furniture to accommodate new staff. Expenses cannot be attributed to a specific amount per month.

LINE ITEM: Office Supplies	Total Amount
	$ 12,134

(Provide a Brief Description & Justification):
Represents supplies utilized for program operation, including office supplies (paper, pens, pencils, folders, staples, paper clips, printer cartridges, binders, folder tabs, etc.), and postage. This also includes supplies for equipment like extension cords, and surge protectors. Expenses cannot be attributed to a specific amount per month. This also pays for housekeeping supplies such as cleaning products, bathroom products, non stationary paper goods, cleaning and trash supplies.

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget
0

Contractor: Mental Health Systems, Inc. **Contract #:** #REF! **Amendment #:**
Budget Period: 12 Months **State Provider Code: 37-** **D/M-C Provider Code:**

LINE ITEM: Other Supplies	Total Amount $ 8,266
(Provide a Brief Description & Justification): Software expenses are included here. These are software expenses needed for items such as MS Office 365 user fees, as well as updates.	

LINE ITEM: Printing	Total Amount $ 740
(Provide a Brief Description & Justification): Includes costs for employment advertisements, printing of brochures, stationery, business cards, and curriculum. Printing expenses for the production of client materials to orient them to the program and for information materials for other referral sources, which assist in treatment.	

LINE ITEM: Drug Testing	Total Amount $ 3,840
(Provide a Brief Description & Justification): Covers the cost of client drug testing	

LINE ITEM: Laboratory Services (e.g., non-drug testing for Clients, etc.)	Total Amount
(Provide a Brief Description & Justification): N/A	

LINE ITEM: Pharmaceutical Cost	Total Amount $ 1,200
(Provide a Brief Description & Justification): Covers the cost of paying for client pharmaceuticals	

LINE ITEM: Client Transportation (e.g., Bus Passes/Tokens, Day Trippers, etc.)	Total Amount $ 1,980
(Provide a Brief Description & Justification): Covers the cost of client transportation in the form of bus passes/tokens and mileage for staff when transporting clients.	

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget
0

Contractor:	**Mental Health Systems, Inc.**	**Contract #:**	#REF!	**Amendment #:**	
Budget Period:	**12 Months**	**State Provider Code: 37-**		**D/M-C Provider Code:**	

LINE ITEM: Travel (includes mileage reimbursement)	Total Amount
	$ 32,632

(Provide a Brief Description & Justification):
Travel includes reimbursements for mileage for staff transporting clients, traveling to and from events, meetings and trainings in conjunction with program operations and responsibilities. Out of county travel is in this budget for designated staff to attend training and travel to the corporate office when necessary. Out of county travel can include flights, hotels, ME&I, rental cars. Also includes gas for leased vehicles.

LINE ITEM: Accounting, Auditing and Legal Fees	Total Amount
	$ 200

(Provide a Brief Description & Justification):
Covers the cost of estimated cost related to the OMB-A133 Single Audit

LINE ITEM: Dues & Subscription	Total Amount
	$ -

(Provide a Brief Description & Justification):
N/A

LINE ITEM: Insurance (e.g., worker's compensation, professional liability, etc.)	Total Amount
	$ 31,472

(Provide a Brief Description & Justification):
Insurance consists of professional liability insurance, which is pro-rated to this program based upon the ratio of program expenses (excluding purchased services) divided by program expenses for all MHS programs during each period of allocation. Workers' compensation insurance based upon workers' compensation ratings for employee classifications in this program applied through actual hours worked. Unemployment insurance is calculated on the first $7,000 of employee salaries (calendar year). This line also includes insurance for Auto's, Commercial, D&O, Umbrella, Criminal Dishonesty, and Sexual Misconduct.

LINE ITEM: Staff Training & Education	Total Amount
	$ 15,600

(Provide a Brief Description & Justification):
Staff Development/Training costs include CPR and First Aid trainings for staff, user fees for Relias, registrations for staff development and trainings held in collaboration with the program's mission.

LINE ITEM: Tax/Licenses/Fees (e.g., Professional Licenses, Memberships)	Total Amount
	$ 13,114

(Provide a Brief Description & Justification):
Represents Municipality licenses (fire inspections, permits, etc) paid on an annual basis. Building and professional licensing fees, staff license and certification renewals, etc. This also covers the monthly user license fee for Avatar/Welligent (EHR System/3rd Party Billing), IT security user fees and associated costs, and can include program DHCS certification costs as required.

BUDGET PROPOSAL
Contra Costa ACTION - MIST
TOTAL BUDGET
12-Month Budget
0

Contractor:	**Mental Health Systems, Inc.**	**Contract #:**	#REF!	**Amendment #:**	
Budget Period:	**12 Months**	**State Provider Code: 37-**		**D/M-C Provider Code:**	

LINE ITEM: Other Business Services (e.g., printing, background check for employees/volunteers, recruitment, advertising, professional subscriptions, FedEx, UPS, US Postal Service, etc.)	Total Amount **$ 3,360**
(Provide a Brief Description & Justification): Other Business Services Expenses are comprised of the HIPAA compliant shredding services, and other miscellaneous services. Also includes associated costs for hiring of new employees such as TB screenings, assessments, drug screenings, background checks, and fingerprinting.	

