



State of California
Department of Health Care Services

**Assessing the Continuum of Care for Behavioral Health
Services in California**
Data, Stakeholder Perspectives, and Implications

January 10th, 2022

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

**Assessing the Continuum of Care for Behavioral Health Services in
California**
Data, Stakeholder Perspectives, and Implications

| | |
|--|-----------|
| I. Executive Summary..... | 5 |
| About the Assessment..... | 5 |
| Envisioning a Core Continuum of Care..... | 6 |
| The State of Behavioral Health in California..... | 7 |
| Key Issues and Opportunities..... | 11 |
| II. Introduction..... | 16 |
| III. Framework for a Core Continuum of Care..... | 27 |
| 3.1 Key Principles..... | 27 |
| The Importance of Telehealth..... | 29 |
| 3.2 Core Continuum of Care..... | 30 |
| IV. The State of Behavioral Health in California..... | 36 |
| 4.1 Key Findings..... | 37 |
| V. Service Challenges Across the Behavioral Health Continuum of Care..... | 42 |
| 5.1 Outpatient Services..... | 42 |
| What data are available, and what do the data say?..... | 44 |
| What did the survey and focus groups say?..... | 48 |
| 5.2 Peer and Recovery Supports..... | 49 |
| Takeaway..... | 49 |
| What data are available, and what do they say?..... | 50 |
| What did the survey and focus groups say?..... | 50 |
| 5.3 Community Services and Supports..... | 51 |
| Housing Supports..... | 53 |
| Availability of Integrated Housing and Supports..... | 55 |
| Supported Employment..... | 57 |
| Availability of Supported Employment..... | 58 |
| 5.4 Intensive Support Services..... | 59 |
| What data are available, and what do the data say?..... | 61 |

| | |
|---|------------|
| What did the survey and focus groups say? | 62 |
| 5.5 Medications for Addiction Treatment (also known as medication-assisted treatment or MAT)..... | 63 |
| Availability of MAT | 65 |
| 5.6 Mental Health and Substance Use Disorder Residential Treatment | 70 |
| What data are available, and what do the data say? | 71 |
| What did the survey and focus groups say? | 77 |
| 5.7 Crisis Services | 78 |
| Mobile Crisis Services | 80 |
| Availability of Crisis Stabilization Units | 85 |
| Availability of Crisis Respite Services (Including Peer Crisis Respite Services)..... | 88 |
| Short-Term Crisis Residential Programs | 89 |
| Sobering Centers..... | 91 |
| 5.8 Withdrawal Management Services..... | 92 |
| Availability of WM Services..... | 92 |
| 5.9 Inpatient Services..... | 95 |
| Availability of Inpatient Services | 95 |
| VI. Populations of Focus | 100 |
| 6.1 Children and Youth | 100 |
| Outpatient Mental Health Services | 103 |
| School-Linked Mental Health Services | 104 |
| Child Psychiatrists | 107 |
| SUD Services for Adolescents..... | 108 |
| First-Episode Psychosis Programs..... | 109 |
| Eating Disorders | 111 |
| 6.2 Populations Who Are Justice-involved | 112 |
| Behavioral Health Services for Individuals Who Are Justice-involved | 118 |
| 6.3 AI/AN Communities..... | 120 |
| Challenges and Opportunities in Behavioral Health Services for AI/AN Individuals and Communities..... | 121 |

| | |
|---|------------|
| VII. Highest-Priority Challenges and Opportunities | 123 |
| VIII. Implications Across the Continuum of Care | 128 |
| 8.1 Preventive, Wellness and Outpatient Considerations | 129 |
| 8.2 Crisis Services Considerations..... | 129 |
| 8.3 Community, Peer and Recovery Support Considerations | 130 |
| 8.4 Intensive Outpatient and Treatment Services Considerations | 130 |
| 8.5 Selected SUD Services Considerations | 131 |
| IX. Conclusion | 133 |
| Appendix A – List of Acronyms | 134 |
| Appendix B – Data..... | 137 |
| Appendix C – Approach and Methodology | 159 |
| Establishing the Framework for a Core Continuum of Care | 159 |
| Quantitative Data Collection | 160 |
| Qualitative Data Collection..... | 163 |
| Assessment Limitations | 163 |
| Appendix D – Assessing the Need | 165 |
| SMI Among Adults | 166 |
| SUD Among Adults..... | 168 |
| SED Among Children/Youth | 171 |
| Adolescents with SUD | 173 |
| Behavioral Health Conditions Among the Justice-involved Population | 174 |
| Appendix E – Additional Tables with County-Specific Information..... | 177 |

I. Executive Summary

About the Assessment

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

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

Specifically, this assessment aims to do the following:

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

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

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

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

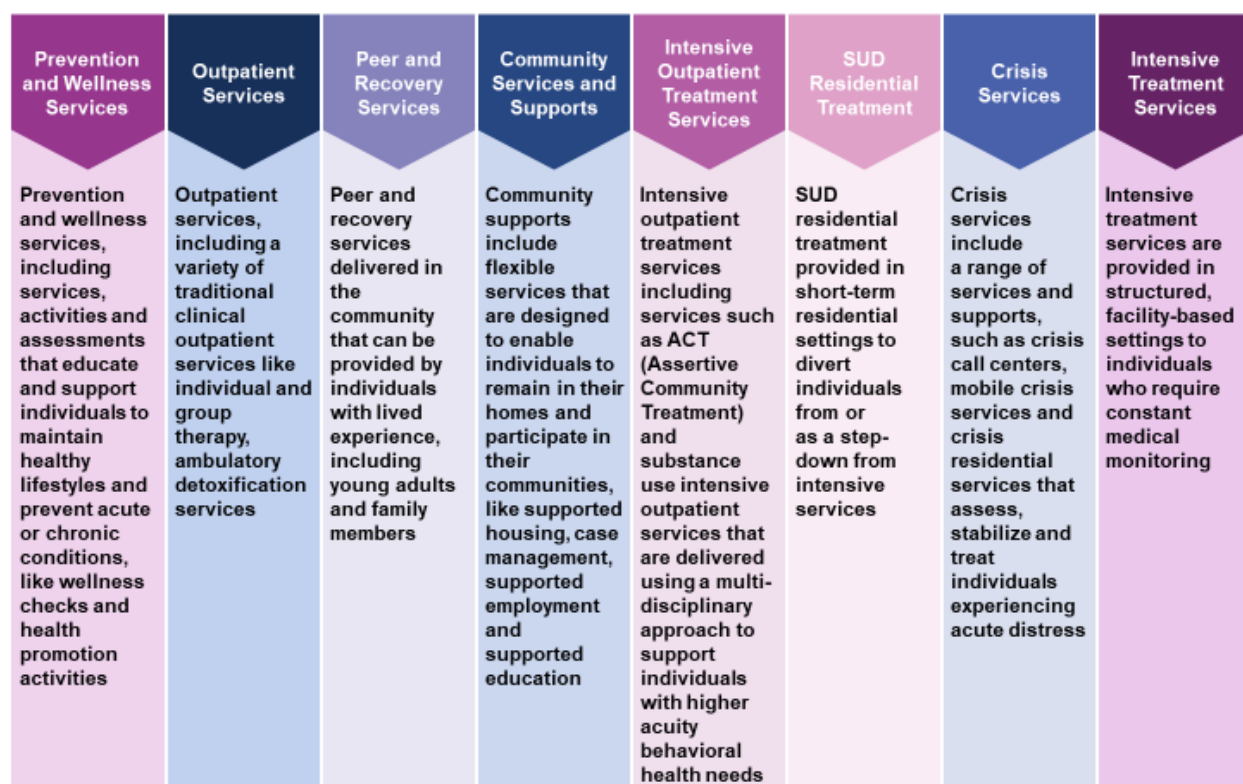
Envisioning a Core Continuum of Care

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

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

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

Figure 1. Core Continuum of Care



The State of Behavioral Health in California

Close to one in ten California adults (9.2 percent) has a substance use disorder (SUD), and nearly one in 20 (4.5 percent) has a serious mental illness (SMI).² Many of these adults living with SMI or SUD are among the 14 million Californians³ enrolled in Medi-Cal. Medi-Cal plays a particularly important role for people living with SMI and SUD. Many others receive services through county and tribal-led entities. Private insurers cover over 21 million Californians, and also play a key role.⁴ However, a number of stakeholders reported that people living with the most serious behavioral health conditions – severe mental illness, serious emotional disturbance (SED) among children and youth, life-threatening eating disorders – often end up served through the public

² SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019.

<https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm>.

