



**STATEWIDE OVERVIEW REPORT 2015:  
DATA NOTEBOOK PROJECT ON  
BEHAVIORAL HEALTH IN CALIFORNIA**

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# DATA NOTEBOOK STATEWIDE OVERVIEW REPORT 2015:

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## Introduction: Purpose, Mandates, and Data Resources

### What is the “Data Notebook?”

The Data Notebook is a structured format for reviewing information and reporting on the behavioral health services in each county. For some questions, the Data Notebook supplied data for each county from public resources (e.g., mental health (MH) data from the External Quality Review Organization<sup>1</sup> and substance use disorders treatment reports from the Cal-OMS group at DHCS). For other questions, we requested that local mental health boards obtain information from their county behavioral health department because there was no public source.

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates<sup>2</sup> to review the local county mental health services and report on performance every year
- function as an educational resource about mental health data for local boards
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate<sup>3</sup> to review and report on the public mental health system in our state.

Every year, the mental health boards and commissions are required to review data about the services for mental health in their county and to report their findings to the CMHPC. To facilitate the reporting, the CMHPC creates a structured document for receiving information. The Data Notebook is organized to provide data and solicit responses from the local advisory board regarding specific topics so that their information can be readily analyzed and synthesized into a report. This CMHPC report informs policy makers, stakeholders and the general public.

The CMHPC serves under the umbrella of the Department of Health Care Services (DHCS) and must fulfill certain legal mandates to report on the public mental health system every year. As part of our reporting mandate, we analyzed all Data Notebooks received in 2014 from the mental health boards and commissions. This information represented 41 counties that comprised a geographic area containing 83% of this state’s population.<sup>4</sup> Our analyses produced the Statewide Overview Report for 2014 that is on the CMHPC website at:

[Statewide Overview Report for 2014 by the CMHPC](#)

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<sup>1</sup> See [CALEQRO website](#) for county level data. Select the Archives folder containing reports for each county MH Plan, or check “New Reports” as available for the most recent year data.

<sup>2</sup> W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

<sup>3</sup> W.I.C. 5772 (c), requires annual reports from the California Mental Health Planning Council.

<sup>4</sup> An additional six counties submitted their documents after our report for 2014 was completed, for a total participation rate of 84%, including 47 counties in partnership with their local advisory boards.

Other recent reports from various committees of the CMHPC can be found at:

[CMHPC Annual Reports](#)

Our overall goal is to promote a culture of data-driven policy and quality improvement in California’s behavioral health services and to improve client outcomes.

**Data Resources for the Data Notebook**

Some questions requested input from members of the local boards. Their experience and perspectives as stakeholders are valuable and that is one reason these boards exist. Most important, stakeholder input is taken into account by legislators, agency policy makers, and local governments when they designate funding and implement programs. Most other data and information for the Data Notebook was available from a variety of local county sources, such as:

- Director, Department of Behavioral Health or Mental Health
- Administrator for Alcohol and other Drug Programs
- Quality Improvement Coordinator
- Mental Health Services Act (MHSA) Coordinator
- Cultural Competence Coordinator or committee

Data about local specialty MH services could be found in reports from the external quality review organization (EQRO) ([CALEQRO website](#)) in the “Archives” file for “Reports,” by selecting the most recent “EQRO MHP Report” for a specific county. “Appendix D” of the county report provides detailed numbers about demographics of clients served and numbers who received different types of services. The “Information Systems Review” section may be consulted for an estimate of the percent of clients with serious mental illness (SMI) who also have substance use disorders (SUD).

Finally, we were able to obtain a new resource from DHCS for substance use disorders treatment data to share with the counties and their local advisory boards. These data were made available for publication by their research group at the Office of Applied Research and Analysis after review by the DHCS office charged with protecting patient privacy and HIPAA compliance.

We customized each Data Notebook report by placing the data specific to each county within the substance use disorders section, followed by discussion questions on this topic. Statewide reference data was presented so that it could be compared to the information for each county. We also included a county data page with a few basic

statistics on specialty mental health, numbers of Medi-Cal eligible beneficiaries, and overall county population. These data were taken from the most recent EQRO reports that were publically available on April 23, 2015.

## **Strategies for Completing the Data Notebook 2015**

California has made substantial strides in integrating mental health treatment with substance use disorder treatment. This Integration is still a work in progress in most counties. The data systems are largely separate entities as are the treatment and billing systems for mental health and substance use. However, a major statewide priority is to coordinate services for individuals across different systems of care.

Additionally, in terms of resources to meet the needs of individuals experiencing a mental health crisis, some counties have inpatient facilities and/or crisis response teams. Some counties have just one such resource available and some have none.

In consideration of the diversity among the counties, their resources and different systems of care, we presented topics covering two critical issues for review by the local advisory boards in this year's Data Notebook. The local advisory boards, in partnership with their respective county departments, were asked to discuss and answer questions for these topics:

- A. Strategies to Meet the Needs of Persons Experiencing Mental Health Crises: Treatment Options and Alternatives to Locked (Involuntary) Facilities
- B. Integrated Care: Treating Individuals with both MH and SU Disorders

We thank all the county departments of behavioral health who assisted the local advisory boards by providing data and key information about resources, programs and unmet needs in their local community. We also deeply appreciate the work and thoughtful discussion prepared by local advisory boards and commissions. Due to all these efforts, we achieved a total county response rate of just over 86%.

## **Methods for Development of Study Design, Data Collection and Analysis**

The selection of topics and development of the Data Notebook arose from ongoing discussions with members of local advisory boards, the California Association of Mental Health Boards and Commissions, the Mental Health Planning Council members, and consultation with individual county Directors of Behavioral Health. These efforts built on the prior year's Data Notebook work group and stakeholder process. The data analysis for the "checkbox" survey items was comprised of descriptive summary statistics. However, analysis of the open-ended survey questions was devised after the fact and

implemented in consideration of the variability of the data submitted, in that the responses represented the diversity of counties statewide.

This year, a greater number of boards (and increased numbers of members) reported that they actively participated in reviewing their data and assisted in adding significant qualitative input, especially regarding local needs. Of the 50 reports received to date, 33 were completed mostly or completely by county staff and/or the Director. Another 4 reports were completed mainly or entirely by advisory board members. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff. A few groups had input from county alcohol and drug treatment services and/or input from a separate alcohol and drug advisory board.

Of the 50 reports received, 29 had been placed on the agenda for discussion at the local MH/BH advisory board meeting and presented for final approval. Such review at the local board meeting is a minimum requirement for meeting state mandates for local MH boards to review data about local mental health needs and services.

This year, at least 12 local boards went beyond collaboration with their county departments in that they developed ad hoc committees or special work groups for this project. These groups subsequently presented their input and the final version of the Data Notebook to their executive leadership and their full board. We recognize these as exemplary practices that produced an excellent final product.

In summary, we received **50 Data Notebooks** that represent data from **52 counties**. These reports reflect information from a geographic area containing **99.4 %** of the state population. Counties that submitted Data Notebooks during 2015 are listed in Table #1 (next page), grouped by size of population. These counties comprise the data set analyzed for the synthesis presented in this Statewide Overview Report for 2015. All these Data Notebooks contribute meaningfully to our efforts to improve the quality and accessibility of services and to promote better behavioral health outcomes for all Californians.

## Table 1. Data Notebook 2015 Summary of Report Progress

Received Reports: (50 reports, covering 52 counties)<sup>5</sup>

<b><u>Small<sup>6</sup> population:</u></b> <b><u>(23 counties)</u></b>	<b><u>Medium:<sup>7</sup> (15 counties)</u></b>	<b><u>Large:<sup>8</sup> (14 counties)</u></b>
Alpine	Butte	Alameda
Amador	Marin	Contra Costa
Del Norte	Merced	Fresno
El Dorado	Monterey	Kern
Glenn	Placer/Sierra	Los Angeles
Humboldt	San Luis Obispo	Orange
Imperial	San Joaquin	Riverside
Kings	Santa Barbara	Sacramento
Lake	Santa Cruz	San Bernardino
Lassen	Solano	San Diego
Madera	Sonoma	San Francisco
Mendocino	Stanislaus	San Mateo
Modoc	Tulare	Santa Clara
Mono	Yolo	Ventura
Napa		
Nevada		
Plumas		
San Benito		
Shasta		
Siskiyou		
Sutter/Yuba		
Trinity		

<sup>5</sup> Sutter and Yuba counties are combined into one Mental Health (MH) Plan, as are Placer and Sierra counties.

<sup>6</sup> Counties with populations less than 200,000.

<sup>7</sup> Counties with populations between 200,000 and 749,999.

<sup>8</sup> Counties with populations of 750,000 and greater on January 1, 2015.

## Strategies to Meet Needs of Persons Experiencing a Mental Health Crisis

### Treatment Options and Alternatives to Locked (Involuntary) Facilities

While every effort is made to notify Californians of the availability of services and to encourage individuals to seek services early, sometimes a crisis occurs and immediate intervention is needed. In a worst case scenario, law enforcement is called to respond. However, in a better case scenario, a multi-disciplinary team, that includes a mental health professional and a peer, will meet with the individual in crisis. The toll and costs of hospitalizations and incarceration of individuals experiencing a mental health crisis are high on both the individual and public system. Many counties have implemented diversionary programs to help persons in crisis manage the situation, de-escalate their symptoms and recover without having to enter an institution. The strategies for MH crises, however, are not necessarily the same as for persons with an SUD-related crisis (including but not limited to overdoses). The urgency for immediate triage may vary with the person, the clinical situation, and other factors.

### The Need to Provide Urgent Care for Serious Mental Illness in Our State

National statistics<sup>9</sup> for the prevalence of serious mental illness show that in California, there was an average of 1,103,000 persons<sup>10</sup> with severe mental illness per year during 2012 and 2013. A larger population is represented by those with “any” mental illness, which was 5,278,000 per year<sup>11</sup> during 2012 and 2013 in California, and includes those with mild to moderate as well as severe mental illness.

For comparison, in 2013 California’s public mental health system<sup>12</sup> served nearly 490,000 persons with serious mental illness (or serious emotional disorders, children<18) out of approximately 10.5 million Californians who received Medi-Cal.

While all of those numbers are very large, only a small fraction needed MH crisis services or psychiatric hospitalizations in any given year. At this time, statewide data on the numbers of Californians who experienced a MH crisis last year are not available.