LINE ITEM: Interpreter Services	Total Amount **$ 500**
(Provide a Brief Description & Justification): Covers the cost of providing interpreters when a bilingual staff isn't available.	

Other: Payee Services	Total Amount **$ -**
(Provide a Brief Description & Justification): N/A	

Other: Curriculum	Total Amount **$ 1,200**
(Provide a Brief Description & Justification): Training materials (videos, workbooks, etc.) and other supplies specifically for psychoeducational groups for families, caretakers, and/or clients.	

When Restoration Fails: One State's Answer to the Dilemma of Permanent Incompetence

Joseph R. Simpson, MD, PhD

The landmark 1972 U.S. Supreme Court decision in *Jackson v. Indiana* prohibited the indefinite commitment of criminal defendants on grounds of incompetence to stand trial if there was no substantial probability of restoration to competency in the foreseeable future. Such defendants are still subject to ordinary civil commitment; however, not all will meet civil commitment criteria, given that the criteria for a finding of incompetency to stand trial do not map directly onto the general criteria for involuntary psychiatric hospitalization. If a person charged with a serious crime, such as murder, has no substantial probability of being restored to competency, but does not meet standard civil commitment criteria, compliance with *Jackson* would seem to require release into the community. This article describes a legislative response to this possibility that became law in California four decades ago, as well as the outcome of its main legal challenge a few years later. Although the law has received harsh criticism from some quarters, it has survived, and provides a legally straightforward, if ethically controversial, means of answering the question of what to do with a permanently incompetent defendant who is charged with a serious violent offense and does not meet traditional civil commitment criteria.

J Am Acad Psychiatry Law 44:171–79, 2016

A 2013 article in *The Journal*[1] describes an intriguing case from Oregon in which ethics complaints were filed against three parties: a magistrate, the district attorney of Washington County, Oregon, and a defense attorney with Portland's Metropolitan Public Defender Agency. The complaints arose from the use of a so-called "mental illness magistrate hold" (Ref. 1, p 116) in the case of Donn Spinosa, a murder defendant who had been found incompetent to stand trial. After he spent three years in Oregon State Hospital (OSH), the maximum commitment period for competency restoration under Oregon law, he was found to have remained incompetent. The charges were dismissed without prejudice, and he was civilly committed to OSH.

Nearly 10 years later, when the hospital sought to release him to a community placement, the charges were refiled, and he was placed in the Washington County jail. He was again found incompetent and transferred back to OSH. There, a psychologist opined that there was no substantial probability that he would become competent. The criminal charges were dismissed, at which point the novel "magistrate hold" was used to recommit him to OSH. The defense attorney and district attorney on the case agreed to the use of this order.

A retired judge who had worked as special master to OSH filed ethics complaints against the magistrate and both attorneys, asserting that they had acted unethically in committing the patient to OSH under a magistrate hold, which, according to the retired judge, is not supported by Oregon law. Following the complaints, the Oregon State Bar opened an investigation and eventually pursued charges of ethics violations against both the defense attorney and the Washington County district attorney. These charges were ultimately dropped. In dismissing the ethics complaints, the Oregon Bar opined that the two attorneys had not attempted to circumvent existing civil commitment laws, but rather to initiate a civil commitment.[2]

The *Spinosa* case is a compelling reminder of the dilemma posed by permanently incompetent defendants who are alleged to have committed serious crimes in the era after the landmark U.S. Supreme

Dr. Simpson is Clinical Associate Professor, Department of Psychiatry, Keck School of Medicine, University of Southern California, Los Angeles, California. Address correspondence to: Joseph R. Simpson, MD, PhD, PO Box 818, Hermosa Beach, CA 90254. E-mail: jrsimpsonmd@gmail.com.

Disclosures of financial or other potential conflicts of interest: None.

Court decision in *Jackson v. Indiana*.[3] *Jackson* holds that incompetency to stand trial is not, in and of itself, sufficient to justify civil commitment once it has been determined that there is no substantial probability of restoration to competency. Given the differences between the criteria for incompetence to stand trial and the criteria for civil commitment, some incompetent, unrestorable defendants will not meet traditional civil commitment criteria and would therefore seem eligible for release from jail or hospital confinement. When the alleged crimes are misdemeanors or less serious felonies, their release may not be a cause for great concern. However, if the charge is serious, such as murder, attempted murder, and the like, the prospect of release raises a significant question of public safety.

The California state legislature addressed the problem of permanently incompetent defendants charged with violent crimes in the immediate aftermath of the *Jackson* decision. By creating a new route to civil commitment, the state plugged the gap resulting from the difference between the criteria needed to be found incompetent to stand trial and those that must be met for long-term civil commitment. The constitutionality of the new commitment scheme was challenged and was ultimately decided by the California Supreme Court.

The general topic of unrestorability of criminal defendants after *Jackson* was reviewed by Parker in 2012.[4] Although the decision in *Jackson* specifically prohibits continued commitment after a reasonable effort at restoration is unsuccessful, Parker found that 10 states had no statute that set a maximum time of commitment for incompetent criminal defendants. Thirty states had laws that specified a maximum period of commitment, either as a certain number of years or as some proportion of the maximum prison sentence for the crime charged (e.g., one-half, two-thirds, or 100 percent). The remaining 10 states allowed for indefinite commitment, but only as long as the defendant met civil commitment criteria. (California is counted among the latter 10; however, as will be made clear herein, this characterization does not fully capture its statutory scheme.)