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

⁴ Kaiser Family Foundation. Health Insurance Coverage of the Total Population:

<https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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

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

- **A significant and increasing number of California residents are living with a mental health condition or substance use disorder.** Relative to the country as a whole, California adults are somewhat more likely to have a substance use disorder and less likely to have a serious mental illness. However, the rate of serious mental illness in California as reported in survey data has increased by more than 50 percent from 2008 - 2019.⁷ A larger and growing number of California residents experience a mental, behavioral or emotional disorder (any mental illness) that does not meet the clinical threshold for SMI, which leads to functional impairment that substantially interferes with or limits one or more major life activities.^{8,9} These individuals may experience mood disorders, including mild depression and anxiety, that can be treated effectively with different forms of evidence-based psychotherapy, such as cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) which are structured treatment modalities.
- **Many children in California are living with a serious emotional disturbance, and behavioral health conditions and suicide rates are rising.** One in 13 children in California has a SED, with rates higher for low-income children and those

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

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

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

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

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

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

Figure 2. Number of Suicides in California per 100,000 Youth Ages 15-24¹³

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

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

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

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

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

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

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

- **Individuals who are justice-involved experience substantially higher rates of mental health conditions and substance use disorders, and often end up incarcerated because of those conditions.** In California, close to one in three adults in prison (30 percent) received mental health services in 2017, more than doubling the rate since 2000. Jails typically have even higher rates of individuals living with mental health and substance use disorders, largely because people may have been arrested and incarcerated for nuisance crimes associated with their conditions (e.g., erratic behavior due to psychosis, possession of illicit drugs). While rates vary by jail and over time, a conservative estimate is that more than 60 percent of adults in jail have a substance use disorder and a quarter to a third have a serious mental illness. Further, data suggest that over half of all youth in the county-based juvenile justice system in California have an open mental health case.¹⁵
- **Many California residents with a behavioral health condition experience challenges in obtaining get treatment.** Among Californians seeking mental health services, more than four in ten (43 percent) reported that it was somewhat or very difficult to secure an appointment with a provider who accepts their insurance. By contrast, 15 percent of Californians seeking physical health services reported that it was somewhat or very difficult to find a provider who accepted their insurance.¹⁶ As much as one third or more of individuals with serious mental illness who are enrolled in Medi-Cal do not receive any Medi-Cal specialty mental health services.¹⁷ Similar issues arise with respect to those with substance use disorders; nationally, nearly 90 percent of people living with a substance use disorder do not receive treatment, and, in California, the rate at which residents accessed treatment for a substance use disorder declined during the pandemic.¹⁸ In some instances, people with significant

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

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

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

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

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

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

- **Medi-Cal plays a significant role in covering individuals living with serious mental illness and substance use disorders.** The rate of serious mental illness among Medicaid enrollees nationally is nearly double the rate among individuals with other sources of insurance and is also higher than the rate among individuals who are uninsured.¹⁹ Medi-Cal claims data suggest that this trend holds in California as well. For close to half of California residents with a substance use disorder, Medi-Cal is the primary source of coverage.²⁰
- **County-level variation in the prevalence of behavioral health conditions is marked.** Given the vast differences across California in the economic and demographic characteristics of county residents, there are sizable differences in the county-level rate of behavioral health conditions. Among Medi-Cal enrollees, the rate (as reflected in claims data) of serious mental illness by county ranges from a low of 4.1 percent to a high of 12.1 percent; substance use disorder ranges from 2.1 percent to 8 percent; and SED ranges from less than 1 percent to 7.8 percent.²¹ Higher rates of SUD among Medi-Cal enrollees in some counties are correlated with greater loss of life—five of the 10 counties with the highest rates of substance use disorder among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall drug-overdose death rates in 2020.²²

Key Issues and Opportunities

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

¹⁹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019.

<https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHDetailedTabs2019/NSDUHDetTabsSect8pe2019.htm>.

²⁰ National Health Law Program. Substance use Disorders in Medi-Cal: An Overview.

https://healthlaw.org/resource/substance-use-disorders-in-medi-cal-an-overview/#_ftn1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Introduction

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

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

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

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

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

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

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

Specifically, the assessment aims to do the following:

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

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

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

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

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

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

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



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

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

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

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

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



Addressing Fragmentation in California’s Public Behavioral Health System

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

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

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

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

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

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

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

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

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

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

Mental Health Parity Act

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

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

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

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

[Bill Text - SB-855 Health coverage: mental health or substance use disorders.](#)

Major New and Planned Behavioral Health Initiatives

New Initiatives

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

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

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

³² [CalAIM In Lieu of Services Informational Webinar](#).

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

³⁴ “Behavioral Health Continuum Infrastructure Program and Community Care Expansion Listening Session,” DHCS, October 2021. Available at <https://ahpnet.adobeconnect.com/p5w2e0xlbaax/>.

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

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

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

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

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

³⁸ “Tribal MAT Project,” MAT Expansion Project. Available at <http://www.californiamat.org/matproject/tribal-mat-program/>.

³⁹ “CalHOPE,” DHCS, Available at <https://www.calhope.org/Pages/default.aspx>.

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

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

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

Planned Initiatives

- A planned Medicaid 1115 demonstration waiver to expand care for adults living with serious mental illness (SMI) and children and youth living with serious emotional disturbance (SED). If approved by the Centers for Medicare & Medicaid Services (CMS), it will allow California to secure federal Medicaid matching funds for additional mental health treatment options, including services in a broader array of residential and community settings.
- New opportunities for counties to establish or expand mobile crisis services for Medi-Cal enrollees using enhanced federal funding available under the American Rescue Plan Act of 2021 (ARPA), beginning on or after April 1, 2022.⁴³
- Plans to pilot contingency management within outpatient treatment settings as part

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

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

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

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

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

III. Framework for a Core Continuum of Care

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

3.1 Key Principles

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

- **Person centered.** It is important that people who live with mental health and substance use disorders are at the center of the behavioral health system. This means that their lived experiences and personal priorities should be paramount when it comes to defining the optimal continuum of care, as well as that they have a key role to play in shaping behavioral health policies and practices. It will require active listening by DHCS and other agencies charged with designing and implementing policies in partnership with those whose lives are affected by them.
- **Focus on equity.** All care provided under the continuum should be designed and delivered in a way that actively addresses disparities by race, ethnicity, ability, sexual orientation, and gender identity. This includes examining where providers are located, investing in a diverse behavioral health workforce, and addressing racism and discrimination with a specific focus on individuals who are experiencing homelessness, justice-involved and other populations who are disproportionately impacted by systemic racism and discrimination.⁴⁵
- **Least restrictive setting.** Services always should be provided in the least restrictive setting that is appropriate for the care and supports needed. While it sometimes is necessary for people to receive inpatient or residential services, the unnecessary use of an inpatient or residential bed is a powerful signal that more community-based and crisis services are required (including housing supports and other community supports).

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

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

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



The Importance of Telehealth

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

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

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

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

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

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

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

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

3.2 Core Continuum of Care

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

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

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

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

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

Figure 1b. Core Continuum of Care

Prevention and Wellness Services

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

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

Outpatient Services

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

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

Peer and Recovery Services

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

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

Community Services and Supports

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

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

Intensive Outpatient Treatment Services

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

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

Intensive Outpatient Treatment Services

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

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

Crisis Services

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

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

Intensive Treatment Services

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

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

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

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

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

IV. The State of Behavioral Health in California

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

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

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

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

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

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

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

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

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

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

4.1 Key Findings

- A significant and increasing number of California residents are living with a mental health condition or substance use disorder. Relative to the country as a whole, California adults are somewhat more likely to have a substance use disorder and less likely to have a serious mental illness. The rate of serious mental illness in California has increased by more than 50 percent from 2008 to 2019.⁵³ A larger and growing number of California residents experience a mental, behavioral or emotional disorder (any mental illness) that does not meet the clinical threshold for SMI, which leads to functional impairment that substantially interferes with or limits one or more major life activities.^{54,55} These individuals may experience mood disorders, including mild depression and anxiety, that can be treated effectively with different forms of evidence-based psychotherapy, such as CBT and DBT, which are structured treatment modalities.
- **Young adults have the highest rates of serious mental illness and substance use disorders.** Compared to other age groups, individuals aged 18 to 25 have the highest rate of serious mental illness—7.1 percent compared to 4.1 percent for all other California adults. Similarly, these young adults are nearly twice as likely to have a substance use disorder as older adults (16.1 percent versus 8.1 percent).

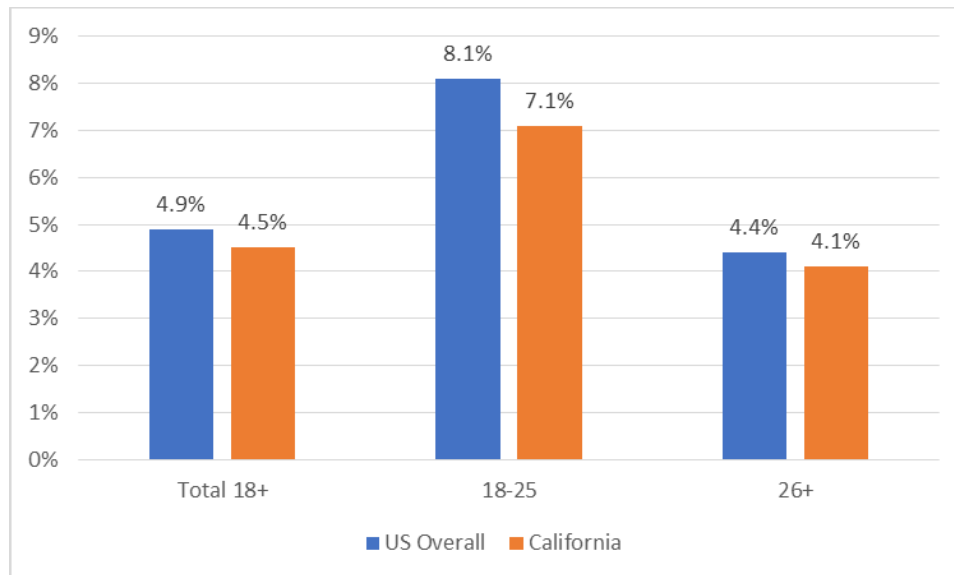
⁵³ SAMHSA. California Behavioral Health Barometer Volume 6.

https://www.samhsa.gov/data/sites/default/files/reports/rpt32821/California-BH-Barometer_Volume6.pdf.