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<sup>9</sup> SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2012. For details on methods, see Section B of the “2011-12 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology,” at <http://www.samhsa.gov/data/population-data-nsduh/reports?tab=33>.

<sup>10</sup> 95% confidence interval: 942,000 – 1,290,000.

<sup>11</sup> 95% confidence interval: 4,902,000—5,676,000

<sup>12</sup> [CALEQRO website](#), data for CY 2013 (calendar year) from Appendix D tables of archived MH Plan reports for FY 2013-14. For general comparison, CA state population was 38,357,121 on Jan 1, 2014, according to CA Department of Finance tables.

We sought to identify resources and options that are available to promote treatment and services in the least restrictive environment that will help individuals experiencing a MH crisis to stabilize and move toward recovery. We bear in mind that the concept of MH recovery may be different than that for SUD treatment. The goal of this project was to highlight effective programs that meet this essential need on the continuum of services. Effective programs are an excellent way to reduce institutionalization and recidivism, reduce stigma and reduce costs allowing those savings to be used in other areas of the service system. By sharing information about programs with a promising track record, we seek to promote programs of quality, excellence and effectiveness.

## **Continuum of Care for Serious Mental Illness in our Communities**

Psychiatric hospitalization services are sometimes necessary, but not all counties or communities have local access to such facilities for adults and even fewer have any type of psychiatric hospital services for children and youth under 18. In order to get a full picture of the services available in each county, we asked for information about the types of acute care psychiatric facilities as well as alternatives to hospitalization.

Some basic definitions of terms and common abbreviations<sup>13</sup> may be helpful to here. Some of the entities and services described below may have partially overlapping functions but have different licensing or personnel requirements or designated funding sources.

IMD: refers to Institutions for Mental Diseases, an older term that implies longer term care for those with severe psychiatric illnesses and other mental health impairments.

PHF: Psychiatric Health Facility means a facility that provides therapeutic and/or rehabilitative services on an inpatient basis to clients who need acute psychiatric care and which meet specific criteria under the regulations.<sup>14</sup> The client's physical health needs should be able to be met on either an outpatient basis or by a general acute care hospital which is affiliated with the PHF. The services of a PHF are different from those categorized as a "Psychiatric Inpatient Hospital."

Psychiatric Inpatient Hospitals provide acute inpatient services for clients who need a level of psychiatric care that is medically necessary to diagnose or treat a covered

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<sup>13</sup>Many of these descriptions are defined in the Performance Outcomes System Measures Catalog: Methodology and Measures Definitions, Department of Health Care Services, February 17, 2015.

<sup>14</sup>"Psychiatric Health Facility" means a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations and which provide services to beneficiaries who need acute care under the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations.

mental illness. These facilities also provide administrative day services, which are inpatient hospital services provided to clients who are ready to move to a less intensive level of care but are awaiting residential placement options. Services at these facilities are covered under Short/Doyle Medi-Cal or Fee-for-Service Medi-Cal, or private insurance. Technically, state hospitals are also psychiatric inpatient hospitals but at the present time they are utilized less often for civil commitments than for forensic commitments (for clients having criminal system involvement).

SNF with PTP: Skilled Nursing Facility that also has the capacity to provide some limited psychiatric treatment program services for their clients.

Licensed adult residential facility for “Board and Care,” either with or without additional mental health-related services. There are a variety of other supported housing services with different licensing and funding sources, and include SLE, sober living environments for those recovering from mental health and substance use disorders.

Crisis Stabilization Unit (or Team) (CSU) provides services that last less than 24 hours, and are for a client that needs a more timely response than a regularly scheduled visit. Services may include assessment, therapy, or “collateral,” which addresses the client’s MH needs to ensure coordination with significant others and treatment providers.

Crisis Intervention Services (or Teams) (CIT) also provide services that last less than 24 hours for clients who require more timely response than a regularly scheduled visit. Services may include assessment, therapy, or “collateral,” which addresses the client’s MH needs to ensure coordination with the client’s designated support system. These services may be provided face-to-face or by telephone with the client, or with the client’s designated significant support system. Services may be provided anywhere in the community including the client’s place. In some communities the CIT may include a member of law enforcement who has been trained to participate in crisis intervention.

Crisis Residential Services (CRS) or Units (CRU): provide an alternative to acute psychiatric hospital services for clients who otherwise would need hospitalization. The CRS/CRU programs for adults provide normalized living environments integrated in residential communities. The services include case management and referrals to other social services, follow a psychosocial rehabilitation model (including milieu therapy), and may integrate aspects of emergency psychiatric care as needed. Generally these units are intended for adults, but some communities also have special crisis residential units designated for older adolescents and transitional-aged youth (young adults).

Adult Residential Treatment Services: occur in a non-institutional residential setting to provide rehabilitative services for those clients who would be at risk of psychiatric hospitalization or other institutional placement if they did not receive such services. Services and programs are designed to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. Therapy, case management and linkage to other social services or to primary health care are provided.

Assisted Outpatient Treatment (AOT), “Laura’s Law”: provides outpatient medication and therapy under certain conditions to selected individuals. A variation on this type of program is IHOT, In-Home Outpatient Treatment, which is deemed less coercive and more respectful of an individual’s self-determination, by seeking voluntary cooperation and acceptance of the medication and therapy program.

Respite Care: A form of short-term crisis residential care for up to 14 days provided in a homelike setting for clients who can largely take care of themselves but need a temporary place of safety so that they can resolve an acute emotional crisis, perhaps by temporarily removing themselves from a precipitating situation in their customary home. In some cases a crisis stabilization unit or crisis residential unit may set aside one or more beds for such respite care.

Next, we list each of the questions asked of the local advisory boards and their departments of behavioral health in this year’s Data Notebook. After each question the responses are summarized in either tables or brief discussions. Some responses received under the “other” option fit the intent of categories listed in the question and were appropriately re-coded.

In those cases for which open-ended questions were asked, in addition to the brief summaries, county-specific information is listed in a related Data Appendices as a companion to this document. A copy of the Data Appendices can be requested but is not included with this report due to the size. Many or most counties have implemented great programs, often with local variations, but there are too many to describe adequately in a summary report. The Data Appendices are intended to provide access to the county-level information as a creative resource for stakeholders and staff in other communities. Such information may provide opportunities for regional-level collaborations and shared solutions.

## How Our Counties Meet the Needs of Persons in Mental Health Emergencies

**1. Do you have these types of facilities in your county? Please check all that apply. Please mark ‘Other’ (and describe) if your county contracts for beds outside of your county.**

The right-hand column shows the number of counties that selected a specific response.

<b>Types of Facilities or Services</b>	<b>#Counties</b>
Psychiatric hospital beds	33
IMDs (Institutions for Mental Diseases, used often for placement of MH clients who are under conservatorship and others)	26
PHFs (Psychiatric Health Facilities)	22
Skilled Nursing Facility (SNF) with Psychiatric Treatment Program	15
State Hospital beds	17
Other	10
None of the above	12

‘Other’ options offered by counties included:

- Mental Health Rehabilitation Facilities: 2
- Adult Residential Facilities: 1
- Residential Care Facilities for Elderly: 1.
- Out-of-county placements for children, adolescents, and/or TAY under 18: 2
- Unspecified as to type: “beds as needed”: 4

The note for only 2 counties listing outside contractors (mainly out of county) for children and youth under 18 is clearly an under-estimate, as there are few counties which have acute care psychiatric hospitalization facilities for this age group available within the county. The question did not ask respondents to differentiate between adults and minors, so the responses would be unlikely to provide a complete picture regarding children and youth under 18.

**2. If you do not have any of the above facilities in your county and you have a need that goes beyond crisis intervention, how do you handle a need for a longer term hospitalization (14-90 days)?**

The right-hand column shows the number of counties selecting a specific response.

<u>Type of Service or Facility</u>	<u>#Counties</u>
Transport to out-of-county psychiatric care facility	30
Licensed adult residential facility (board and care home) that receive extra funding from the county (or placing agency) for additional MH-related services	16
Crisis intervention services (includes triage or mobile crisis teams)	14
Other	7
Does not apply	17

The responses under “not applicable” came from those counties whose options were listed previously for Question #1. The responses to “Other, please list” indicate that this question could have included some additional options.

- Finding treatment for children is a major concern, for large and small counties (children’s wait time for beds prolonged in Emergency Departments: 2.
- Board and Care (6-beds with one bed dedicated to respite care up to 14 days): 1.
- Although IMD, psychiatric and state hospital facilities are located within county, competition with other counties results in clients being sent out-of-county: 1.

**3. What alternatives to a locked facility do you have for those experiencing an immediate MH crisis? Please check all that apply.**

The far right-hand column shows the number of counties that selected a response.

<b><u>Crisis Service, Program, or Facility</u></b>	<b><u>#Counties</u></b>
Mobile Crisis Intervention Teams or other Crisis Intervention Program (have or currently developing)	33
Licensed adult residential facility (board and care home) that receives extra funding for additional MH-related services	28
Crisis Stabilization Unit Services (23 hours)	27
Crisis Residential Treatment facility	27
Transport to another county for treatment	24
Assisted Outpatient Treatment (AOT) teams (Laura’s Law type programs)	13
Transport to another state for treatment	4
Crisis Triage Teams, which may be embedded in Hospital Emergency Department, or homeless shelters/service centers, etc.	3
Other	24

A variety of options listed under “Other” included the following resources, services, and programs. Some may provide similar programs but under slightly different names or with different specifications to meet local needs and/or licensing requirements.

- MHSA FSP services for those individuals who qualify: 2
- Respite Housing options and/or peer-run respite center: 2
- Board and Care: 2 (one of which has a dedicated 14-day ‘respite’ bed)
- Trainings for CIT teams involving law enforcement and multiple agencies: 2
- Transitional Housing: 1
- Contracted agency for homeless services (housing) and recovery innovations (peer-run program): 1
- Outpatient Treatment alternative (RBEST) funded by MHSA: 1
- Crisis drop-in center for those not meeting 5150 criteria: 1
- Crisis Response Line (24-hr): 1
- Comprehensive Children and Family Support Services (CCFSS): 1 (includes a continuum of wrap-around services for children and youth).

**4. Does your county have a MH court, jail diversion program, or similar mechanism to help individuals whose MH crisis or illness contributed to their involvement with the criminal justice system? Please check all that apply.**

The right-hand column shows the number of counties that selected a specific response.