Parker also pointed out how a theoretical ban on indefinite commitment may not translate into *de facto* compliance with the *Jackson* holding. He cited the *Jackson*-respondent state of Indiana, where, until 2010, the state hospitals "always sought the renewal of the civil commitment of incompetent defendants, and it was always granted by the courts" (Ref. 4, p 172). Similarly, in an empirical study of defendants who were found to be incompetent and unrestorable in Maricopa County, Arizona, and who were referred for civil commitment, Levitt *et al.*[5] reported that the unrestorable defendants were civilly committed at a higher rate than comparison patients, despite meeting fewer admission criteria, and had a longer length of stay.

This article describes an unusual California statute addressing the long-term involuntary commitment of incompetent, unrestorable defendants facing serious felony charges. These defendants are eligible for a one-year, renewable civil commitment, even if they do not meet the traditional standard of grave disability, the standard that must be proven in California for a one-year civil commitment outside of the criminal justice system. Some readers may find this commitment scheme surprising and perhaps even disturbing from an ethics standpoint.

Several characteristics of this type of commitment are remarkable, setting it apart from most other civil commitment laws and raising questions of ethics and fairness. Unlike civil commitment after a finding of not guilty by reason of insanity, the statute does not require proof beyond a reasonable doubt that the crime charged was committed by the patient. An indictment or information is sufficient; not even a preliminary hearing is required. The question of inability to care for oneself because of a mental disorder, which must be established for most other types of long-term civil commitment, is not relevant, nor are questions of amenability to or availability of treatment. As written, the law does not even require the state to establish that the patient remains dangerous, other than by the implication of the original, unproven criminal charge. Long-term deprivation of liberty on such grounds is likely to give some (perhaps many) forensic mental health professionals pause.

California's law providing for the civil commitment of permanently incompetent criminal defendants requires only three facts to be established: that the defendant is currently charged with an enumerated violent felony, is incompetent to stand trial, and cannot be restored to competency. These latter two facts are established using the preponderance-of-evidence standard of proof. In most other long-term commitment proceedings in most U.S. jurisdictions, either the clear-and-convincing-evidence or the

beyond-a-reasonable-doubt standard of proof is required. As will be seen, the lack of a requirement for a showing of ongoing dangerousness was held to be a fatal procedural flaw, but with this adjustment made by case law, the commitment law has now been used for more than 30 years.

Plugging the Gap

California passed the groundbreaking Lanterman-Petris-Short (LPS) Act[6] in 1967. Under this statutory scheme, long-term civil commitment requires the presence of grave disability, which the law defined as: "[a] condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter" (Ref. 7). Individuals who meet this criterion can be civilly committed for a period of 12 months. This commitment is described by statute as a conservatorship for gravely disabled persons and is commonly referred to as mental health conservatorship, LPS conservatorship, or simply conservatorship. The public guardian's office or a private party can be appointed as the conservator for the person, the estate, or both the person and the estate. A conservatorship of the person grants the conservator the power to make decisions about the conservatee's residence, including consenting on his behalf to psychiatric hospitalization or placement in a locked mental health facility (such as an institution for mental disease or IMD) and consenting to the administration of psychotropic medications.

Under the LPS Act, patients who are dangerous to themselves or others due to a mental disorder, but are not gravely disabled, can be involuntarily committed to an inpatient psychiatric hospital unit for shorter periods, but do not qualify for a one-year commitment unless they are gravely disabled. In the years since the passage of the LPS Act, most U.S. jurisdictions have eliminated long-term commitment (i.e., greater than three to six months) on grounds other than grave disability (i.e., danger to self or danger to others).[8]

In the aftermath of the *Jackson* decision and a related California Supreme Court case, *In re Davis*,[9] the state changed its law governing incompetency to stand trial. The maximum commitment after a finding of incompetency was fixed at three years or the maximum prison or jail sentence for the most serious offense charged, whichever was less. Thereafter, if a defendant was still not restored to competency, he had either to be released or civilly committed according to the procedures set forth in the LPS Act.

Marjory Winston Parker was Deputy Attorney General for California in the early 1970s. She was asked by State Assemblyman Frank Murphy to assist in drafting Assembly Bill 1529, which became law in 1974. In a 1975 law review article,[10] Ms. Parker described AB 1529 as:

> . . . a complex attempt to integrate and resolve the conflicting concerns of protecting society from dangerous individuals who are not subject to criminal prosecution, preserving a libertarian policy regarding the indefinite commitment of mentally incompetent individuals who have not been charged with criminal conduct, and safeguarding the freedom of incompetent criminal defendants who present no threat to the public [Ref. 10, p 485].

In explaining the dilemma that the bill was intended to resolve, Ms. Parker wrote:

> A defendant charged with an atrocious crime would be close to complete freedom if he could initially convince a jury that he was mentally incompetent to stand trial, and then at his civil commitment hearing, establish that he was capable of caring for himself, and not, therefore, gravely disabled as required for long-term civil commitment [Ref. 10, pp 488–9].