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

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

Figure 3. **Percentage of Individuals Aged 18+ Living with Serious Mental Illness in California Relative to United States Overall⁵⁶**



- Many children in California are living with a serious emotional disturbance, and behavioral health conditions and suicide rates are rising. One in 13 children in California has a serious emotional disturbance, with rates higher for low-income children and those who are Black or Latino relative to other racial and ethnic groups. In recent years, the suicide rate among youth in California has been rising, and the pandemic appears to have worsened the situation.⁵⁷ Nationwide, visits to emergency departments due to a mental health crisis have climbed by 24 percent for children between the ages of 5 and 11 and 31 percent for those ages 12 to 17.⁵⁸
- **Marginalized groups experience higher rates of behavioral health conditions and more difficulties securing care.** As in the rest of the country, marginalized groups in California often are at higher risk for behavioral health issues but also are less likely to be able to access services. For example, AI/AN populations nationally report higher rates of posttraumatic stress disorder and alcohol dependence than any other ethnic/racial group, while Black and Latino children in California face

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

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

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

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

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

⁵⁹ “The 2021 CHCF California Health Policy Survey.” California Health Care Foundation. Available at <https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf>.

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

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

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

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

- **County-level variation in the prevalence of behavioral health conditions is marked.** Given the vast differences across California in the economic and demographic characteristics of county residents, there are sizable differences in the county-level rate of behavioral health conditions. Among Medi-Cal enrollees, the rate (as reflected in claims data) of serious mental illness by county ranges from a low of 4.1 percent to a high of 12.1 percent; substance use disorder ranges from 2.1 percent to 8 percent; and SED ranges from less than 1 percent to 7.8 percent.⁶⁶ Higher rates of SUD among Medi-Cal enrollees in some counties are correlated with greater loss of life—five of the 10 counties with the highest rates of substance use disorder among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall drug-overdose death rates in 2020.⁶⁷

⁶³ “The 2021 CHCF California Health Policy Survey.” California Health Care Foundation. Available at <https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf>.

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

⁶⁵ “The 2021 CHCF California Health Policy Survey.” California Health Care Foundation. Available at <https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf>.

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

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

V. Service Challenges Across the Behavioral Health Continuum of Care

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

5.1 Outpatient Services



Takeaway

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

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



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

– County Behavioral Health Director

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

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



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

With rising deaths associated with stimulant use, it is critical for California to identify and implement effective treatment options for people living with a stimulant use disorder. In California, opioids still account for the largest share of drug-related deaths in the state, but deaths from methamphetamine and other stimulants have almost quadrupled since 2010.⁶⁹ The widely-covered overdose crisis disproportionately affected White and AI/AN populations, but in the past decade, the most dramatic increases in overdose rates have been among Black people due in part to stimulant and polysubstance use.⁷⁰ Unlike for

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

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

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

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

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

The quality and extent of data available on outpatient services is mixed, reflecting in part that the service category includes a vast number of different kinds of treatment providers and services. To gather insight on outpatient services, the assessment relies on a combination of SAMHSA’s Behavioral Treatment Locator (see box above); Medi-Cal network adequacy data from county SMHS systems⁷⁵; data on licensed psychiatrists from the Medical Board of California; and quantitative information provided by county behavioral health directors in their survey responses on community health

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

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

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

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

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

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

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

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

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

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

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

In addition:

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

Harm Reduction Efforts

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

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

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

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

distributed over 600,000 units of naloxone, and recorded over 30,000 overdose reversals.^{78,79,80,81}

- In fiscal year 2019, small counties like Sierra and Alpine had only three and four, respectively, SMHS contracted behavioral health providers, while larger counties like Los Angeles had nearly 4,500. On a per capita basis, however, some small counties like Sierra and Alpine have more SMHS contracted providers per 10,000 residents than larger counties. Alpine and Sierra had 38.5 and 9.9 respectively, SMHS contracted providers per 10,000 residents relative to only 4.5 providers per 10,000 residents in Los Angeles County.
- There is a shortage and maldistribution of psychiatrists and other behavioral health professionals across the state. Data provided by the Medical Board of California indicate that eight counties do not have any psychiatrists, and the number of psychiatrists per 100,000 residents ranges from 1.7 in San Benito County to 68.1 in Marin County. Additionally, the state has 536 designated mental health professional shortage areas (HPSAs) or areas with a shortage of psychiatrists as of September 2020.⁸² While California-specific data were not available, national Medicaid surveys indicate that Medicaid participation among psychiatrists is low.⁸³ Nationally, approximately 55% of psychiatrists accept private insurance, and slightly more than 40% accept Medicaid.⁸⁴ A recent study found that ratios of behavioral health

⁷⁸ “Directory of Syringe Services Programs in California,” California Department of Public Health. Available at: https://www.cdph.ca.gov/programs/cid/daa/pages/oa_prev_sepdirectory.aspx.

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

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

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

⁸² Federal regulations define a mental health HPSA as having a population-to-provider ratio of at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community).

<https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁸³ <https://www.macpac.gov/publication/physician-acceptance-of-new-medicaid-patients-new-findings/>;

<https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf>.

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

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

What did the survey and focus groups say?

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

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

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

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

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

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

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



Outpatient Services Success Story

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

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

5.2 Peer and Recovery Supports



Takeaway

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

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

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

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

What data are available, and what do they say?

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

What did the survey and focus groups say?

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

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

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

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

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

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



Peer and Recovery Supports Success Story

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

5.3 Community Services and Supports⁹³



Takeaway

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

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

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

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

Loss of Licensed Adult and Senior Care Settings

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

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

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

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

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

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

Housing Supports

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

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

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

service. These “community supports” or “in lieu of services,” include a range of housing supports⁹⁷. DHCS is strongly encouraging managed care plans in all counties to offer these services beginning on January 1, 2022, including the following related to housing supports:

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

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

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

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

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

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

Additional California Housing Initiatives

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

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

Availability of Integrated Housing and Supports

What did the survey and focus groups say?

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

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

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

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

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

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

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



Housing Supports Success Story

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

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

Supported Employment

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

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



Individual Placement and Support (IPS) is an evidence-based model of supported employment for people living with serious mental illness (e.g., schizophrenia spectrum disorder, bipolar disorder, depression). It is increasingly being used by California counties as it is shown to be more effective at helping individuals living with SMI retain their jobs for longer and earn more money than people in traditional employment programs¹⁰⁵

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

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

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

Availability of Supported Employment

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

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

What did the survey and focus groups say?

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

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

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



Supported Employment Success Story

Similar to many other California counties, San Diego has invested in expanding employment opportunities for individuals living with behavioral health needs. It has provided a series of annual trainings for its county behavioral health providers to encourage them to build supported employment capacity, hosted employment socials to introduce program participants to potential employers in nonwork settings and developed a consumer and employer toolkit. The county's latest Five-Year Strategic Employment Plan (fiscal years 2020-24) builds on its earlier efforts in this area and reflects input from an array of stakeholders, including individuals with lived experience. Among other things, San Diego is expanding its use of evidence-based employment support models for transitional-age youth¹⁰⁸ and individuals living with SUD, enhancing data collection and analysis, and championing peer employment and advocacy.¹⁰⁹

5.4 Intensive Support Services



Takeaway

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

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

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

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

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

The key intensive support services addressed in this section include:

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

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

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



Full-Service Partnerships

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

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

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

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

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

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

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

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

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

What did the survey and focus groups say?

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



Intensive Outpatient Treatment Services Innovations

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

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



Takeaway

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

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

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

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

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

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

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

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

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

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

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

Availability of MAT

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

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

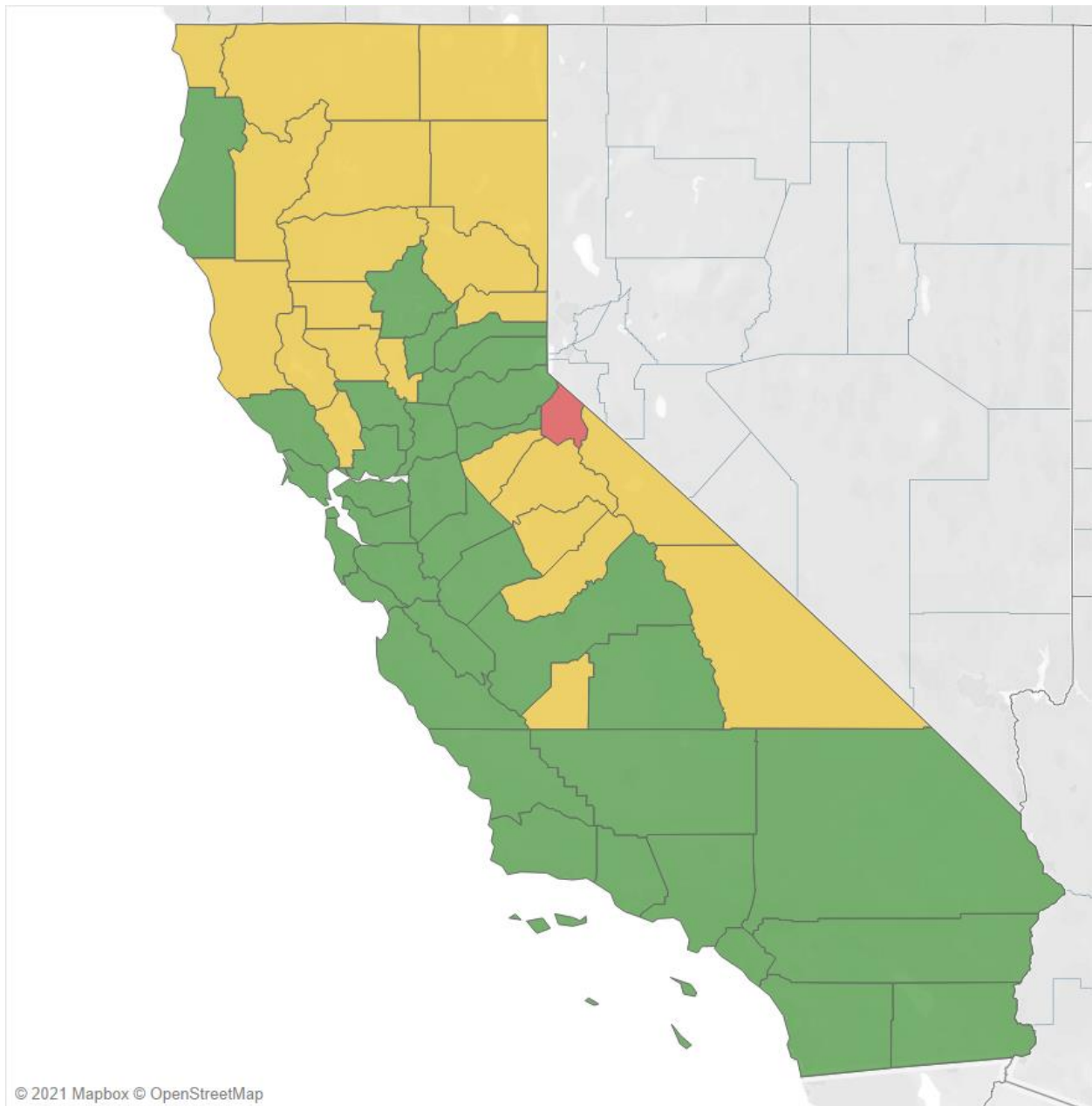
The data indicate that MAT is available in most California counties through NTPs or buprenorphine prescribers, but as discussed below, significant concerns remain about the adequacy of this supply. Specifically:

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

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

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

Figure 5. Counties with Buprenorphine Prescribers and/or NTPs¹¹⁷

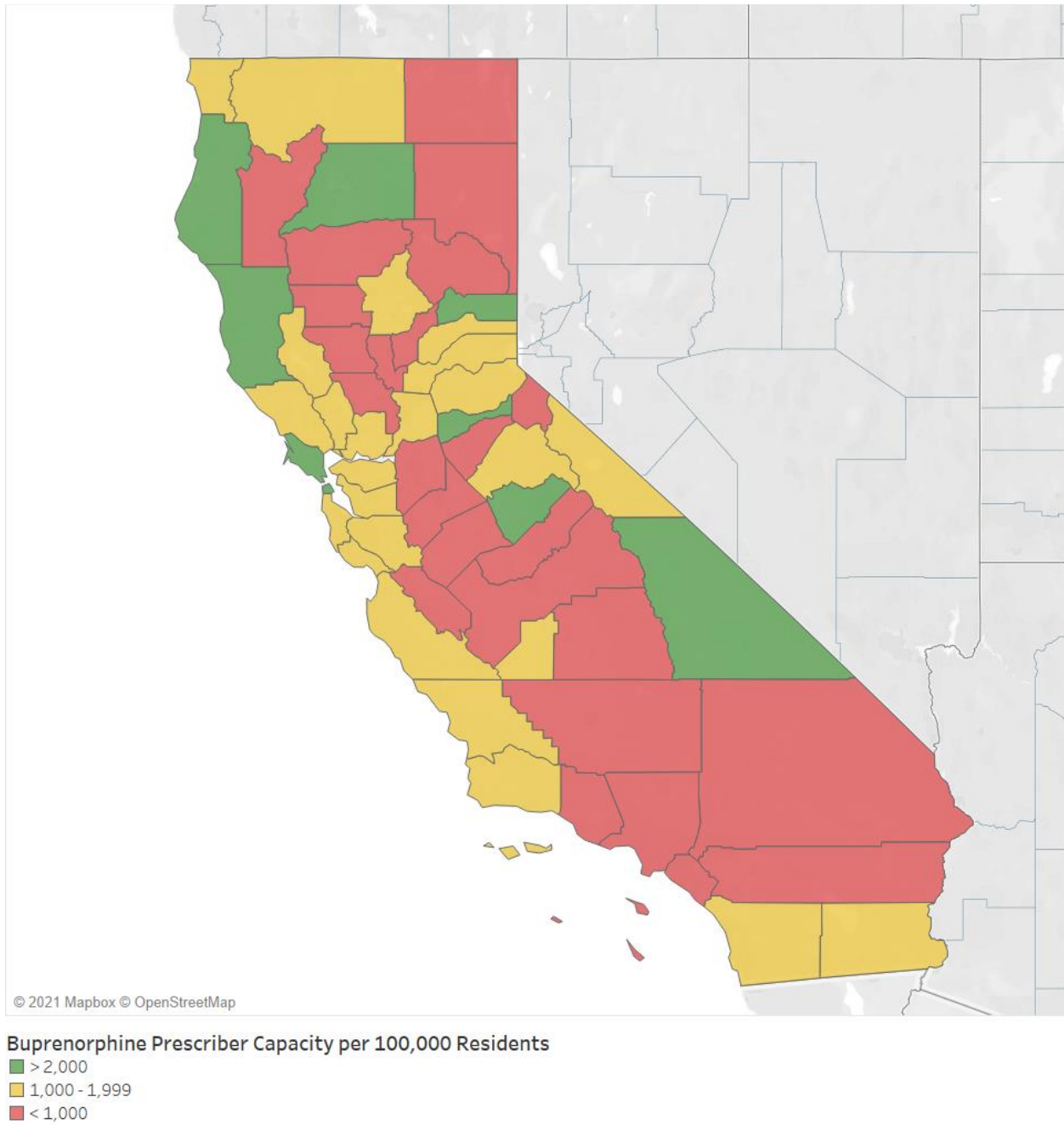


MAT Available

- Buprenorphine Prescriber and NTP
- Buprenorphine Prescriber Only
- No Buprenorphine Prescriber or NTP

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

Figure 6. Total Buprenorphine Prescriber Capacity per 100,000 Residents by County¹¹⁸



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

What did the survey and focus groups say?

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

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

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



MAT Success Stories

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

5.6 Mental Health and Substance Use Disorder Residential Treatment



Takeaway

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

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

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

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

SUD Residential Treatment

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

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

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

Figure 8. ASAM Levels of Care¹²²

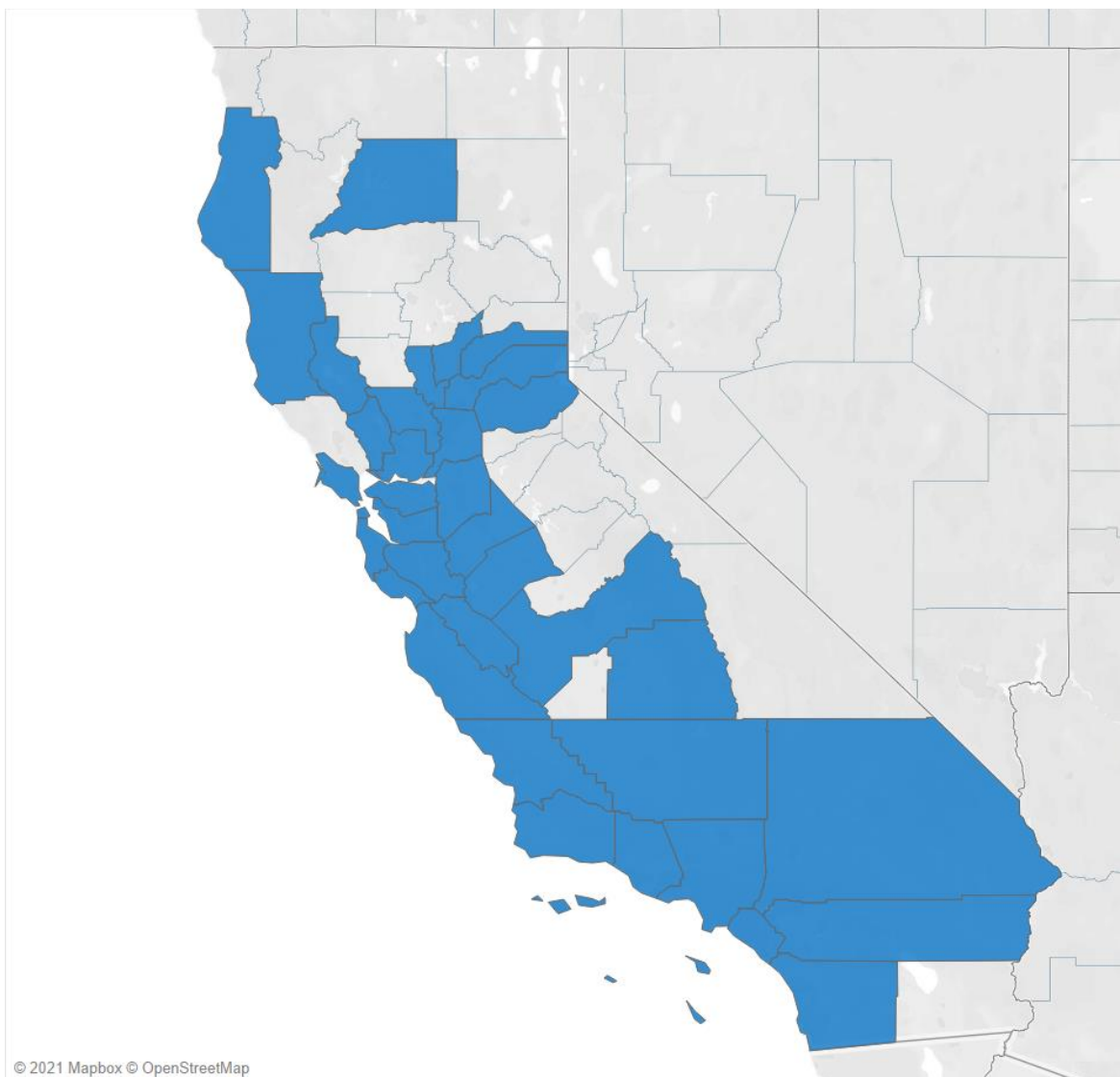


¹²² Guyer, J., et al. Speaking the same language: a toolkit for strengthening patient-centered addiction care in the United States. American Society of Addiction Medicine. <https://www.asam.org/asam-criteria/toolkit>. Published November 9, 2021.