<b>MH/BH Alternatives in Criminal Justice System</b>	<b>#Counties</b>
Re-entry programs with MH/BH services to assist persons released into the community after leaving a correctional facility (e.g. programs funded by AB 109, Proposition 47, or related services)	42
Drug Court (some counties have combined these into “problem-solving courts”), includes “co-occurring disorders court”	38
MH court	35
Jail diversion program (a court-ordered MH program where client avoids jail); includes “deferred entry of judgment” programs	21
Veterans Courts	3
None of these options	3
Other	19

“Other” resources and programs included variations on the already defined options, as well as some specific services or linkage to needed services.

- Full Service Partnership programs: 2
- County is developing Laura’s Law assisted outpatient treatment program: 2
- Probation Youth Reporting Centers (diversion day program): 1
- Commercially Sexually Exploited Children (CSEC) Court: 1
- MH clinician embedded in probation department to assist persons with connection to MH services: 1

- In-custody MH services for adult facility and 3 staff at Juvenile Hall, to provide medication support, individual and group counseling, crisis intervention and other support services including a bilingual jail discharge planner, and link those in need to ongoing MH treatment and to eligible services such as Medi-Cal, Social Security, or temporary housing, etc.
- Juvenile Justice MH Program that is stationed on the same campus as Juvenile Commitment Center; this program makes contact with minors in custody for evaluation and to ensure follow-up at release for those with MH issues.
- Crisis Counselors in jails, (re-entry AB 109): 1
- Inmate Discharge Medication Program, which involves a social worker who focuses on jail discharge planning and arranges with a local grocery/pharmacy to partner with the Rx program for released persons.
- One county contracts with CIBHS for Moral Reconditioning Therapy (MRT) training and consultation, a specific type of cognitive behavioral therapy program for substance use treatment and criminal justice offenders. Training is attended by those who work in youth and young adult services, adult services, and the probation department. Also, rehabilitation technicians assist consumers with linkage to applicable services: shelter, clothing, food baskets, SSI/SSA benefits, Section 8 housing, referrals to substance use treatment, physicians, dentist, driver's license and/or immigration paperwork.

**5. Creative Solutions. Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?**

The numbers below indicate the number of counties that selected a specific response. A summary of some programs described under “yes” option is provided below. Detailed answers for ‘yes’ are shown in the Data Appendices.

No	16
Yes	33

Every county has approached MH crisis services a little differently, but the common theme is commitment to meeting the client’s needs “wherever the client is”, meaning not only the client’s location, but at whatever stage of recovery the individual is experiencing. No summary can do justice to the variety of programs and strategies

implemented by many counties. Details are listed in the Data Appendix for those counties who supplied their information. Upon review, it appears that a number of counties which answered “No” to this question actually had developed fairly innovative approaches as described in their answers to prior questions.

### Crisis Teams and MH Triage Workers

Many counties have implemented mobile Crisis Response Teams. Some have Crisis Intervention Teams that incorporate a member of law enforcement specially trained to assist in a psychiatric emergency along with the MH personnel. And some crisis teams include trained peer specialists or peer mentors. A number of counties place a MH Triage worker in local emergency departments or in a walk-in clinic that may be part of a Wellness Center or Behavioral Health clinic (e.g., Lake County, San Bernardino County).

### Respite Care

Some counties, such as Trinity County, have created respite care units, which may have designated beds that are part of, or associated with, a crisis stabilization unit or crisis residential facility. A different variation on respite care was developed by San Francisco as The Hummingbird Place, a peer-designed and managed respite care facility with a home-like setting and feel. A number of counties specifically mentioned funding from SB 82 helped them develop their own strategies to assist clients in crisis.

### MHSA and other State-funded Programs

Other counties cited MHSA funding for Full Service Partnerships (FSP), Innovation programs, or Prevention and Early Intervention programs. Some, such as Shasta County, are using Full Service Partnership services to assist individuals as they transition from crisis stabilization or hospitalization to community living, or to avoid hospitalization altogether. One program in Placer-Sierra counties was designed as a co-occurring disorders FSP program. A few counties listed MH care and assessment in Jail or Juvenile Detention for youths and others, as part of a pre-release program to link individuals to the MH and SUD treatment services, physical health care, or social services, as needed (AB 109 funded programs).

### Crisis Needs of Children and Youth Served Separately from Adults

San Joaquin County described several strategies to assist children and youth in crisis. They have separate adult and juvenile mobile crisis stabilization teams, a Crisis Bed program for juveniles with MH crises and who have run away or are at risk, in-home therapy and other services to juveniles, and a 24-hr crisis line. Also, the county is building a voluntary CSU with facilities for children and youth as well as adults.

San Bernardino also has implemented a Crisis Residential treatment program for transition-aged youth, developed with MHSA Innovation funds.

### Regional Collaboration Between Counties

Some programs seemed especially innovative in the way they developed collaborative relationships with other agencies or counties. Madera County entered into a partnership with four other central valley counties to develop crisis residential beds in Merced through funding from SB 82.

### Inter-Agency Collaborations to address a County's Homeless Problems

Through the collaboration of at least nine county agencies and several faith-based and private industry groups, Yolo County implemented an ambitious Bridge to Housing (B2H) Program to assist 71 long-term homeless persons move from a river encampment to temporary housing (including their 47 dogs and 22 cats). Residents were provided with 90 days of short-term housing, assistance with job training, health insurance, disability benefits applications and one year's free cell phone service. Links to various services were designed to help these clients transition to longer-term housing. Yolo County is also in the process of developing a Homeless Court for problem-solving similar to MH and Drug Courts.

## **6. Prevention. Does your county have any programs implemented specifically as alternatives to locked facilities that haven't been addressed above?**

This is an open question that could include MHSA-funded programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). Other strategies could engage public and private partnerships, regardless of funding source.

The right-hand column shows the number of counties that selected a specific response. Some of the responses for 'Yes' answers are discussed in the summary which follows. A detailed listing of county-level information is provided in the Data Appendices.

No	5
Yes	44

The types of programs described in response to this question tended to overlap with those listed for the previous question. However, few counties listed the same program(s) twice in response to this second question, but instead described additional programs or services.

The responses generally focused more on Prevention and Early Intervention programs, increased numbers of Wellness Centers, and more FSP programs. More counties specifically described outreach to groups historically underserved based on race/ethnicity, or persons for whom English is not their primary language, and an emphasis on outreach and services for transition-aged youth (TAY).

Again, no summary can do justice to the rich variety of programs and strategies implemented by the counties who supplied information for this question. Details are listed in the Data Appendix for each county who answered in the affirmative.

### Diverse Approaches for Prevention and Early Intervention Programs

At least 25 counties described some type of prevention and early intervention program (PEI) for psychosis, under various names: MHSA-funded PEI programs, Mental Health Block Grant or SAMHSA-funded First Episode Psychosis (FEP) treatment programs, Prevention and Recovery in Early Psychosis (PREP) programs, and the Portland Identification and Early Referral (PIER) Model, an evidence-based treatment program.

- Sacramento and Placer-Sierra Counties are using the UC-Davis EDAPT or Sac-EDAPT model programs that involve training to recognize signs and symptoms associated with major mental illnesses in young populations. Those programs link individuals to Turning Point Community Programs, which is contracted to provide early intervention and treatment for those identified as being at high risk.
- Del Norte County's new perinatal program provides services to new mothers and families at risk of crisis.

### Mobile Teams and Crisis Workers

A variety of other resources play important roles in counties' efforts to help those in crisis avoid hospitalization and to remain in their communities. At least 13 counties described having Mobile Crisis teams, CIT teams or new MH Triage workers that are funded by SB 82, The Investment in MH Wellness and Recovery Act of 2013.

### Housing Supports, Longer-Term Residential Treatment, and Coordination with FSP

Another 5 counties listed housing supports or long-term residential treatment. FSP program services were listed as part of several counties' strategies to help adults and youth in crisis and provide support to those who were homeless or at risk of becoming homeless.

- One example is the Odyssey Team of Marin County that serves those who are homeless or at risk of becoming homeless, one of several FSP teams. Another county team, “Support and Recovery after Release” (STAR) team helps those at risk for incarceration or re-incarceration. Two other FSP teams focus on the needs of Transitional Aged Youth.
- Amador County and many others have developed a permanent supportive housing program with funding provided by the MHSA.
- Nevada County runs the Odyssey House, a 10-bed adult residential program that is staffed 24/7, another example of a program supporting better client outcomes.

### Expanded Role for Wellness and Recovery Centers

More wellness centers were added or more services were offered at existing wellness centers to assist clients in crisis in at least six counties.

Some small-population counties use specialized approaches to reach out and engage potentially underserved groups.

- Lake County has four Peer-Guided Wellness and Recovery Centers (Native American, Latino, Adult, and TAY) to assist community members with wellness and recovery programs and referrals to reduce the possibility of crisis and for post-crisis services. These community centers are in addition to mobile crisis workers, PEI services, suicide prevention task force, and outreach crisis workers that go into the community.
- Glenn County also has different wellness centers to serve adults, TAY, a center for Week-end Wellness, and a Transitions Learning Center.
- Lassen County has opened the Renaissance Center for Transitional-Aged Youth to prevent first-break psychosis.

### **What Resources are the Top Priorities to Address Unmet Urgent Needs?**

**7. Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.**

**Compilation of answers for each of the three age groups listed, plus an “all populations” option for needs which apply to several groups.**

### **Unmet Needs for Children and Youth <18:**

Difficult to find psychiatric inpatient facilities or psychiatrist services.

Lack of group home Residential Care Level 14 facility in-county.

Increase child psychiatrists, increase local inpatient beds, increase MH staff.

No crisis facility or hospital in county, also need more Spanish bilingual staff.

Increase use of Evidence-Based Practices and work with CiBHS to increase Evidence-Based clinical services for children and families.

Increase child psychiatry, increase local inpatient beds, increase MH staff .

All 5150 evaluations occur in our sole hospital ED; but for children and TAY we do our best to rally their natural supports and then provide support to those systems.

Children inpatient psychiatric hospital beds; now they go out-of-county.

CSU for children to meet urgent needs.

Need psychiatric beds for children under 12.

Identification and treatment of sexually exploited children, with ongoing collaboration of CPS, courts, and probation department.

Lack of any 5150 placements, including PHFs or IMDs in-county which accept juveniles.

Crisis residential treatment.

Crisis Stabilization Unit to meet the unique needs of this age group.

No psychiatric inpatient beds in county.

No local acute hospital options for minors.

In-county hospital treatment lacking.