She added in a footnote:

> Assemblyman Murphy was especially concerned with the problem since his district included Santa Cruz County where three mass murderers, Edmund E. Kemper III, Herbert Mullin, and John L. Frazier, [who,] among them[,] had perpetrated 23 killings in less than a three year period . . . [Ref. 10, p 489, fn 36].

AB 1529 added a second category to the definition of the legal term "gravely disabled." Now, in addition to the original group of those unable to provide their own food, clothing, and shelter because of a mental disorder, a criminal defendant who had been found incompetent to stand trial, who had a pending indictment or information, and who remained incompetent at the conclusion of the three-year statutory maximum, was defined by statute as being gravely disabled, if he was charged with "having committed a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person" (Ref. 10, p 493). Such individuals were now subject to a one-year renewable civil commitment, even if they did not meet the standard criterion of being unable to provide for their own food, clothing, and shelter. This type of commitment has become commonly known as a "Murphy conservatorship," after the author of the law.

The new law was not without its critics. Grant Morris, law professor and, at the time, acting dean of the University of San Diego School of Law, authored a law review article that questioned the wisdom of the entire concept of LPS conservatorship, provocatively titled "Conservatorship for the 'Gravely Disabled': California's Nondeclaration of Nonindependence."[11] Included in his critique is the following indictment of the Murphy law:

> Such expansion of the LPS conservatorship criteria is not warranted. In [*Jackson*] the Supreme Court held that the mere filing of criminal charges does not justify fewer procedural and substantive protections against indefinite commitment than those generally available to nondefendants. The Court struck down as violative of the equal protection clause an Indiana statute that subjected mentally incompetent criminal defendants to commitment standards more lenient and release standards more stringent than those applicable generally to civil commitment.
>
> California's attempt to create a new category of civilly committable patients—a category into which only mentally incompetent defendants charged with violent crimes can fit—is an obvious attempt to circumvent the requirements of *Jackson* and should not be sanctioned. Proof of the commission of a violent felony—that is, a finding of guilt in a criminal trial—is not, without more, proof of the future dangerousness of the individual. *A fortiori*, proof only of probable cause to believe that the defendant committed a violent felony and an adjudication of mental incompetence to stand trial do not in themselves justify a prediction of future dangerousness and preventive detention of this presumably innocent individual [Ref. 11, pp 212–3, fn 58].

Putting the Law to the Test

It would not be long before the California courts mediated between the opposing viewpoints represented by Ms. Parker and Mr. Morris. The case of Glenn Hofferber made its way up to the California Supreme Court and was decided in 1980 in *Conservatorship of Hofferber*.[12]

Mr. Hofferber was originally charged with murder in 1974. Later that year, he was found incompetent to stand trial and remanded to the state hospital. He had been on a standard LPS conservatorship, which had been terminated before the alleged crime. He was reported to have arrived at his work place on the day of the crime "in a specially tailored, 10-star-general's uniform befitting his self-proclaimed position as Commander-in-Chief of the armed forces" (Ref. 12, p 840). It was also noted that he:

> . . . perceives himself as God and the President of the United States (and thus as supreme director of the FBI, the CIA, etc.). He was secret president by arrangement with Lyndon Johnson, but only Dwight Eisenhower was fully aware of his mission. He has deposited substances which will change everything at secret locations near the United Nations and in the Los Angeles sewer system [Ref. 12, p 840].

In 1977, after Mr. Hofferber had been confined for the statutory maximum three-year commitment for restoration of competency, the Department of Health determined that there was "no substantial likelihood he would regain mental competence in the foreseeable future" (Ref. 12, p 840), and he was returned to the criminal court. He was again found incompetent by a jury at a competency trial, using preponderance of the evidence as the standard of proof. In 1978, he was adjudicated to be gravely disabled and placed on a Murphy conservatorship.

Hofferber appealed his civil commitment on three grounds:

> . . . that (1) a person charged with a violent felony and found mentally incompetent to stand trial may not be civilly committed for reasons and under procedures that differ from those applicable to other mentally disordered persons, (2) to establish grave disability his incompetency must be proved beyond a reasonable doubt, and (3) his conservatorship violates the proscription of retroactive or ex post facto laws [Ref. 12, p 840].

The court's ruling was divided, with a four-justice majority opinion, a concurring and dissenting opinion by two justices, and Chief Justice Rose Bird dissenting. The majority opinion summarized Hofferber's claims:

> Appellant argues that the new scheme is a transparent and unsuccessful evasion of *Jackson* and *Davis*. Despite the law's attempt to make incompetents committable under the "customary" civil commitment law, he suggests, it still denies them equal protection because their incompetence bears no rational relationship to the "grave disability" provisions of the LPS Act. *Jackson* and *Davis*, he urges, make unproved criminal charges and a subsequent finding of incompetence insufficient grounds for any distinction, procedural or substantive, from other persons subject to civil commitment. Since he has been found hopelessly incompetent, he contends, he may now be civilly committed only under LPS Act provisions not dealing with criminal incompetence. He also asserts that the new scheme denies due process because it allows indefinite commitment of hopeless incompetents on that ground alone, without any new showing that they are dangerous, helpless, or otherwise in need of further confinement. Therefore, he concludes, he must be released unless his confinement can be justified under laws articulating one or more of those grounds [Ref. 12, p 843].