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

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

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



Mental Health Treatment

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

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

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

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

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

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

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

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

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

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

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

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



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

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

What did the survey and focus groups say?

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

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

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

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



SUD Residential Treatment Success Stories

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

5.7 Crisis Services



What Is a Behavioral Health Crisis?

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



Takeaway

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

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

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

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

but that do not require evaluation and stabilization in an ED.¹²⁴ Individuals who require additional treatment and observation can be referred to crisis residential services.

- Crisis respite services, which can provide 24-hour observation and support until a person is stabilized. The services are provided by crisis workers or trained counselors, sometimes including peer support specialists.
- Crisis residential services for individuals who are experiencing an acute psychiatric crisis and could benefit from short-term (usually less than seven days) 24/7 medical and treatment supports.
- Sobering centers, which provide a safe place for individuals waiting for the effects of alcohol or drug intoxication to wear off while being monitored for underlying medical conditions or injury.

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

Mobile Crisis Services

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

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

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

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

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

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

The available data and calculator estimates suggest the following:

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

What did the survey and focus groups say?

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

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



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

– *Drug/Alcohol Program Association*

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



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

– *County Behavioral Health Director*

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



Alternative Transportation Options for Individuals in Crisis

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

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

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

Availability of Crisis Stabilization Units

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

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

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

What did the survey and focus groups say?

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

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

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

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

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



Crisis Services Success Stories

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

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

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

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

What did the survey and focus groups say?

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

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

Short-Term Crisis Residential Programs

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

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



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

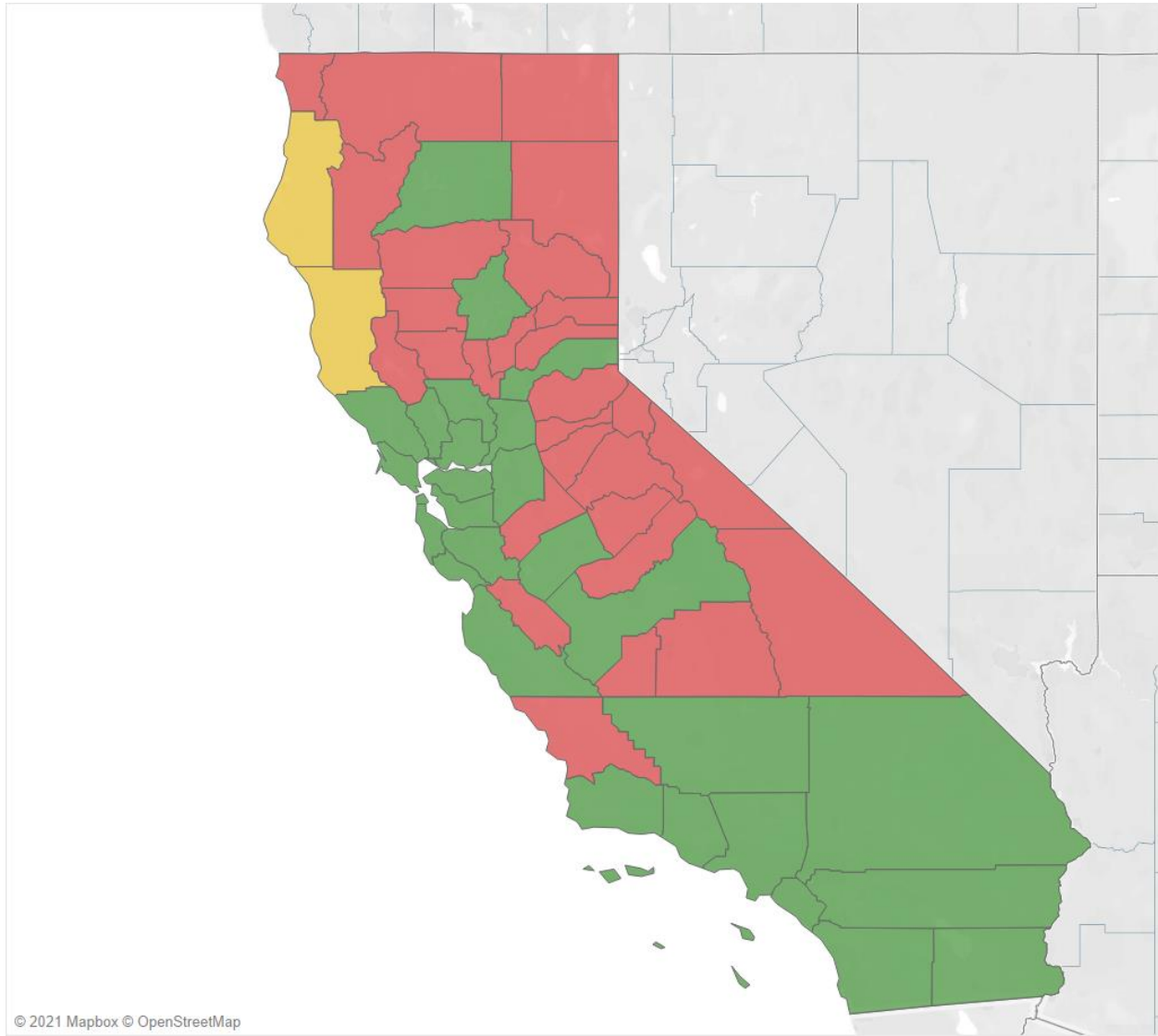
– *County Behavioral Health Director*

What did the survey and focus groups say?

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

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

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



Counties with Operational Crisis Residential Treatment Programs

- Yes
- Not yet, in planning
- No

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

Sobering Centers

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

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

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

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

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

What did the survey and focus groups say?

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

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

5.8 Withdrawal Management Services



Takeaway

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

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

Availability of WM Services

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

Coverage of and access to WM services in the Medi-Cal program varies by county. DMC-ODS provider reports and DHCS Alcohol and Drug Program Certification data revealed that residential WM programs are more commonly available than are ambulatory WM services. Table 10 in Appendix B displays the number of facilities providing ambulatory and residential SUD WM services in each county in 2021.¹³⁵ Figure 13 below shows counties with treatment facilities providing ambulatory or residential WM services. Specific findings include:

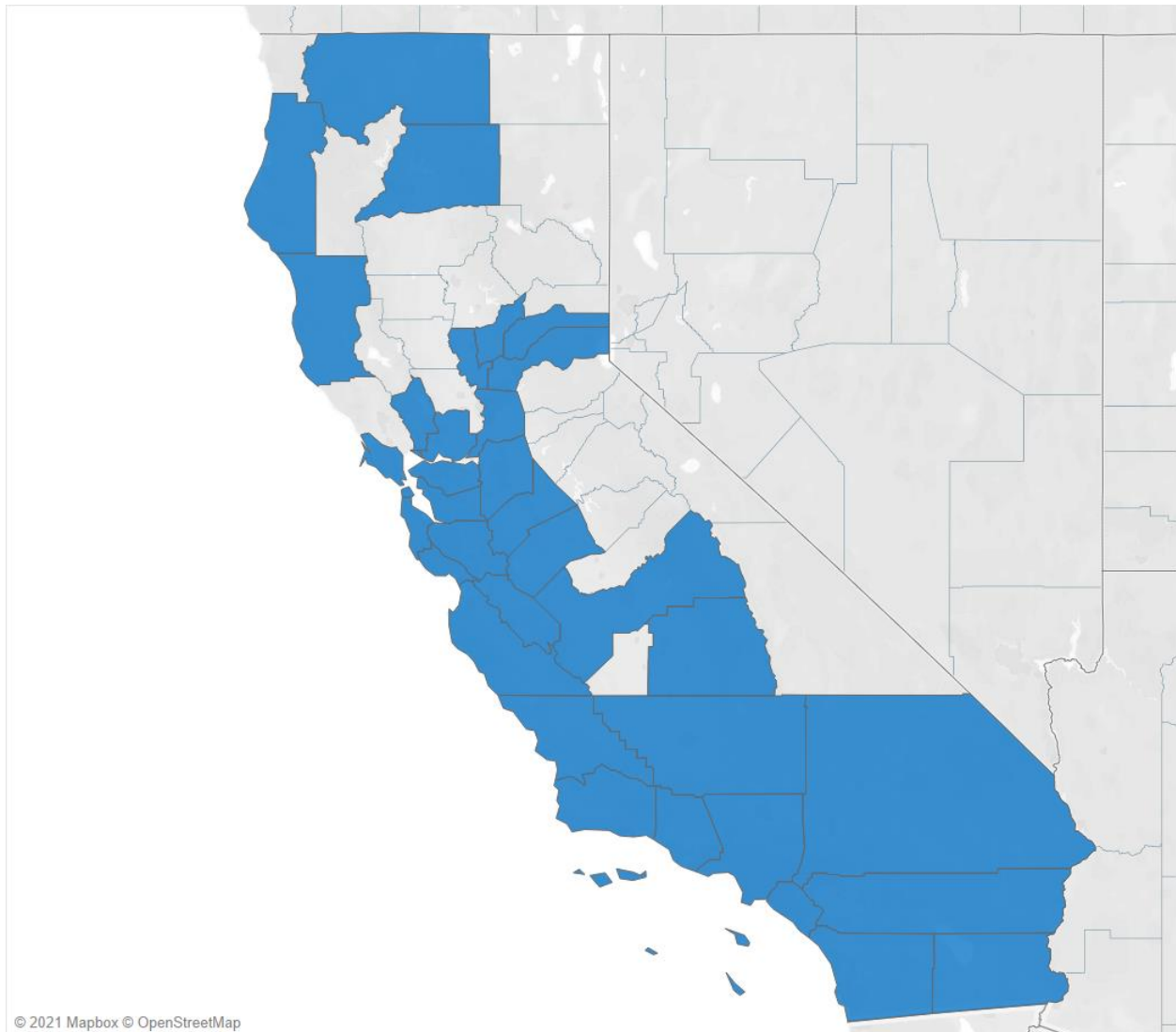
- Most counties in California have at least one facility that provides residential ASAM Level 3.2-WM services, with a total of 108 facilities spread across 31 counties.
- Only 15 counties have facilities providing ambulatory WM, and over half of those facilities are located in Los Angeles County.
- Medically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

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

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

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

Figure 13. **Counties with Treatment Facilities That Provide Ambulatory or Residential SUD WM¹³⁶**



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

What did the survey and focus groups say?