### **Unmet Needs for Transitional-Aged Youth (age group 16-25)**

Youth need a less dramatic environment to go to for a hospitalization than the PHF.

Need better skills/training than county FSP teams have for working with youth; also could use an intensive treatment program like EDAPT for early onset thinking disorders.

Safe and affordable housing for TAY.

Lack housing and supportive services for emancipated foster youth or problem youth ages 18-25. Lack of safe and affordable housing is major barrier for TAY population who need supports for their recovery.

Supportive housing options.

Limited number of programs (only 5) in N. CA for Board and Care or transitional living.

Increased demand for TAY services in county.

Crisis Stabilization Unit to meet the unique needs of this age group.

Crisis residential placements for youth.

Increase crisis stabilization services and crisis residential for TAY; increase capacity.

More effective outreach to teens & TAY for our great programs.

Acute need for crisis residential and respite services for youth < 18.

Psychiatric bed shortage, clients sent out-of-county; need 23hr crisis stabilization unit & crisis residential facility; both would help to avoid hospitalization and assist with step-down services post-hospitalization.

No crisis unit or psychiatric hospital in county, also need more Spanish bilingual staff.

Lack of youth crisis residential treatment programs, lack of group home RCL level 14 facility in-county, lack of youth psychiatric hospital beds.

Difficult to find psychiatric inpatient facility, or psychiatrist services, also need a CSU.

Need to develop a supported housing plan and also address needs for persons under the influence who need a "sobering crisis station" as in some other counties.

Identification and treatment of sexually exploited youth, with ongoing collaboration of CPS, courts, and probation department.

### **Unmet Needs for Adults:**

Crisis help for people experiencing emotional instability that does not result in suicidal or homicidal tendencies but are still fraught with anxiety, depression, mania, and/or obsessive thoughts. In our county, only physical safety is addressed.

Lack of adult Crisis Residential treatment programs, lack in-county IMD or state hospital beds, lack SNF beds, lack field crisis mobile teams, shortage of county psychiatric adult hospital beds.

Difficult to find psych services, need a CSU or respite center to avoid hospitalization; would consider developing a regional resource for a CSU.

Need to develop a new housing plan for supported housing; also our county currently has no services for people under the influence and is exploring "sobering crisis stations" as in other counties.

No crisis facility or psychiatric hospital in-county; the ER is for temporary 5150 holds until transport out-of-county. Need more Spanish-speaking bilingual staff for our large Latino population.

All 5150 evaluations occur in our one hospital ED; depending upon which ED doctor is on duty, meds can sometimes be administered to adult patients who are willing.

No inpatient psychiatric facility or IMD in our county, no mobile crisis, no CSU, no transitional housing for released offenders with BH issues. (These apply across all adult and youth age categories).

Need for integration of response to 5150 assessment between our Mobile Crisis Response Team and ED. Also, significant unmet need for comprehensive treatment of psychotic disorders in all age categories in our community, need a program like the SacEDAPT program at UC Davis (from a northern county not adjacent to Sacramento).

More culturally-competent outreach within communities about MH & SUD treatment services available.

Current unmet need for crisis serve to increase hospitalization rates and ER use.

Transportation in hospitalization; respite care as alternative to hospitalization.

In-county shortages of PHF beds for adults and of Board and Care beds.

Shortage of inpatient beds in county; large homeless population but insufficient services, such as forensic psychiatry for "incompetent to stand trial" (IST) population and services for released offenders with MH issues.

Safe and affordable housing for adults, both female and male.

Need a peer respite facility.

Outpatient case management; supportive housing; additional Crisis Stabilization Unit and Crisis Residential Unit should be available to other regions of county besides the county seat.

**Unmet Needs for Older Adults:**

Needs for the increasing number of elderly adult mentally ill plus homeless population. Available resources are extremely limited. Services needed include food, clothing, shelter, medical care, benefits assistance and linkage to community services.

Lack of transitional housing, long wait time and lack of beds in county, and no crisis residential treatment or 23-hr crisis stabilization services locally.

Need to contract with a hospital to open a geriatric psych unit for elderly psychiatric hospitalization, especially for those who also have medical needs.

Lack of in-patient beds in-county for older adults with co-occurring dementia or significant physical health needs.

Need in-county resources for psychiatric beds/hospitalization, further development of our crisis drop-in center, and need to work more closely with Law Enforcement. We have very limited resources with our 2 ERs in a rural county.

Community-based crisis treatment for older adults who are isolated, depressed, and at-risk of suicide.

Problem with opioid dependence in seniors; need treatment for those with dual diagnosis or co-occurring disorders.

Peers for seniors with MH issues and outreach to seniors, especially 'shut-ins.'

No geriatric specialty MH inpatient services in county.

Elderly Medicare clients are sometimes not accepted into local Psychiatric Hospital because beds are occupied by out-of-county clients—hence, a lack of capacity.

**8. If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?**

**Priorities listed may apply to one age group, several groups, or to all stages of the lifespan.** These priorities included many of the needs identified under the responses for Question #7.

<b><u>Priority Resource Needed</u></b>	<b><u>#Counties</u></b>
PHFs, psychiatric hosp. beds, IMD beds, SNF, MH Urgent Care	<b>13</b>
Crisis Residential Services/ Facilities	<b>10</b>
Crisis Stabilization Unit Services (23-hour)	<b>9</b>
Supportive housing of any type, including Sober Living Environments (SLE).	<b>9</b>
Respite Care, Peer-respite care and/or Drop-in centers (24 hr)	<b>6</b>
More case management services and/or 'wrap-around', transitional assistance, services to help homeless.	<b>5</b>
Mobile Crisis Unit and/or PERT (Psychiatric Emergency Response Team)	<b>4</b>
Increased number of psychiatric appointments/services	<b>4</b>
MH personnel, all types including RNs, psychiatrists, peers.	<b>4</b>
More training of MH staff to be qualified to treat AOD disorders	<b>3</b>
Detoxification (medical) unit/facility and temp. sobering stations	<b>3</b>
Dual Diagnosis residential treatment programs	<b>2</b>
Assisted Outpatient Treatment (Laura's Law) or AOT	<b>2</b>
MH Triage Teams	<b>2</b>
More bilingual MH staff or clinicians	<b>2</b>
Eliminate exclusions of IMDs and limitations by managed care for geographic regions	<b>2</b>
More FSP programs or "FSP-like" services.	<b>1</b>

## Integrated Care: Treating Individuals with both MH and SU Disorders<sup>15</sup>

### Understanding the Scope of the Problem using National Statistics

We show examples of national data from the NSDUH<sup>16</sup> survey to give perspective on the mental health and substance use data for our state. Many experts believe these data are an under-estimate of the true scope of the problem. All figures in this section are from the NSDUH survey report. We ask: how many people are affected by these disorders?

The report describes adults who had any mental illness, or a substance use disorder, or both problems in the U.S. during 2013, the most recent year for which there are reports.

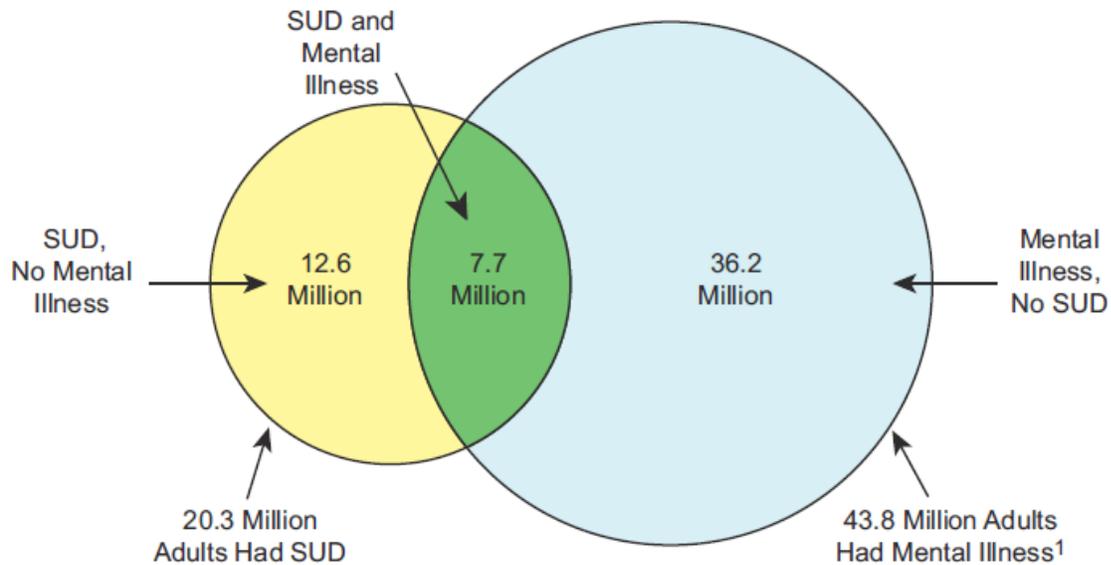
- A total of 43.8 million adults had a mental illness. Of that group, 7.7 million (17.5 percent of total) also had a substance use disorder. But, in contrast, only 6.5 percent of adults without any mental illness had a substance use disorder.
- Among the 20.3 million adults with substance use disorder, 7.7 million (37.8 percent) also had a mental illness.

Figure 1. Past Year Substance Dependence or Abuse Co-Occurring with any Mental Illness among Adults Aged 18 or Older in the U.S., 2013.

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<sup>15</sup> SU = substance use. SUD= Substance use disorders, referring to problems with abusing drugs, alcohol, or both. Drugs refer to both illegal substances and prescription drugs used for purposes other than those legally prescribed or intended. See [National Institute on Drug Abuse website](#) for more information.