In summarizing the state's position, the majority opinion noted:

> The conservator responds that the new commitment procedures do meet constitutional standards because they follow a determination of probable cause to believe defendant committed a violent felony. . . . Separate treatment and indefinite confinement of such a defendant, he contends, are

> justified on grounds of public safety because the probable criminal conduct evidences extraordinary dangerousness [Ref. 12, p 843].

The majority opinion also noted the deliberations that ultimately led to the passage of AB1529:

> In 1973 hearings on the Jackson-Davis problem (Assem. Select Com. on Mentally Disordered Criminal Offenders, Dec. 13–14, 1973) legislators, health professionals, and the Attorney General's representative contended that incompetents charged with violent felonies warranted special treatment precisely because their past conduct implied future danger. Participants in the hearings also feared that many of those persons, while delusional and potentially violent if released, would "slip through the cracks" if they neither behaved violently in short-term confinement (a requirement for renewal of 90-day "imminent threat" commitments under the LPS Act) nor could be proved unable to care for themselves (necessary for a traditional LPS Act "gravely disabled" conservatorship) [Ref. 12, p 846].

Although favorably disposed to the state's argument, the majority vacated Hofferber's Murphy conservatorship and remanded the case for further proceedings. The court held that depriving an individual of his liberty requires a showing of ongoing dangerousness. The Murphy statutory scheme did not require a finding specifically addressing the potential conservatee's current dangerousness, and so no determination of this was made in Hofferber's original commitment proceeding. The court held that ". . . every judgment creating or renewing a conservatorship for an incompetent criminal defendant . . . must reflect written findings that, by reason of a mental disease, defect, or disorder, the person represents a substantial danger of physical harm to others" (Ref. 12, p 847). The standard of proof for establishing dangerousness was specified as beyond a reasonable doubt.

The court rejected the contention that incompetence to stand trial must also be established beyond a reasonable doubt. "It would be anomalous if indefinitely he could avoid penal treatment by consecutive, preponderant judgments that he was incompetent and then, though dangerous, also avoid LPS Act confinement as a 'gravely disabled' person because incompetence could not be established beyond a reasonable doubt" [Ref. zrefol12, pp 847–8]. They also rejected Hofferber's *ex post facto* objection on the grounds that the commitment statute is not penal.

Two justices concurred in the judgment, but opined that the standard of proof for dangerousness should be preponderance of the evidence, rather than the reasonable-doubt standard specified in the majority opinion. In other words, these two justices believed that the decision granted too much procedural protection to the incompetent, unrestorable defendant.

Chief Justice Rose Bird issued a strongly-worded dissent, which began:

> It is with considerable bewilderment that one reads today's majority opinion. Explicit words—not to mention fundamental premises—of a United States Supreme Court decision are ignored, as if they do not exist. Firmly established methods of equal protection analysis are fleetingly alluded to and then forgotten. Plain truths that this court has heretofore openly embraced are now somehow repealed [Ref. 12, p 852].

The Chief Justice first referred to the landmark U.S. Supreme Court decision in *Baxstrom v. Herold*[13] some 14 years earlier. That decision struck down the differential treatment under New York law of a prison inmate whom the state sought to civilly commit. Under New York law at the time, civil commitment could be ordered by a court (i.e., a judge) for a prison inmate completing his sentence, but all other persons had the right to a jury determination. The Supreme Court found that this difference violated equal protection. The Chief Justice then referenced the high court's *Jackson* decision and the California Supreme Court's *Davis* decision and opined that the Murphy statute violated equal protection according to the precedents established by these three decisions.

Specifically, Chief Justice Bird identified two ways in which the Murphy scheme failed the equal protection test: first, whereas others could only be civilly committed for dangerousness to receive treatment, incompetent defendants could be committed, even if there was no treatment available; second, the length of an incompetent defendant's commitment is theoretically indeterminate, whereas anyone else committed for dangerousness could only have his commitment renewed if he threatened, attempted, or engaged in violence during the preceding commitment period.

In addition to these failings, Chief Justice Bird's dissent raised the question that this type of conservatorship might constitute cruel and unusual punishment, with its potential to result in the lifelong institutionalization of a person on the basis of the status of having a dangerous mental condition, where it has not been proven beyond a reasonable doubt that a violent crime was committed and the mental condition is untreatable.

After *Hofferber*

The California legislature did not change the language of the Murphy conservatorship statute after the *Hofferber* decision. Mr. Hofferber was committed after a new hearing and was retained in a state forensic hospital. Presumably, the second hearing included a written determination of his present dangerousness. The state was never able to try him, and he remained on conservatorship (Murphy for many years, and later on a standard LPS conservatorship) until his death in a skilled nursing facility in 2007, 33 years after his alleged crime (D. Meyer, JD, personal communication, May 2014). He had one episode of freedom, however: two or three years after the supreme court's decision, he escaped from Metropolitan State Hospital in the Los Angeles suburb of Norwalk, took a bus to downtown and traveled by bus to Las Vegas. After spending a few days at a hotel there, he went to a police station and told them he was an escaped murderer from California (D. Meyer, JD, personal communication).