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

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

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

5.9 Inpatient Services



Takeaway

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

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

Availability of Inpatient Services

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

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

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

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



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

– *County Behavioral Health Director*

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

What did the survey and focus groups say?

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

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

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

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

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

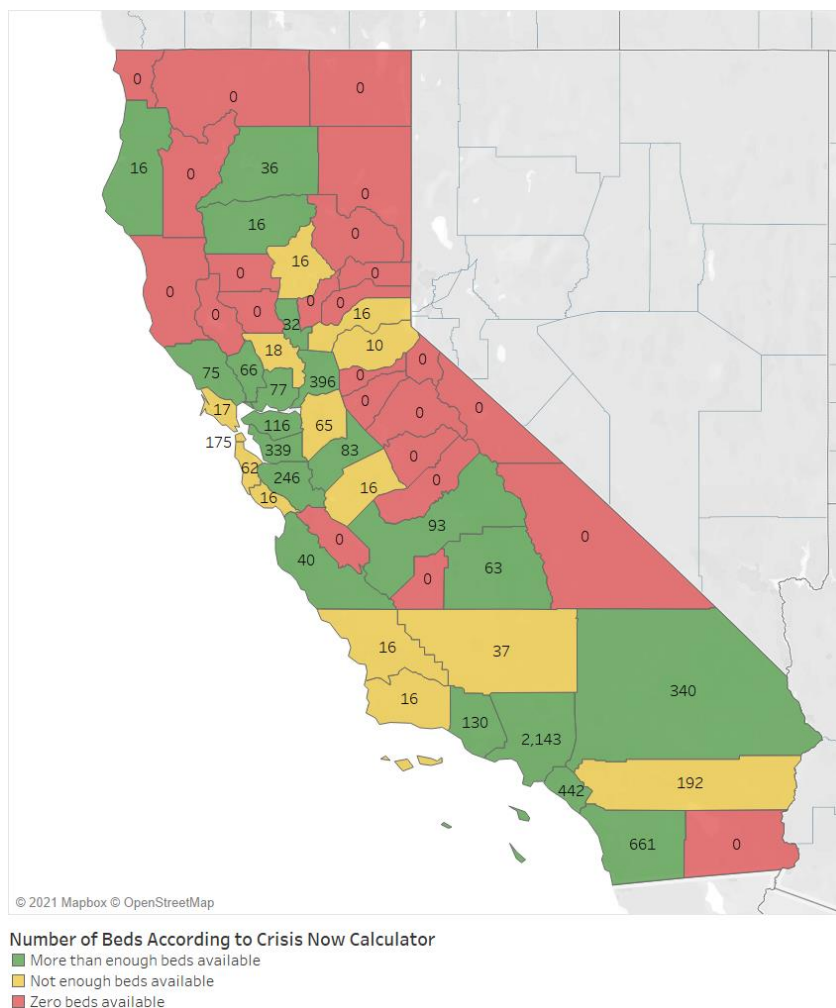
¹³⁸ The Crisis Resource Need Calculator was developed by Recovery International for the National Association of State Mental Health Program Directors and uses data from a cross-state analysis to determine projected utilization of crisis services and other behavioral health services. Available at www.crisisnow.com.

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

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

Figure 14. Number of Acute Mental Health Inpatient Treatment Beds and Estimates of Need for Additional Capacity¹³⁹

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



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

VI. Populations of Focus

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

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

6.1 Children and Youth

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



“If you know the adult system, that does not mean you know the youth system.”

– *Medical Professional Association Focus Group*

The COVID-19 pandemic has added more strain to the mental well-being of children and youth due to missed school, loss of contact with peers and frayed community connections. Many children, especially those in low-income families, faced greater economic uncertainty and, in some instances, the illness or even death of parents and grandparents. Nationally, one in every four high school students reported having worse emotional and cognitive health in 2020; one in five parents of children aged 5-12 said that their children’s emotional health was diminished.¹⁴² During 2020, the proportion of mental health–related ED visits among adolescents (12-17 years old) increased 31

¹⁴⁰ California Youth Suicide Rate 2011-2019, KidsData. Accessed October 26, 2021. Available at <https://www.kidsdata.org/topic/213/suicide-rate/table#fmt=2772&loc=2&tf=134,125,122,120,93,86,81&sortColumnId=0&sortType=asc>.

¹⁴¹ California Health Care Almanac, Mental Health in California: For Too Many, Care Not There, California Health Care Foundation, March 2018. Available at <https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf>.

¹⁴² Rabah Kamal, et al., Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic. Kaiser Family Foundation, 2021. Available at <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>.

percent and suspected suicide attempt ED visits for girls increased 51 percent compared to 2019.¹⁴³

In addition, adverse childhood experiences (ACEs) such as poverty, food insecurity, homelessness and toxic stress may place children and youth on a life path that has higher rates of mental illness, addiction, and other chronic medical conditions. ACEs are much higher for low-income children because of the hardships associated with scarce resources, but they can affect any child anywhere. In California, the rates of children and youth under 18 experiencing two or more ACEs varies from a low of 11.5 percent in Marin County (a wealthy urban county) to 23.5 percent in Shasta County (a less wealthy rural county).¹⁴⁴

California's children and youth at risk for or living with behavioral health conditions are not a homogenous group. Some have modest issues or risks and may benefit from preventive and traditional outpatient services provided by agencies, schools, and individual practitioners. Other children and youth have more complex behavioral health needs. Children and youth living with SED, adolescents living with SUD, as well as children and youth involved in child welfare, intellectual/developmental disability systems and juvenile justice require different services and approaches not only to address their behavioral health conditions but also to coordinate services across multiple child-serving systems.

In Medi-Cal, children and youth now can receive treatment for behavioral health services prior to a formal diagnosis and access services through any of the Medi-Cal delivery systems, including the FFS system, MCPs and county- and tribal entity–led behavioral health plans, regardless of their level of care or care needs. Medi-Cal enrollees under age 21 are entitled to all medically necessary services, including mental health and SUD services, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

Based on significant stakeholder input, DHCS is actively implementing several policy and program improvements to clarify the responsibilities of each delivery system, reinforce its no-wrong-door approach for individuals accessing care and ensure seamless access to medically necessary services for children and youth living with or at risk for behavioral health conditions. As part of this effort, DHCS is working with stakeholders to develop standardized screening and transition tools that are specific to individuals under the age of 21 for use by county behavioral health plans and MCPs

¹⁴³ Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:888–894. doi:<http://dx.doi.org/10.15585/mmwr.mm7024e1>.

¹⁴⁴ Children with Adverse Experiences (Parent Reported) by Number 2016-2019, KidsData. Accessed September 8, 2021. Available at <https://www.kidsdata.org/topic/1927/aces-nsch-county/table#fmt=2449&loc=2,127,1657,331,1761,171,2168,345,357,324,369,362,360,2076,364,356,217,354,1663,339,2169,365,343,367,344,366,368,265,349,361,4,273,59,370,326,341,338,350,2145,359,363,340&tf=139&ch=1256,1454,1456>.

across the state. These tools will be used to support children and youth living with behavioral health needs ultimately are referred to, and seamlessly transition to, the most appropriate Medi-Cal delivery system based on their needs, regardless of where and when they initiated behavioral health treatment.

Given the heightened concern about California's children and youth, this section reviews the issues and opportunities associated with the following services for this population of focus:

- Traditional outpatient behavioral health services offered through facilities (e.g., Community Mental Health Centers outpatient clinics) and individual licensed practitioners.
- School-linked behavioral health services, including preventive and treatment services.
- Child and adolescent psychiatrists.
- Treatment for SUD for adolescents and young adults.
- Services for first-episode psychosis (FEP) and anorexia nervosa, two of the less common but also harder-to-treat behavioral health conditions that affect youth.

Emerging and Existing Initiatives to Improve the Behavioral Health of California's Children and Youth

In recent years, the California legislature and Newsom Administration have adopted a number of high-profile initiatives to support children's mental health and well-being.

The Children and Youth Behavioral Health Initiative, which is intended to transform California's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported and served for emerging and existing behavioral health needs. Key components include:

- Creation of a virtual behavioral health services platform for youth.
- New funding for behavioral health services in schools and in school-linked settings.
- Development and expansion of evidence-based behavioral health programs.
- Establishment of a Behavioral Health Continuum Infrastructure Program (BHCIP), with grants funding new facilities and expansion of existing facilities.
- Launch of a public education and social change campaign on children's and youth's behavioral health.
- Investments in the behavioral health workforce, including a multiyear plan for a statewide school behavioral health coach and counselor system.
- Expanded education and training for pediatric and primary care providers.
- Empowering youth and incorporating youth voice through a variety of strategies including to review progress and provide quality improvement guidance.
- Comprehensive independent evaluation.

ACEs and developmental screening in Medi-Cal.¹⁴⁵ DHCS provides for enhanced reimbursement for ACEs screening, developmental screenings and well-child visits. Originally, funding was slated to expire on December 31, 2021; however, the 21-22 budget eliminated the planned suspension of the payments.