<sup>16</sup> **NSDUH:** The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence and patterns of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. population. See “Results from the 2013 NSDUH: Mental Health Findings,” at: [Results from 2013 National Survey on Drug Use and Health](#)

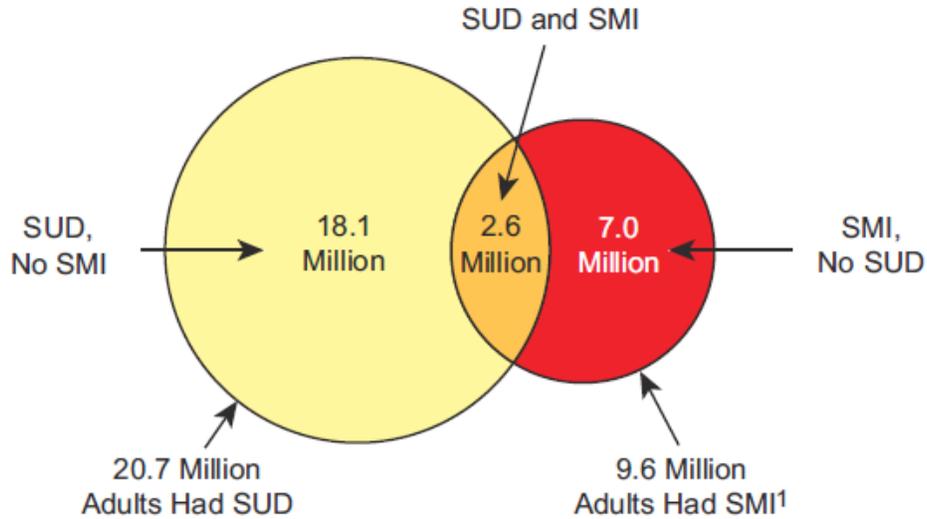


SUD = substance use disorder.

The problem is even more serious as we consider the risks for those with serious mental illness (SMI), a subset of those with “any” MH disorder shown above. So let us focus on the seriously mentally ill sub-group of the overall mental health population.

The following data are also taken from the NSDUH report cited above. For the 20.7 million adults in the U.S. who had a substance use disorder, 2.6 million (12.6 percent) also had serious mental illness (SMI). (The numbers for total persons with SUD and SMI differ slightly between this figure and the preceding one due to statistical modeling and the effects of rounding on estimates).

Figure 2. Serious Mental Illness and Past Year Substance Abuse or Dependence Among Adults Aged 18 and Older in the U.S., 2013.



SMI = serious mental illness; SUD = substance use disorder.

Who received treatment and what kind? In the co-occurring disorder population we hope for better recovery outcomes for clients who receive treatment for both disorders. However, such integrated treatment may be difficult to obtain or access. Let us consider the data for all affected persons with “any” mental illness, as well as SMI.

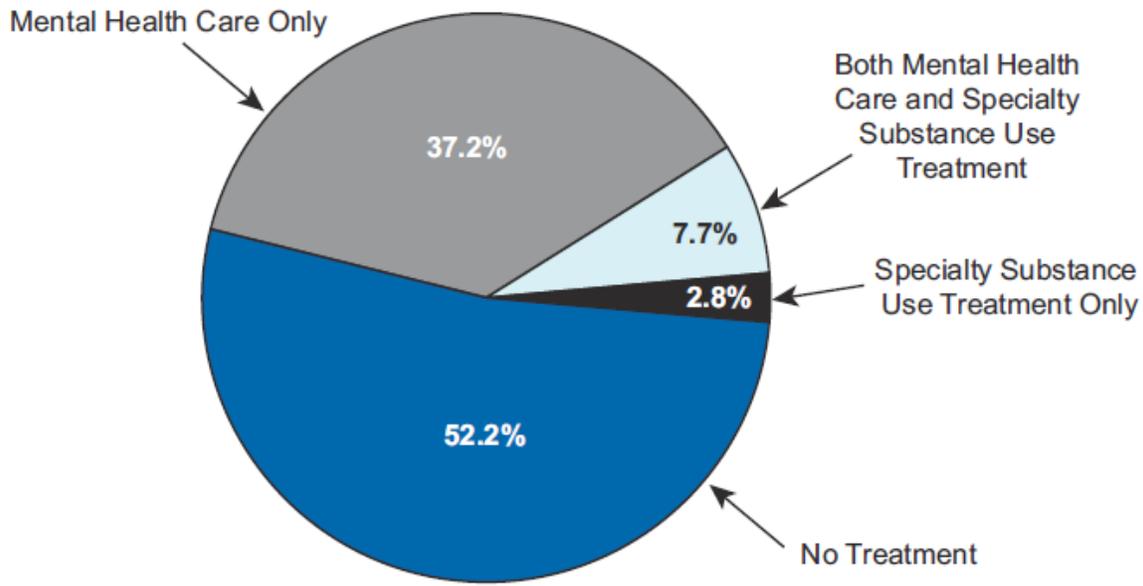
For the 7.7 million adults with co-occurring disorders in 2013, how many received treatment in the last year for MH disorders, SUD, both, or neither?

The NSDUH (2013) reports that: 47.8 percent received some kind of treatment for either SUD or mental illness during the past year, however:

- 37.2 percent received MH care only
- 2.8 percent received SUD treatment only, and
- just 7.7 percent received treatment for both disorders.

But more than half, or 52.2 percent, received no treatment at all for either disorder. Those findings may be surprising. Examine what that data looks like in the next figure.

Figure 3. Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older who had Both a Substance Use Disorder and Any Mental Illness in the U.S., 2013.



**7.7 Million Adults with Co-Occurring  
Mental Illness and Substance Use Disorders**

Note: Mental health care is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Specialty substance use treatment refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Many will be surprised that such a large percentage, over 52%, who have both SUD and MH disorders do not receive any treatment within a given year. We focus on the co-occurring disorder population for a number of reasons in this report.

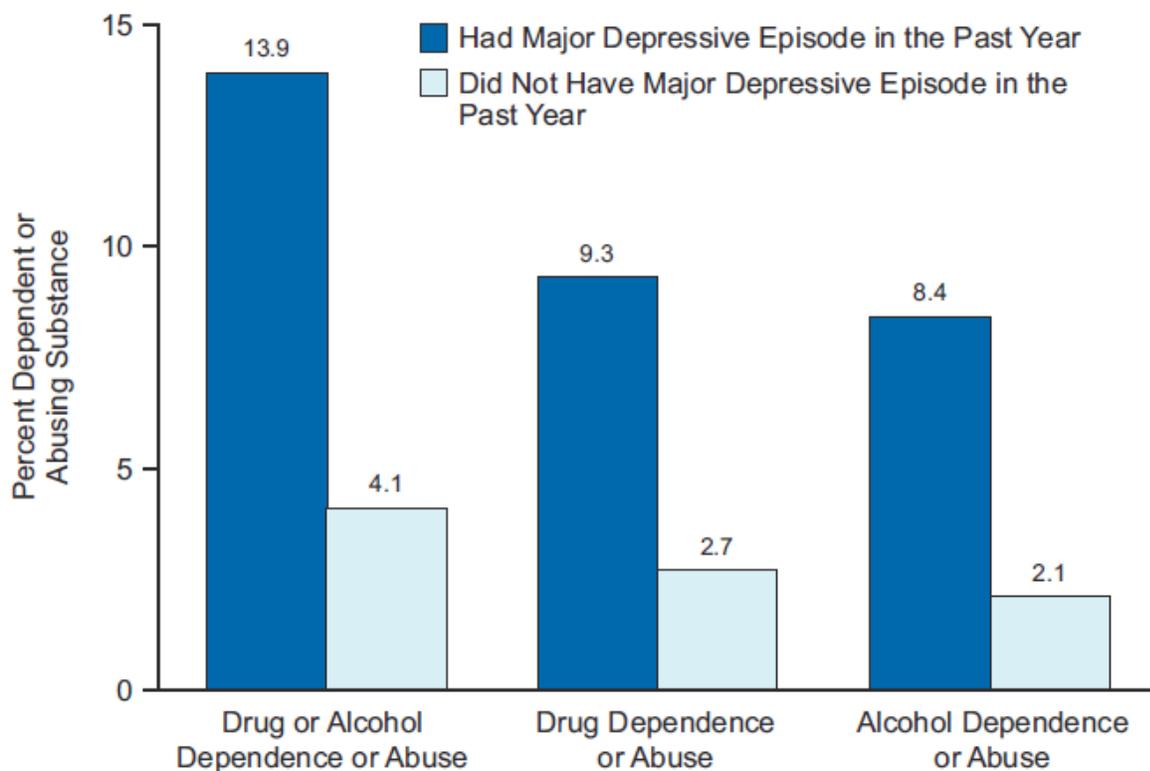
If instead, we examine the data for all persons with substance use disorders (most of whom have not been diagnosed with mental illness), the numbers paint a much more alarming picture. Within any given year, typically **more than 95%** of those with substance use disorders do NOT seek treatment. Put another way, **only 5%** of those who need substance use treatment each year actually seek/receive treatment.

The larger number of persons who have a substance use disorder (but most of whom do not have a major mental illness) would likely exceed the capacity of all treatment resources available. Many experts believe that, as a society, we cannot “treat our way” out of this problem. Investing in effective prevention is essential. Later in this report, we discuss strategies used by counties to address substance use education and prevention programs, especially those efforts targeted for children and youth. Next, we focus on youth under 18 in order to understand how frequently co-occurring SUD and MH disorders occur in this vulnerable group.

## Risks for Children and Youth with Co-occurring MH and SU Disorders

Children and youth under 18 who had a major depressive episode were three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who did not have depression.<sup>17</sup> Experiencing a major depressive episode more than doubled the risk for abusing each of the major illicit drugs (see data in next figure, from the 2013 NSDUH survey). Such episodes of depression may be an early indicator of risk for more severe emotional disorders later in life.

Figure 4. Youths Aged 12-17: Past Year Substance Abuse or Dependence by Major Depressive Episode in the Past Year in the U.S., 2013.