As the description of the *Spinosa* case by Rodol *et al.*,[1] and research such as that reported by Parker[4] and Levitt *et al.*[5] illustrate, the dilemma posed by permanently incompetent, arguably dangerous defendants such as Mr. Hofferber has not been addressed in most U.S. jurisdictions. In 1986, the American Bar Association (ABA) issued a nearly 500-page document containing recommended standards for many key concerns at the interface between the fields of mental health and criminal law.[14] Standard 7-4.13 addresses the disposition of permanently incompetent defendants. It recommends that after a specified period of competency restoration efforts, a hearing should be held to determine whether the defendant is permanently incompetent. If the defendant is permanently incompetent, "and has been charged with a felony causing or seriously threatening serious bodily harm" (Ref. 14, p 239), then a hearing on factual guilt is held, followed (assuming the defendant's guilt is proved) by a special commitment proceeding akin to that for a defendant found not guilty by reason of insanity. Defendants who are not charged with felonies causing or threatening serious bodily harm and who are found permanently incompetent must be released or civilly committed through traditional means.

Although it resembles California's solution to some degree, the ABA standard does not reference California's law or the *Hofferber* decision. According to a commentary published alongside the article by Levitt *et al.*, the ABA proposal for the management of permanently incompetent defendants has been "long ignored" throughout the country (Ref. 15 p 363).

Morris, who, as discussed above, questioned the LPS scheme generally,[11] took a more in-depth look at laws governing the disposition of permanently incompetent defendants 15 years later. He collaborated with forensic psychologist J. Reid Meloy, on a 96-page law review article, published in 1993.[16] The authors first reviewed the statutory responses to *Jackson* in all U.S. jurisdictions and then presented an analysis of patients committed under the Murphy statute in California. They found that, in September 1992, there were 97 patients committed under the Murphy law in the state hospital system. The duration of confinement ranged from less than 1 year to 12 years, with the majority (55.7%) having been confined for 4 years or less (not including the preceding 3 years of commitment for competency restoration).

The extremely small number of patients committed under the Murphy law is a reminder of the rarity of the situation in which a defendant charged with a serious felony cannot be restored to competency, even after three years of inpatient hospital treatment. It is impossible to determine how many of these patients may also have met criteria for traditional civil commitment if the option of the Murphy conservatorship were not available, but this arguably could make the pool of defendants who would have to be released but for the existence of the Murphy law even smaller. The sparing use of this type of commitment has continued for the two decades since the Morris and Meloy review.[16] Despite the intervening growth of California's population and of its state hospital population, the number of patients confined under Murphy is actually smaller now, with 69 patients residing in the state hospitals in June 2014.[17] The total capacity of California's five forensic hospitals is approximately 6,000 patients.[18]

It is not clear why the number of patients on Murphy conservatorship has declined. If any clinical, as opposed to institutional (e.g., the practices of forensic hospital staff), factors have contributed to the decrease, one such factor could be the advent of atypical antipsychotic medications, beginning with the introduction of clozapine in 1990, which may have allowed for a higher percentage of these severely ill

patients to be restored to competency; but in the absence of any recent systematic studies of this population, this is mere speculation.

Oregon's Response: A (Slightly) Different Approach

The *Spinosa* case and another high-profile case in Oregon in 2011 involving the murder of a police officer led to the passage of Oregon Senate Bill 421 as §426.701 in 2013.[19,20] The new law creates a two-year renewable commitment for individuals who have a mental disorder that is resistant to treatment, who are currently exhibiting symptoms, and who are extremely dangerous. Extreme dangerousness is defined by having been found to have committed, as a result of a treatment-resistant mental disorder, one of several listed violent or criminal sexual acts. Clear and convincing evidence is the standard of proof. A criminal conviction is not a requirement.

Unlike the Murphy conservatorship, the language of Oregon's new commitment law for the extremely dangerous is not specific to criminal defendants in general or to defendants who have been found incompetent or unrestorable in particular. However, two cases involving murder defendants who were incompetent for an extended period were the impetus for the law, and, given the entry requirement of a serious violent or criminal sexual act, it may be that many or even most patients committed under the new law will in fact be criminal defendants, indeed incompetent defendants.

The law's requirement of a violent crime or sex offense sets a high threshold for commitment. Situations where a person, who can be shown to have committed a crime of violence, does not have any charges pending are presumably quite rare. On the other hand, defendants who are charged and are initially competent or are restored to competency will be either sentenced to a term of incarceration or found not guilty by reason of insanity; in either case, they would not be committed under this law. One scenario other than an incompetent criminal defendant would be someone who was previously convicted and sentenced to prison or found not guilty by reason of insanity, who is off parole or has been unconditionally released from supervision. If such a person, who presumably had improved clinically, were to relapse such that he again exhibited severe symptoms and presented a serious danger to others, he could theoretically be subject to commitment under Oregon's statute, even without committing a new violent act.

Conclusion

Thanks to the Murphy conservatorship, California courts do not face the dilemma of the type that led to ethics charges being filed against two attorneys and a magistrate in Oregon who devised an unusual method of coping with an unrestorable defendant charged with murder. Some may find it surprising that California, which is often perceived as highly patient-rights oriented (the LPS Act revolutionized civil commitment procedures and has been emulated by many states) has this type of law. However, the California legislature and courts have not shied away from passing and upholding relatively restrictive laws regarding criminally convicted persons with mental illness, including a sexually violent predator law[21] similar to those of nearly half the states and a law allowing for the civil commitment of prison inmates with severe mental disorders at the time of parole,[22,23] a rarity in the United States.