New family and community-based services. Beginning in January 2022, Medi-Cal will cover dyadic services for families with children, doula services and services provided by community health workers.

Implementation of the Title IV-E Prevention Program. California has adopted a five-year plan to implement the program established by the Family First Prevention Services Act. The plan seeks to implement prevention services (to prevent child welfare involvement and promote family stability) as well as to expand services for children requiring residential treatment and to ensure each child and family is provided a trauma-informed prevention plan rooted in evidence-based practices.¹⁴⁶

System of Care (AB 2083). AB 2083 (Chapter 815, Statutes of 2018) requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. The MOU is designed to help build communication and shared responsibility across local agencies to avert the need for state-level intervention. The System of Care also includes:

- The establishment of a Children and Youth System of Care State Technical Assistance Team consisting of representatives from California Department of Social Services, Department of Health Care Services, Department of Developmental Services, and the California Department of Education.
- The establishment of process to request technical assistance from the State Technical Assistance Team.
- The identification of gaps in placement types and services.
- The development of a multiyear plan for increasing capacity in placements and services. *(In development)*

Outpatient Mental Health Services

As noted above, outpatient services are the cornerstone of efforts to identify and prevent the development of more serious behavioral health conditions. Some outpatient providers, however, only have the capacity to treat adults. Based on the SAMHSA Behavioral Health Treatment Services Locator and county survey results, the disparity in outpatient services in California appears to be particularly large for children and youth.

¹⁴⁵ Along with supplemental payments for developmental screening and ACEs, Proposition 56 funds are used to increase the base rate payment for well-child visits and for value-based payments to providers for serving at-risk members (including children with SUD or SMI or experiencing homelessness).

¹⁴⁶ Family First Prevention Services Act. More information about California's five-year implementation plan is available here: <https://www.cdss.ca.gov/inforesources/ffpsa>.

- Approximately 32 percent of outpatient mental health treatment facilities in California listed on the SAMHSA Behavioral Health Treatment Services Locator do not indicate that they accept children or youth.
- While most counties have at least one treatment facility that serves children and youth, some do not. Five counties (Glenn, Kings, Modoc, Mono and Tehama) do not have any outpatient mental health treatment facilities that accept children or youth, according to the SAMHSA Behavioral Health Treatment Services Locator, which does not include individual practitioners. Fortunately, each of these counties has at least three SMHS-contracted behavioral health providers according to DHCS network adequacy data.
- Thirty percent of counties report an urgent need for non-specialty treatment services, such as individual and group counseling, for children and youth.
- One-fourth of counties report that they face an issue with identifying providers who are willing to treat youth involved in the justice system.

School-Linked Mental Health Services

Research shows that students are more likely to seek counseling when services are available in schools.¹⁴⁷ However, students may also be hesitant to access mental health services at school due to stigma and privacy concerns.¹⁴⁸ Comprehensive, culturally responsive school-linked mental health services can help address inequities in access and help reduce the stigma associated with receiving mental health services. Schools also have a unique opportunity to offer preventive services and education that build resilience and the ability to cope with difficult emotions, potentially staving off the development of more significant conditions for some.

¹⁴⁷ Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools, SAMHSA, July 1, 2019. Available at <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf>.

¹⁴⁸ Kaiser Permanente, Combating Mental Health Stigma in the Community, August 6, 2019. Available at <https://lookinside.kaiserpermanente.org/combating-mental-health-stigma-in-the-community/>.



“There is a need to provide services in locations convenient for youth, like schools. They are more likely to access services if it’s convenient for them.”

– *County Representative*

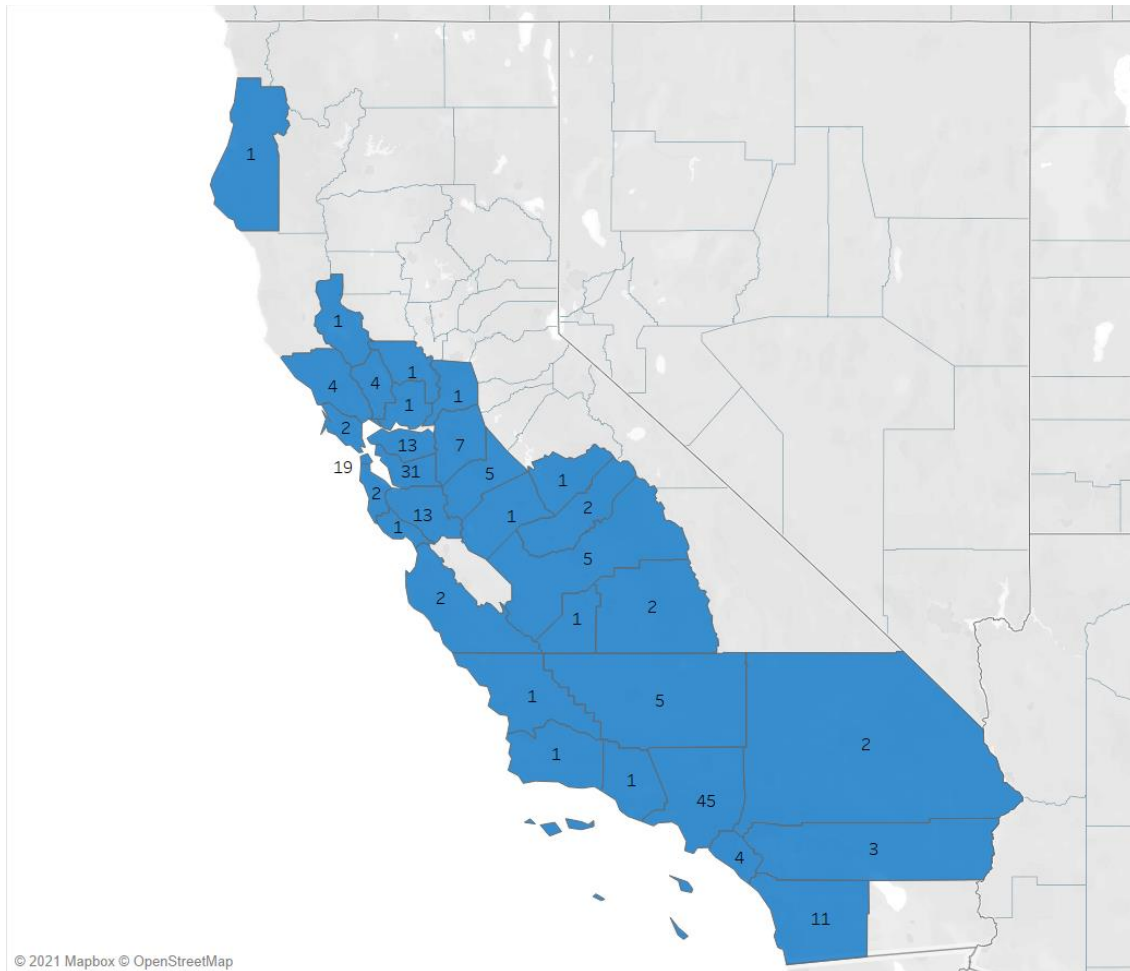
For this assessment, data from the California School-Based Health Alliance were used to identify school-linked health programs with a mental health component. Please note that these data only capture school-based health programs with mental health components that are tracked by the School Based Health Alliance. DHCS recognizes there are additional models of county-supported school-linked mental health services that are available throughout the state, but are not captured in these data, including innovative county-operated programs. These initiatives also offer important help to children and youth; it will be critical in the future to determine how best to catalogue and understand the extent to which they are offered throughout California.

Data from the School Based Health Alliance indicate:

- Most counties—32, or approximately 55 percent—have school-linked health programs with a mental health component.
- Approximately 70 percent of school-linked health programs tracked by the California School-Based Health Alliance provide mental health treatment services.¹⁴⁹
- An additional three counties have school-linked health programs, but they do not have a separate mental health component.
- Counties with large population centers (San Francisco, Alameda, Contra Costa, Los Angeles, and San Diego) were significantly more likely to have at least some school-based mental health programs.

¹⁴⁹ About School Health Programs, California School-Based Health Alliance. Accessed September 8, 2021. Available at <https://www.schoolhealthcenters.org/school-based-health/programs>.

Figure 15. **Counties with School-Linked Health Programs That Provide Mental Health Treatment Services**¹⁵⁰



Among stakeholders, there was deep interest in the new school-linked behavioral health initiatives and excitement about the powerful role they could play. With the COVID-19 pandemic illustrating the critical role of school and community for children and youth, stakeholders repeatedly raised the need for outpatient and intensive outpatient services that can be delivered in schools, via telehealth or through intensive in-home services that allow children to remain with their families.

Stakeholders highlighted the importance of using some of the new funding to provide children with skills and resources before they develop significant issues. Currently, school-linked clinics can offer individual counseling for students with a diagnosis via the local education agency Medi-Cal billing option. However, it is much harder to offer support groups to the general population without a specific mental health diagnosis, such as for students coping with grief, LGBTQ+ concerns, or school and social

¹⁵⁰ Data provided by the California School-Based Health Alliance via personal correspondence in July 2021.

pressures. Stakeholders also noted that students without a diagnosis would benefit from mental health services, as is likely to become more common with the recent policy changes announced by DHCS allowing access to early intervention services and behavioral health treatment prior to diagnosis. In addition, stakeholders indicated that schools are not well equipped to offer SUD services. Due to workforce and other issues, many schools lack the SUD practitioners who could offer SUD counseling.



School-Linked Mental Health Services Success Story

Several “pace car” school-linked initiatives were identified through the survey and focus groups. For instance, Santa Barbara County uses funds from the Youth Opioid Response grant and the cannabis grant to provide targeted outreach to schools. Stanislaus County plans to use the Youth Opioid Response grant to place SUD treatment professionals in educational settings and increase outreach to physicians to incentivize increased access to MAT prescribing in the primary care setting.