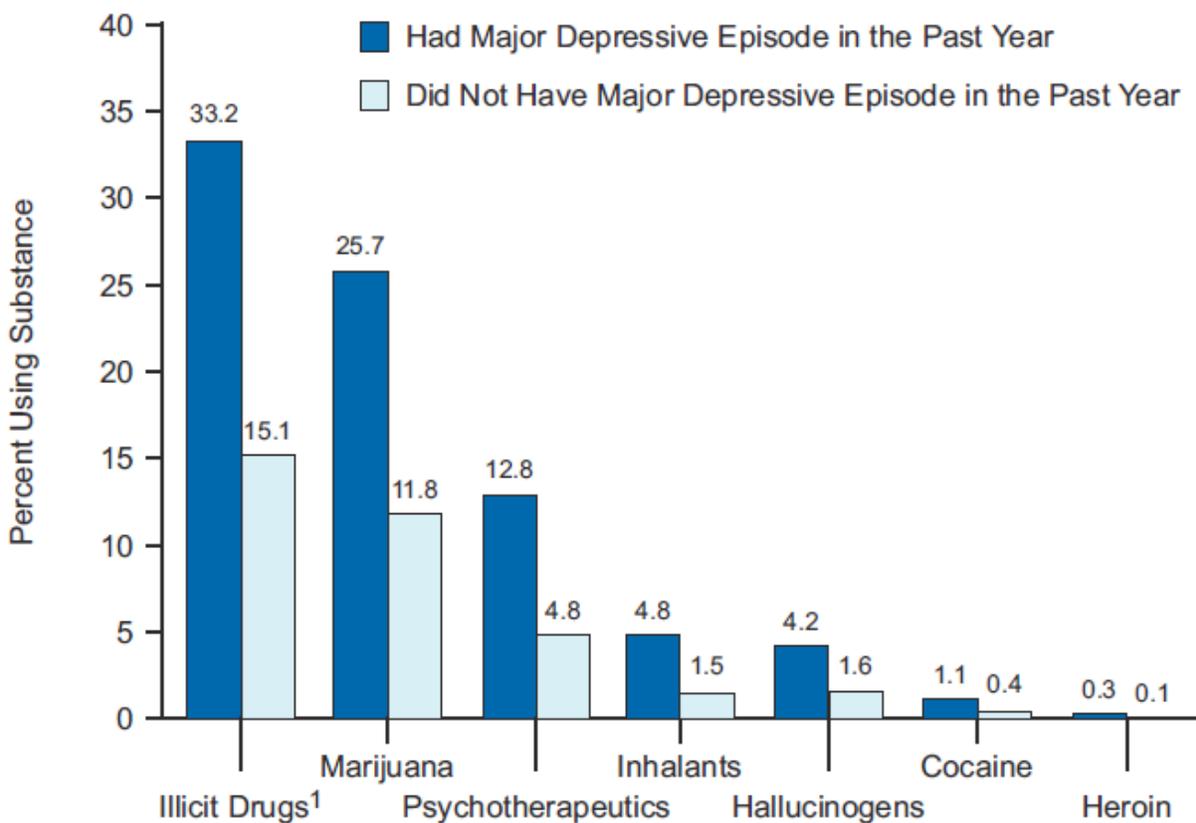
The data above, shown for youths in the U.S. aged 12-17, resembles a very similar profile of risk for substance abuse in adults who had a major depressive disorder in the prior year (data not shown). These data highlight the importance of recognizing and seeking treatment for depression and for health care providers to initiate depression screening.

<sup>17</sup> Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: [National Survey on Drug Use and Health](#)

The NSDUH report also found that youth with a major depressive episode had an increased risk for use of any type of illicit drug. A related but very serious concern is the increased risk for abuse of prescription drugs (when taken for non-prescribed uses).

The data for youth shown below are very similar to those for adults who had depression, except that adults' use of cocaine was greater than that of hallucinogens, inhalants, or heroin (the least frequent choice).

**Figure 5. Youths Aged 12-17: Type of Illicit Substance Use and Relation to Having a Major Depressive Episode in the Past Year in the U.S., 2013.**



<sup>1</sup> Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

### State Level Impact: Prevalence Data for Co-occurring Disorders in California

Our major concern in this overview report is to understand the scope of the problem, need for treatment and resources in the state of California and our communities. Now that we have considered some of the scope and prevalence of the problems presented by SU and MH disorders, we next turn our attention to the data for treatment and

services within our state. Some resources for statewide data are available.<sup>18</sup> We will be examining only a subset of the overall data in order to get a basic foundation for understanding our system of care and treatment outcomes. As we examine these data, we keep in mind the perspectives gained from the national data and consider how that may compare to California's data.

## **Data: Who Receives SUD Treatment in California and Treatment Outcomes**

The next few pages show statewide information supplied by researchers in the Office of Applied Research and Analysis at the Department of Health Care Services (DHCS). The data are from fiscal year 2013-2014 and represent counts of individuals admitted to publically-monitored alcohol and other drug treatment programs. The data are for unduplicated individuals and only for the first admission to any treatment program during that treatment year regardless of what came before or after that year's initial service.

Access: Who Receives Services? The first section presents data for the demographics of those admitted for SUD treatment and the type of service admissions. Demographics include age, gender, major race/ethnicity groups, and county of service. Service types included in this dataset are outpatient, detoxification, or residential treatments. Not broken out are perinatal programs or narcotic treatment programs (NTP, medication-based maintenance programs such as methadone or buprenorphine).

What are the Client Outcomes? The second section contains a snapshot of statewide data regarding client outcomes at time of discharge from outpatient drug-free programs. This represents the most common type of treatment program. Discharge outcomes are measured for the 30 days immediately following discharge and include:

- return to substance use
- arrests
- employment
- housing situation (homeless vs. stable housing of any type)
- social supports within the last 30 days (includes 12-step programs as well as general social support activities, more than 4 or fewer than 4 per month).

There is a certain percentage of data assigned as "not collected," which otherwise might be described as missing data. These are not redacted (hidden) numbers. "Data not

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<sup>18</sup> Here is the most recent data source for state-level estimates for prevalence of MH and SUD disorders and population with co-occurring disorders, and some estimates of patient access to treatments. [state-level estimates for prevalence of MH and SUD disorders](#)

collected” indicates the numbers of clients for which no further data were obtained by the treatment program. Some clients were no longer reachable by program staff or were otherwise lost to follow-up. However, with such a large percentage (e.g. 43.5 %) not collected, increased efforts are needed to collect more data so that unbiased outcome statistics for all treatment clients can be developed and used.

Finally, as stated earlier, please examine the county data reference pages in the Data Appendices. We live in a highly diverse state and so your county data may or may not resemble the statewide data. However, these data are worth review and discussion as we consider advocacy and policies regarding demographic disparities in service access and unmet needs.

**CALIFORNIA State Data. Totals include all counties.**

**ACCESS: Who Receives Services and in What Type of Program?**

**Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment**

**Service Type:**

<b>Outpatient</b>	<b>Detox Treatment</b>	<b>Residential</b>	<b>Total</b>
89,071	19,904	24,763	133,738
66.60%	14.88%	18.52%	100%

**Age at Admission:**

<b>Under 18</b>	<b>18 - 25</b>	<b>26 - 35</b>	<b>36 and Older</b>	<b>Total</b>
14,957	23,614	38,042	57,125	133,738
11.18%	17.66%	28.45%	42.71%	100%

**Gender:**

<b>Male</b>	<b>Female</b>	<b>Total</b>
84,615	49,123	133,738
63.27%	36.73%	100%

**Race/ Ethnicity:**

<b>American Indian or Alaska Native</b>	<b>Asian or Pacific Islander</b>	<b>African American, not Hispanic</b>	<b>Hispanic or Latino</b>	<b>Multiracial/ Other Race, not Hispanic</b>	<b>White, Not Hispanic</b>	<b>Total</b>
1,612	2,984	16,926	49,352	5,070	57,794	133,738
1.21%	2.23%	12.66%	36.90%	3.79%	43.21%	100%

**CALIFORNIA State Data. Totals include all counties.**

**CLIENT OUTCOMES: Key Indicators of Client Recovery for the 30 Days preceding Discharge from Outpatient Drug-Free Programs for FY 2013-2014.**

**Substance Use at Discharge from Program (as reported by clients):**

<b>No Substance Use</b>	<b>Substance Use Documented</b>	<b>Use Data Not Collected</b>	<b>Total</b>
28,093	9,533	29,016	66,662
42.14%	14.33%	43.53%	100.00%

**Arrests:**

<b>No Arrests</b>	<b>1 or More Arrests</b>	<b>Arrest Data Not Collected</b>	<b>Total</b>
36,486	1,160	29,016	66,662
54.73%	1.74%	43.53%	100.00%

**Employment:**

<b>Employed</b>	<b>No Employment</b>	<b>Employment Data Not Collected</b>	<b>Total</b>
10,596	27,050	29,016	66,662
15.90%	40.58%	43.53%	100.00%

**Housing Situation**

<b>Stable Housing</b>	<b>Homeless</b>	<b>Housing Data Not Collected</b>	<b>Total</b>
34,479	3,167	29,016	66,662
51.72%	4.75%	43.53%	100.00%

**Social Support Participation (SSP), days per month**

<b>4+ SSP days</b>	<b>&lt;4 SSP days</b>	<b>SSP Data Not Collected</b>	<b>Total</b>
19,306	18,340	29,016	66,662
28.96%	27.51%	43.53%	100.00%

## Meaning and Limitations of County-Level ‘Snapshot’ Data for SUD Treatment

Comparable data summaries for individual counties were also released and are displayed in the Data Appendices. These are the numbers that were presented in the Data Notebooks prepared for each individual county. When examining the county data, some data cells may not have any numbers, but instead are marked by an asterisk, “\*” which means that the numbers were redacted (hidden) to protect patient privacy because the total number is too small. Counties with small populations may see many such asterisks, with the result that only limited data can be seen.

The statewide and county-level data are presented for review and discussion to promote increased access to services and more evidence-based programs. The overall goal is to identify what leads to more successful client outcomes. The data show that a major continuing challenge is shown by substantial, persistent disparities by demographic in service access and unmet needs for all counties and including small-population counties with large land areas and limited resources.

For a better understanding of SUD treatment in our state, please consult the Data Appendix describing the list of SUD Treatment providers in each county. What becomes evident is that substantial numbers of small-population counties have no narcotic treatment programs available and very few have residential substance use treatment programs. Of the other types of programs listed, some counties with physically large land areas but small populations have only one outpatient SUD treatment program, usually an abstinence or drug-free program.

The lack of specific types of treatment programs (e.g. Residential, Intensive Outpatient, NRT) explains the data seen in the Admissions to Treatment tables (Appendix 1 and Appendix 2) for small-population counties—the presence of multiple “zeroes” suggests that certain programs may not exist in that county.

Finally, the substantial travel distances necessary to access treatment and other transportation-related issues present significant barriers to SUD treatment in at least 29 counties, as shown by other data presented later in this report summarizing responses to question #10 of the Data Notebook.

## The Impact of Substance Abuse on the MH System of Care in your County

9. This next question was intended to help define the nature and scope of substance use in each county, a first step that is essential for each community to assess needs and develop strategies for addressing the problems of alcohol and substance abuse.

**What substances are the most commonly abused in your county? Please select the top three drug categories below (and indicate estimated percentage if known).**

The far right-hand column shows the number of counties that prioritized these specific responses.