Although some forensic mental health professionals may find the Murphy solution ethically objectionable for reasons described earlier, a layperson, hearing that there is a controversy over what to do with someone who is so impaired by mental illness that he cannot be put on trial for a violent crime, yet who is at the same time able to provide for his own food, clothing, and shelter and therefore is not eligible for traditional long-term involuntary commitment, would probably be incredulous at the idea that unconditional, unsupervised release would be considered to be one of the available choices. This attitude may have more to do with the imperfect fit between legal definitions and categories on the one hand and the realities of mental illness on the other, than with any inclination on the part of forensic mental health professionals to release potentially dangerous people. Many professionals have written about the difficulty inherent in attempts at predicting future violence. We do know that among many relatively poor predictors of future violence, the best predictor is a history of past violence. Although an incompetent defendant charged with a crime of serious violence has not been proven through the mechanism of a trial to have perpetrated a violent act, as a matter of probability, it could be argued that the defendant is more likely to commit violence in the

future than someone who has never been charged with a violent crime, all other things being equal.

Faced with the extremely difficult choice of either releasing a person accused of murder or some other serious violent felony or keeping him confined despite the inability to prosecute him, a legal device such as the Murphy conservatorship could be considered the lesser of two evils (i.e., hospitalizing someone who might not be dangerous versus releasing someone who might be). As with sexually violent predator laws, this appeal to public protection and the police powers of the state may go a long way toward explaining why the Murphy law was passed in the first place and why no court has seen fit to overturn it in the 40 years since its passage.

The small number of patients committed under Murphy may provide an explanation for why few other jurisdictions have a specific law to deal with permanently incompetent defendants charged with serious crimes. California is the most populous state and currently has very few patients confined under the Murphy statute, indicating that the circumstances where it is needed are rare. Indeed, some states with lower populations may never have had a case of this type. The Murphy statute was passed at a time of increased attention to mental illness and crime. As mentioned above, at the time the law was created, nearly two dozen people had been murdered by three perpetrators in a single county over a three-year period. This was a few years after the LPS Act had drastically changed civil commitment laws in the state and shortly after *Jackson* prohibited the indefinite commitment of incompetent criminal defendants. Concern about violent patients with mental illness falling through loopholes in the legal system and being released without supervision was presumably high at that time. Similar factors in Oregon led to that state's recent legislative response.

It seems very likely that most patients who cannot be restored to trial competency after extended efforts including enforced medication in a hospital setting will remain sufficiently impaired that they will meet the traditional civil commitment criterion of being gravely disabled and can therefore be placed in a hospital setting without invoking their status as an incompetent criminal defendant as the justification for confinement. Furthermore, judges and juries asked to determine the grave disability of an incompetent defendant may very well be inclined to interpret the "grave disability" term of art in an expansive fashion, relative to patients who do not have unresolved serious criminal charges. That such a scenario occurs is suggested by the studies by Parker[4] and Levitt *et al.*[5]

Nevertheless, it is clear that the match between incompetency to stand trial and grave disability is not perfect, and the *Spinosa* case illustrates how the legal system can be thrown into disarray when there is no means to address the problem. California and now Oregon provide examples of U.S. jurisdictions that address the public policy dilemma posed by an unrestorable criminal defendant charged with a serious violent crime who does not meet traditional civil commitment criteria, without violating the letter of *Jackson*. The California Supreme Court's 1980 decision in *Hofferber*, requiring a finding of present dangerousness, arguably brings the Murphy statute closer to compliance with the spirit of *Jackson* as well, in that the patient is not committed solely on the basis of incompetency to stand trial.

The question of predicting future dangerousness remains an ethically challenging aspect of the Murphy approach, as well as Oregon's §426.701. There is a temptation to argue that the existence of the criminal charge constitutes sufficient evidence of the patient's dangerousness; as we have seen, the language of the Murphy statute does not require any additional showing of dangerousness. Thus, it contains an element of the logical fallacy of arguing from the conclusion: because the defendant is charged with a crime, he is presumed to be dangerous and in need of confinement. The court in *Hofferber* mitigated this to some degree, increasing the burden on the state by mandating additional evidence of ongoing dangerousness, independent of the original criminal charge.

Oregon's new law, while not exclusive to criminal defendants, can and most likely will be used in the context of incompetence to stand trial. It requires some evidence indicating that the patient has been responsible for a serious criminal act, but does not require conviction. Like Murphy commitments post-*Hofferber*, it also requires a showing of present dangerousness. But what if the defendant did not actually commit the crime charged? The Murphy law has no mechanism to establish factual guilt or innocence, such as a trial on the facts as described in the ABA proposal[14] discussed above. Similarly, if Oregon's commitment law for the extremely dangerous is applied in the case of an incompetent defendant, there will be no criminal conviction. Thus, neither law is immune from the risk of a person with mental

illness who is factually innocent of a charged crime being confined in a mental hospital indefinitely, as incompetence to stand trial precludes being acquitted.