<b><u>Major Substances Abused</u></b>	<b><u>#Counties</u></b>
Alcohol	46
Amphetamines, methamphetamine, prescription stimulants (ADHD drugs)	42
Marijuana, hashish or synthetic marijuana-like drugs (e.g. 'spice', 'bath salts')	35
Opioids (heroin, opium, prescription opioid pain relievers)	30
Cocaine, 'crack' cocaine	4
Club Drugs (MDMA/Ecstasy, Rohypnol/ flunitrazepam, GHB)	1
CNS depressants (prescription tranquilizers and muscle relaxants)	1
Dissociative Drugs (Ketamine, PCP/ phencyclidine/ angel dust, Salvia plant species, dextromethorphan cough syrup)	1
Other: "Polysubstances"	1
Hallucinogens (LSD, Mescaline/ peyote/ cactus, Psilocybin/ mushrooms)	0
Inhalants (solvents, glues, gases, nitrites/ laughing gas)	0

The results shown above, and further supported by the following table (showing percentages), indicate that the top four substances abused statewide are (1) Alcohol, (2) Amphetamines and related stimulants, (3) Marijuana/Hashish, and (4) Opioid class drugs, including both heroin and prescription narcotic pain relievers. Note that some substances received few or no responses, but that does not mean that these drugs are not problems in our communities. These other substances are well-documented elsewhere as important concerns in our society. They simply were not perceived as being in our top list of substances abused.

The next table below shows data for those counties that supplied percentages for type of substance used. Some variations are apparent among different counties and regions of the state. Note that some counties provided data for those substances which are a problem in their general population, but others supplied data regarding substances for which clients were most often seeking treatment (“seek Tx”). A few counties volunteered data for youth<18. Note that the choice of substance(s) abused by youth tends to differ from those of adults. Generally, the percentage numbers for each county will not add up to 100% due to the way the question was framed regarding the top three or four substances abused.

<u>County</u>	<u>Substance Abused</u>	<u>Seek Tx</u>	<u>Youth &lt;18</u>	<u>Alcohol</u>	<u>Marij./hash</u>	<u>Amph/meth</u>	<u>Cocaine/crack</u>	<u>Opioids</u>
Contra Costa	X			19.9	15.1	31.1	6	9.1
Imperial	X			19	7	74		
Imperial			X	9	87	4		
Kings	X			21.4	35.7	37.9		
Los Angeles		X		16.0	17.6	24.8		30
Madera	X			20	25	43		
Marin	X			37.6	9	21.5	5	26.2
Mendocino	X			75	50	50		
Mono	X			70				30
Monterey	X			19	8	36	5	27
Napa	X			50	10	40		
Placer-Sierra	X			24		30		30
Riverside	X			18	8	50		19
Riverside			X	8	85	10		<3
Sacramento	X			23		41		20
San Bernardino	X			19		48		13

San Diego	X			23	20	36		
San Francisco			X	25	25			5
San Joaquin		X		8		16		51
San Mateo	X			33.72		28.3		13.08
San Mateo			X	11.4	83.0		1.8	
Santa Barbara	X				17	28		29
Sonoma	X			42	9.6	25.6	0.9	21
Santa Clara	X			24.9	16.7	44.2		
Ventura		X		12		36		38
Yolo				13	21	33		

**10. With respect to SUD treatment in your county, what are the main barriers to access and engagement with treatment?**

The most striking result of this question indicates that there are marked changes in client motivation and participation in Drug Courts following recent changes in law. Drug court is a way to reduce criminal penalties for some crimes in exchange for the client engaging in treatment for substance use and successful completion. However, Proposition 47 reduced penalties for some substance use crimes, thus individuals now may choose not to apply for drug court/supervision of their case.

The right-hand column the shows number of counties that selected a specific response.

<b><u>Barriers to SUD Treatment</u></b>	<b><u>#Counties</u></b>
Client not ready to commit fully to stopping use of drugs and/or alcohol	41
Reduced motivation of clients due to changes in court-required drug treatment programs post-Proposition 47	29
Transportation	29
Failure to complete treatment program	24
Lack of treatment programs or options locally	19
Stigma and prejudice regarding diagnosis or participation in treatment	19

Lack of workforce licensed/certified to treat co-occurring MH and SUD disorders	17
Wait list to enter treatment	17
Language and/or cultural issues	10
Safe housing needed while clients work to be clean and sober or for dual diagnosis clients, but funding streams are limited	8
Insufficient funding for SUD programs and treatment, and/or limited financial resources of clients	5
Lack of Dual Diagnosis programs for co-occurring disorders	4
Different factors are more significant barriers for adolescents and TAY, so need more programs specific to their needs and outreach	3
Other	10

**Compilation of “Other” Answers for each key barrier itemized.**

A variety of items were deemed to be among the most significant barriers to treatment for substance use disorders. Some responses were sufficiently frequent that they were grouped into additional categories created above. Following is a partial selection of additional responses to “other.”

- Homeless population has difficulties accessing services and environmental stress impedes full engagement and recovery: 2.
- Need more transitional long-term recovery programs: 1.
- Too much reliance on ‘abstinence’ model: 1.
- “The unbridled availability of methamphetamines in our county:” 1

**11. What could be done to increase successful outcomes for SUD recovery in your county? Choose the top three priorities.**

This question resulted in responses that represent the vision of an ideal approach, in the sense that we are asking what COULD be done for clients to help improve their chances of success and recovery. One important option which was not listed, but which emerged as quite important in subsequent discussions, is “Collecting and using program performance and service recipient outcome data to help inform service improvement decisions.” This is one important perspective as we consider the choices offered and responses gathered in the table below. Options listed in the table below

may, or may not, be used in the responding county at present. (A subsequent question will address what programs or services actually are being offered currently).

The right-hand column shows the number of counties that selected a specific response.

<b><u>Perceived Ideal Ways to Improve SUD Outcomes</u></b>	<b><u>#Counties</u></b>
Ongoing case management, including connecting individuals to other services and longer-term support, ‘wrap-around’ services	44
Medication services	30
Vocational training and support, including employment readiness classes, and more employment options	20
Support individuals to make necessary changes in social patterns (new neighborhood; change routes to home, school or work; change circle of friends); including court-approved relocation	19
Family treatment/education and engagement	17
Onsite access or referrals for primary health care screening and treatment	14
Housing supports, including Sober Living Facilities for females as well as males or “dry” shelter options	10
More residential treatment beds, co-occurring disorders treatment medical ‘detox’ services and/or funding for these	5
Health and nutrition classes	4
Parenting classes	3
Transportation of clients (e.g. funding for bus passes, and other)	3
Other	8

The following items or comments were listed in response to the “other” option. Some respondents listed multiple items under “other.”

- Treatment facilities within county and/or geographically accessible services: 2.
- Individualized treatment: provide appropriate treatment at the appropriate time: 2.
- More sober recreational activities, especially family-oriented: 2.

- Collecting accurate baseline data for measuring outcomes: 1
- Different approaches needed by adolescents: 1
- Engagement before release for consumers that are incarcerated: 1
- Screening, Brief Intervention, and Referral to Treatment (SBIRT): 1
- Increase knowledge of SUD system by Medi-Cal Managed Care Plans (MCP): 1
  - especially for complex care management of medically fragile and psychiatrically complex individuals: 1
- Shift to more Evidence-Based Practices: 1.

**12. Have any SUD treatment strategies been shown to be especially successful in your county?**

The right-hand column shows the number of counties that selected a specific response.

No, none	2
Yes	47

If 'yes,' please describe.

Nearly all respondents indicated that there were successful SUD treatment strategies being employed in their county and cited them. Many counties listed several successful programs. Some of the successful programs are described below with the goal of sharing with other communities what programs and services are being found most successful in each county. Some counties engage in regional collaborations, so it may be useful to know what is working well in nearby communities. Detailed listing of programs by county is available in the Data Appendix for this question.

The most common type of program that was considered successful are those associated with problem-solving courts of all types, i.e., modeled on Drug Courts and MH Courts, including Veterans Courts, Homeless Courts, and “Deferred entry of judgment” programs. This finding takes on more importance with the perceived negative changes to client engagement in treatment following the enactment of Proposition 47—which has resulted in unforeseen outcomes.

One important observation was that Motivational Interviewing and Motivational Enhancement therapies can be very effective, but they need to be offered with careful fidelity to best practices. Practitioners need to be well-trained to be effective.

The following substance use treatment strategies were most frequently cited as helping clients succeed in their treatment:

<b><u>Program or Treatment Strategy</u></b>	<b><u># Counties</u></b>
Drug Courts and other Problem-solving Courts	14
Motivational Enhancement and Motivational Interviewing	12
Trauma-informed Therapy, including “Seeking Safety”	10
Cognitive Behavioral Therapy, Dialectical Behavior Therapy, or Moral Reconciliation Therapy (for justice-involved clients)	9
Coordinated MH and SUD Treatment	8
Case management, may be intensive or long-term	7
Drug-assisted Narcotic Treatment Programs (Methadone, Suboxone, Buprenorphine, Vivitrol, etc).	6
Perinatal Treatment Programs, including those with intensive case management	5
Matrix Therapy—may be coordinated with 12-step programs	4
AB 109 funded programs for in-custody or released offenders	3
Sober Living Environments	3
Red Road to Recovery based programs (also: “Right Road”)	3

**13. (a) How does your county support individuals in recovery to increase their rates of success? Please check all that apply in your county.**

**(b) In your opinion, which of the above are the four factors most essential to client success in SUD recovery?**

Program and treatment strategies are listed in the left column. The numbers in the middle column below indicate how many counties indicated that strategy is currently used in their county.

The numbers in the far right column indicate choices within the top four factors that were deemed most essential to recovery.

<b><u>Strategies Used to Promote SUD Recovery in your County</u></b>	<b><u># of Counties Use This</u></b>	<b><u>Deemed Most Essential</u></b>
Motivational interviewing	43	19
Linkage to primary care clinic for health tests and treatment	40	10
Facilitate a change in the person's culture, to build new relationships, routines, patterns <u>not</u> linked to alcohol or drug use.	38	23
Peer support, mentors or sponsors in the community	37	13
Teaching about activities of daily living	35	4
Transportation to outpatient treatment and therapy appointments	33	12
Case management/ aftercare/ follow-up services and referrals	32	30
Parenting classes	30	2
Medication services	31	13
Job readiness training, vocational services, GED/ college classes, or supported employment	28	14
Classes about nutrition, cooking, exercise, and care of one's own health	27	1
On-site health testing and treatment	26	1
Family treatment and/or family education	24	11
Smoking cessation classes or treatment	21	0
Services more like FSP <sup>19</sup> or wrap-around services	20	8
Supported housing and recovery residences, SLE	2	9
Collaboration between caregivers and/or having co-	N/A	6

<sup>19</sup> Full Service Partnership mental health services, programs funded by the Mental Health Services Act.

occurring services under the same roof, including primary care		
Other	17	28

In the second part of this question, respondents were asked to identify the four most important factors for client recovery, of the options listed in the table. Besides those choices, we received a number of responses under the “Other” option, listed below.

- Enhanced services for pregnant and postpartum women with SUD, including childcare and parenting training: 2
- For youth, add family treatment and/or education: 1
- Strength-based approaches: 1
- Appropriate level of care placement: 1
- Complexity-capable services: 1
- Positive genuine engagement with clinic/counselor: 1
- Understanding health concerns with respect to substance use: 1
- Community efforts to provide stigma reduction via law enforcement and medical providers: 1
- Access to alcohol or other drug (AOD) services: 1
- Matrix model: 1
- 12-Step program attendance: 1

In summary, recurring themes cited in the responses to Questions 11, 12, and 13 included “adopting a harm reduction approach with the goal of achieving sobriety in contrast to requiring immediate sobriety,” and a non-punitive “client-centered approach” that meets the client where he/she is on the road to recovery, rather than a rigid “one size fits all” approach.

Finally, we agree with the following perspective in one county’s response to the question about which factors are most essential to client success:

“All of the factors listed. Our belief is that all of the items checked above are essential to success in SUD recovery. The factors that are chosen depend on the individual client’s needs.”

### **Prevention Strategies: Coordination of Mental Health and Substance Use Prevention Programs**

14. **Prevention.** This last question is about coordinating prevention efforts between different agencies and groups. We believe that prevention and education activities are

important to help reduce the number of persons using drugs or abusing alcohol, especially for youth under 18 and young adults.

The evidence shows that prevention efforts are much more effective when coordinated across multiple service systems. Currently, funding for MH efforts have a different source than that for substance abuse prevention<sup>20</sup> and therefore must be devoted to mental health. This results in most programs being separate or ‘siloed’ which risks producing fragmented, patchwork efforts and less than optimal outcomes for consumers.

**Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?**

The numbers below indicate the number of counties that selected a specific response.

No	8
Yes	41

To date, eight counties answered in the negative. However, as some of these respondents included large counties which are well-known to have both SUD prevention programs and MHSA programs for PEI, it appears that the negative response is to “coordination” of prevention programs from the two different systems. A strict view of coordination takes into account the different cultures and targeted approaches for SUD and MH prevention, and the restrictions arising from the different funding sources. Many of those responding took care to emphasize that MHSA funds were not used for non-mental health purposes to assure compliance with regulations.

An example of a thoughtful response to this issue came from Alameda County.

“While there is definite benefit to have coordinated programs, currently [Alameda] BHCS does not jointly fund any MH/SUD prevention programs. The main reason for this is that the definition for ‘prevention’ is different depending on which funding stream (MH/SUD) you look at. On the SUD side, prevention is defined more narrowly as only ‘primary’ prevention, meaning services can only be provided to those not in need of treatment, whereas on the MH side, prevention is defined more broadly, e.g. preventing a mental illness from becoming severe or disabling as well as increasing access to underserved populations.

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<sup>20</sup> Examples of programs funded from different sources could include MHSA Prevention and Early Intervention programs or the substance Abuse Prevention and Treatment Block Grant. You may know of others in your community.

[Alameda] BHCS recognizes that SUD and MH issues may come hand-in-hand, so we have taken the approach in SUD prevention of looking at the risk factors for substance use experimentation, which include many mental health issues such as depression, anxiety and bullying. Because of this approach, BHCS SUD prevention providers are able to weave in MH issues into their programming. Similarly on the MH side, education around SUD issues are also addressed since we know substance use can be a coping mechanism/self-medication tool. So even though BHCS does not fund blended prevention programs (at the moment) the communities we serve do receive both MH and SUD prevention.”

**14. (Continued.) If ‘yes,’ please provide a brief description of the program, target audience, and activities.**

The responses below demonstrate that there is a considerable variety of programs and strategies to address prevention for both BH and SUD issues. It is evident that there is an overall commitment to providing coordination of programs and services where possible and practical, and especially to provide integrated care even when coordinated prevention strategies may not yet be feasible.

Here are some of the most common prevention programs<sup>21</sup> presented by counties in our state. Where possible, the purpose and targeted group are described.

Recovery Assistance for Teens (RAFT)

- Target Population Category - Indicated Youth
- Services- Screening and Referral, Educational Groups

Description- RAFT offers an educational-based approach to work with youth that have had academic, legal, or social consequences for drug involvement but do not meet the criteria for treatment. Youth are placed into weekly educational groups which cover information centered around how to change behavior over an 8 week period.

Friday Night Live Mentoring (SAPT)/ Middle School Mentoring (MHSA PEI)

- Target Population Category - Selective Youth
- Services- Screening, Alternative Activities, Educational Groups

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<sup>21</sup> Some of these descriptions were taken from Data Notebook reports by Merced, Stanislaus, San Joaquin, Imperial, Orange, San Bernardino and Orange Counties.

Description- FNLM is an afterschool mentoring program that uses older youth to mentor younger youth who are struggling in a variety of areas. This program uses the evidence-based curriculum, "Project ALERT!" for its educational purposes.

### Club Live

- Target Population Category - Universal
- Services- Alternative Activities, Environmental Prevention

Description- Club Live offers afterschool enrichment activities that provide opportunities for leadership, team building, and community service projects. As a part of the Friday Night Live programs, Club Live is based in the evidence based practice of youth development and follows the Friday Night Live Standards of Practice.

### Strategic Prevention Framework State Incentive Grant to Reduce Underage Drinking (SPF SIG)

- Target Population Category - Universal
- Services- Community Mobilization, Environmental Prevention

Description- SPF SIG is a grant-funded operation which brings together community-based service providers, law enforcement and local government agencies to address the core issues in the community that lead to underage drinking. This includes increased enforcement, community social norms, visibility and training.

### Prevention Community Wide

- Target Population Category- Universal
- Services- Community-Based Process, Information Dissemination, Education, Screening and Referral, Alternative Activities

Description- This program provides an array of services depending on the needs of the community/agency/family that is requesting assistance and/or support. The Prevention Unit offers workshops, speaking engagements, trainings, program development, consultation and many other services that may assist an agency or community address their concerns with AOD use.

### Strengthening Families Program:

This is a national evidence-based curriculum for youth and caregivers. The aim is to reduce initiation of alcohol in 9<sup>th</sup> graders and reduce or prevent binge drinking in 11<sup>th</sup> graders. These primary prevention programs are aimed at youth alcohol use patterns

that are part of the population health alcohol prevention strategy that includes healthier neighborhood, stores, etc.

Too Good For Drugs Program:

This program is delivered to middle and high school campuses. Students learn about depression, the relationship between alcohol, drugs, and suicide, as well as learn about their feelings and how to share them.

The Committed Program Model (also, 'Athletes Committed'):

This program blends youth development principles with innovative youth-led environmental prevention strategies and school climate initiatives. The goal is to build leadership skills, broaden young peoples' social network, and implement youth-led projects to reduce youth access to alcohol.

Behavioral Health Promotoras:

SUD and PEI have begun to partner on training support and coordinated efforts for BH *promotoras* to provide education and information to the community about drug and alcohol use, treatment, and prevention efforts.

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Finally, other Prevention programs focus on stigma reduction, student mental health, and suicide prevention, and enforcement of laws prohibiting local stores from selling alcohol to minors. In summary, we know from other statewide reports that 54 out of 58 counties have a current substance use prevention plan. Twenty-six counties refer individuals for additional services directly from primary prevention settings to further screening and treatment.

## Summary and Conclusions

Programs funded by SB 82 and AB 109 are making an impact. MHSA-funded PEI and Innovation programs continue to contribute to improved access to services and outreach to underserved communities and improve outcomes for many individuals. In particular, Full Service Partnerships provide the type of intensive support for adults, children and youth that is needed by many with the most severe mental illness or emotional disorders. Supported Permanent Housing programs are helping to reduce homelessness, but it is important to note that the stability and safety of having a place to live also contribute substantially to the affected client's ability to recover from MH and SUD challenges.

The results of the 2015 Data Notebook indicate the most significant areas of need to be facilities for inpatient care and more alternative programming to serve individuals experiencing a mental health crisis especially in the small-population counties. Limited funding, workforce shortages and burnout of the few providers available combine with transportation challenges to limit access to needed treatment by their residents, whether MH treatment, crisis services, or SUD treatment of any type. The rising suicide rates and rates of overdose deaths in many small-population counties are but two measures of the hidden suffering and unmet need. There is an imperative to advocate for sustained state funding to help meet locally-informed solutions and provide sustainable support for facilities such as crisis stabilization units and crisis residential treatment. Additionally, there are too few facilities, MH therapists, or psychiatrists specially trained to treat children, adolescents or TAY in all the counties.

What we see in the wide-ranging programs and services offered in counties across our state is evidence of a statewide behavioral health system in the process of enormous change. Regardless of category of resource or program, there are many, many more than just three years ago. And many counties are employing more programs that have creative or flexible approaches that meet the client where they are in their process or stage of recovery. A large number of programs cited funding from MHSA Innovation programs, MHSA Community Services and Supports, SB 82, and other governmental initiatives such as those for supportive housing of multiple types.

The challenges of integrating the systems of care for mental health and substance use disorders treatment have been considerable and yet we see substantial evidence of concerted, dedicated efforts to meet these challenges. The system of care is succeeding more often at providing integrated care or at least well-coordinated care across systems and provides robust linkages with primary health care. The data systems still face considerable hurdles to meet full integration and are constrained by a variety of technological and legal issues regarding HIPAA and privacy regulations.

We have endeavored to present an overview of the most critical needs for mental health and substance use disorders treatment. We see the ongoing needs in rural and small-population counties that still remain as challenges to be met. However, we see hopeful signs of regional collaborations on building and operating various facilities to meet acute MH needs, to grow their workforce and to provide more types of substance use treatment services. Our hope is that we have helped to promote improved services and more regional collaboration by presenting substantial detail about services and programs in each county under the different areas of inquiry posed in this year's Data Notebook project.

**FINAL NOTE OF ACKNOWLEDGEMENT:**

Thank you to all who participated by preparing data, engaging in discussion, and completing reports for the Data Notebook project.

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