Predicting future dangerousness is difficult to do with any reasonable degree of accuracy,[24,25] perhaps especially when attempting to predict rare events such as serious physical assaults and homicides. Given the prejudicial weight that finders of fact (as well as forensic evaluators) might give to serious criminal charges, a mechanism such as a trial on the facts would guard against the risk of indefinitely confining an innocent defendant who cannot be restored to competency. Given that nearly 30 years later no U.S. jurisdiction has adopted any part of the ABA's recommendations in this area,[15] that risk is likely to remain.

The incompetent, unrestorable defendant charged with a serious violent crime poses a significant problem for the criminal justice system and the forensic mental health system, especially when the situation cannot be resolved, at least temporarily, through a civil commitment on grounds of grave disability because the defendant does not satisfy that criterion. The Murphy conservatorship is a legislative attempt to solve the dilemma posed by this type of case. In 2013, Oregon passed a new law that, although it did not specifically address incompetent criminal defendants, was, like the Murphy law, drafted in response to that situation. These types of laws raise their own ethics-related concerns, including the difficulty of making accurate predictions about future dangerousness and the possibility of committing a defendant who did not in fact commit the charged crime. It is hoped that this review will stimulate research in this area and raise awareness regarding the need for other jurisdictions to devise a management strategy for defendants such as Hofferber and Spinosa.

References

1. Rodol L, Epson MF, Bloom JD: Limitations of constitutional protections in *Jackson v. Indiana* pertaining to charges with no statute of limitations. J Am Acad Psychiatry Law 41:114–20, 2013
2. Neil M: Bar drops complaint against DA and defense lawyer over 'undeniably invalid' court order. American Bar Association Journal, September 24, 2013. Available at http://www.abajournal.com/news/article/bar_drops_complaint_against_lawyers_over_unusual_mental_illness_magistrate_. Accessed November 13, 2014
3. Jackson v. Indiana, 406 U.S. 715 (1972)
4. Parker GF: The quandary of unrestorability. J Am Acad Psychiatry Law 40:171–6, 2012
5. Levitt GA, Vora I, Tyler K, *et al*: Civil commitment outcomes of incompetent defendants. J Am Acad Psychiatry Law 38:349–58, 2010
6. Cal. Welf. & Inst. Code §§5000 *et seq* (1967)
7. Calif. Welf. & Inst. Code §5008(h)-(1) (2013)
8. Bloom JD: Thirty-five years of working with civil commitment statutes. J Am Acad Psychiatry Law 32:430–9, 2004
9. In re Davis, 505 P.2d 1018 (Cal. 1973)
10. Parker MW: California's new scheme for the commitment of individuals found incompetent to stand trial. Pac L J 6(2):484, 1975
11. Morris GH: Conservatorship for the "gravely disabled": California's nondeclaration of nonindependence. San Diego L Rev 15: 201, 1978
12. Conservatorship of Hofferber, 616 P.2d 836 (Cal. 1980)
13. Baxstrom v. Herold, 383 U.S. 107 (1966)
14. American Bar Association: Criminal Justice Mental Health Standards, Part IV: Competence to Stand Trial, 7-4.13. Disposition of permanently incompetent defendants. Washington, DC: ABA, 1986, pp 239–52
15. Hoge SK: Commentary: Resistance to *Jackson v. Indiana*—civil commitment of defendants who cannot be restored to competence. J Am Acad Psychiatry Law 38:359–64, 2010
16. Morris GH, Meloy JR: Out of mind? Out of sight: the uncivil commitment of permanently incompetent criminal defendants. U C Davis L Rev 27:1, 1993
17. California Dept. of State Hospitals, Response to Public Records Act Request 14-114, July 1, 2014
18. California Department of State Hospitals. Available at http://www.dsh.ca.gov/hospitals/. Accessed November 13, 2014
19. Bloom JD: Recent changes in Oregon Mental Health Law: mental health law at the boundary of civil commitment and the criminal justice system. Grand Rounds Presentation. Available at http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/grand-rounds/upload/Dr-Bloom_GRNOV-19_CST-2013.pdf/. Accessed November 13, 2014
20. Or. Rev. Stat. §426.701 (2013)
21. Cal. Welf. & Inst. Code §§ 6600 *et seq* (2006)
22. Cal. Penal Code §§2962 *et seq* (2012)
23. Simpson JR, Farhadi P: California's mentally disordered offender law. Am Acad Psychiatry Law Newsletter 37:23:30, 2012
24. Miller SL, Brodsky SL: Risky business: addressing the consequences of predicting violence. J Am Acad Psychiatry Law 39: 396–401, 2011
25. McDermott BE, Scott CL, Busse D, *et al*: The conditional release of insanity acquittees: three decades of decision-making. J Am Acad Psychiatry Law 36:329–36, 2008

Mental Health Commission
Proposed Motion(s)

Meeting Date: January 20, 2022

Motion (original): MHSA-Finance Committee Meeting 1/20/22 (Agenda Item VIII)

MOTION:

Ask Behavioral Health to include the necessary Housing, Treatment, and Services needed for this most vulnerable and highest need population, including:

a. Multi-Service level Forensic and Civil Mental Health Rehabilitation Center (MHRC) treatment and services
b. Multi-level step down housing, treatment, and services