Child Psychiatrists

There are approximately 8,300 practicing child and adolescent psychiatrists in the United States. Ratios of child and adolescent psychiatrists range by state from one to 60 per 100,000 children (below the age of 18), with a median of 11 child and adolescent psychiatrists per 100,000 children.¹⁵¹ In California, there are 13 child and adolescent psychiatrists per 100,000 children below age 18.¹⁵² Some psychiatrists often require direct payment and may choose not to participate in either commercial or Medi-Cal provider networks, leading to access challenges, especially for low-income children.

For the county-specific analysis, the number of child and adolescent psychiatrists in each county was identified using licensure data provided by the Medical Board of California in July 2021. These data were analyzed to identify the number of active board-certified child and adolescent psychiatrists operating in each county in the state. These data, combined with the county survey results, indicate most counties have at least one child psychiatrist, although almost all of California’s counties reported shortages. For instance:

- According to the American Academy of Child and Adolescent Psychiatrists, 39 of California’s 58 counties were identified as having a high or severe shortage of

¹⁵¹ Workforce Maps by State, American Academy of Child and Adolescent Psychiatry. Accessed September 8, 2021. Available at https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.

¹⁵² Ibid.

child and adolescent psychiatrists.¹⁵³

- According to data provided by the California Medical Board, 22 counties had no child or adolescent psychiatrists as of July 2021.
- More than 70 percent of counties—42 of 58—report a lack of psychiatrists who specialize in working with children.
- Los Angeles County has significantly more child psychiatrists than any other county, with nearly one-third of all the child psychiatrists in the state and more than double the number of child psychiatrists of any other county. While Los Angeles County has many more psychiatrists than any other county, it does not rank at the top in terms of the number of psychiatrists per 100,000 individuals below the age of 18. San Francisco and Marin Counties had 52.4 and 48.7 respectively, child psychiatrists per 100,000 individuals below age 18, relative to only 14.2 per 100,000 in Los Angeles County.

SUD Services for Adolescents

The vast majority of adults—approximately 90 percent—with SUD started using a substance before age 18.¹⁵⁴ The earlier a person begins using alcohol or drugs, the more likely they are to develop SUD that persists into adulthood. Individuals who begin drinking before age 14 are seven times more likely to develop alcohol dependence than those who begin drinking at age 21.¹⁵⁵ SUD services are not yet widely available for adolescents and young adults. For instance, the county survey found:

- The majority of California counties lack available residential beds specifically for youth (75 percent, 45 respondents).
- Forty-one out of 56 respondents (68 percent) lack providers with the training and experience to meet the specific needs of youth living with SUD.
- There is limited provider availability to treat co-occurring mental health and SUD needs of adolescents (58 percent, 35 respondents).
- Funding was identified by 40 out of 56 respondents (71 percent) as a reason for why they have not expanded SUD services for adolescents.



“The absence of SUD services in my world is so absolute and complete I don’t know where to begin to discuss gaps.”

¹⁵³ Ibid.

¹⁵⁴ NIDA. Introduction. National Institute on Drug Abuse website. <https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction>. August 3, 2021.

¹⁵⁵ Hingson RW, Heeren T, Winter MR. Age at Drinking Onset and Alcohol Dependence: Age at Onset, Duration, and Severity. *Arch Pediatr Adolesc Med*. 2006;160(7):739-746. doi:10.1001/archpedi.160.7.739.

Insufficient SUD services for adolescents and young adults across the continuum of care was echoed in most focus groups. Participants reported:

- Insufficient available intensive and clinically managed low-intensity residential beds for youth; as a result, teens sometimes must be placed in facilities with adults.
 - School-based counseling programs are limited and have shrunk in recent years.
 - School-based mental health professionals do not have adequate training to address SUD.
 - Some of the evidence-based practices for treating SUD that are increasingly common for adults—such as MAT—still remain largely unavailable to adolescents.
 - A lack of inpatient WM beds (levels 3.7 and 4.0) for youth living with SUD.



Innovation for Adolescents with SUD

There are “pockets” of innovation for adolescents with SUD. Orange County has developed a peer mentoring program to support youth in their transition from out-of-county providers back home to in-county outpatient services. The [Peer Connector Program](#) connects individuals via phone with trained mentors with lived experience; mentors are matched according to their common experiences and/or backgrounds and services are available in English and Spanish.

First-Episode Psychosis Programs

According to the National Institute of Mental Health, about 100,000 adolescents and young adults in the U.S. experience FEP each year.¹⁵⁶ Interventions for young adults experiencing FEP are team-based, recovery-oriented approaches to care that commonly include psychotherapy, medication management, family education and support, case management, supported employment and supported education. Increasingly, FEP programs offer primary care coordination, peer support services and supportive housing services in addition to the traditional core components of the model. Young adults participating in FEP programs experience significantly greater symptom

¹⁵⁶ National Institute of Mental Health, Fact Sheet: First Episode Psychosis. Available at <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis>.

reductions, fewer hospitalization episodes, and better school and work participation compared with those in usual treatment.¹⁵⁷

Over the past decade, the number of counties with programs for young adults experiencing FEP has increased. As of 2021, 41 counties (71 percent) offer 52 programs that are serving individuals living with FEP.¹⁵⁸ These programs are underwritten using federal (SAMHSA set-aside funds), state and local funds. FEP programs often rely on philanthropic contributions or other funding sources, limiting the ability to grow and sustain much-needed programs. In addition, stakeholders recognized that there is interest in bringing FEP services to all counties in the state. Participants said that making FEP treatment programs available in rural counties should be a high priority. In addition, experts pointed out the importance of overseeing and monitoring the quality of FEP programs. While there are program standards, there currently is not an organized statewide approach for measuring program fidelity.



Innovation for Young Adults Living with FEP

The UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics), founded in 2004, are located within the University of California Davis Health System's Department of Psychiatry & Behavioral Sciences. UC Davis is nationally recognized as a leading provider of outpatient team-based coordinated specialty care for early psychosis. The programs serve transitional-age youth across the spectrum of early psychosis, including threshold affective and nonaffective psychosis ("early psychosis" or EP), as well as individuals who are at clinical high risk for psychosis.

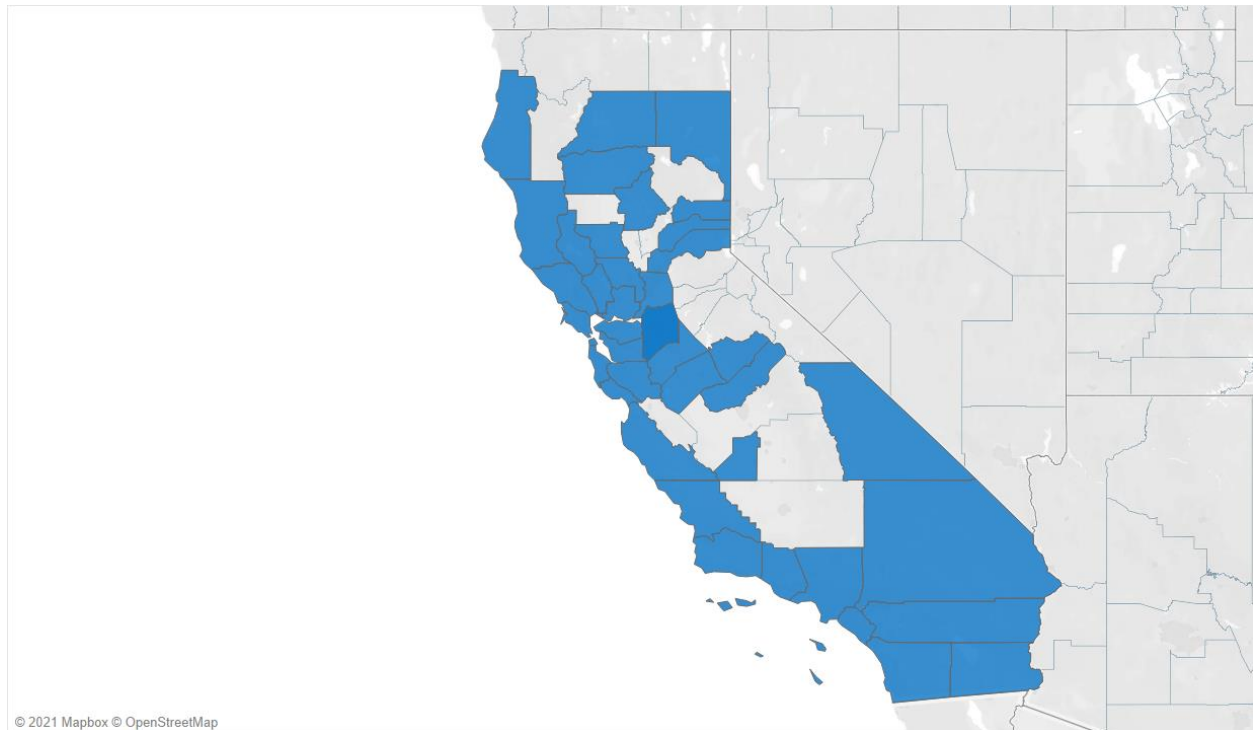
The EDAPT Clinic serves individuals ages 12-40 who have commercial insurance and come from across the Central Valley of California. With the support of Sacramento County MHS prevention and early intervention funding, EDAPT was expanded in 2011 to create the SacEDAPT Clinic, which serves residents of Sacramento County ages 12-30 who have Medi-Cal or are uninsured. Their family-centered model provides community outreach to support early identification; state-of-the-art assessments; individual, family and group psychotherapy; medication management; supported education/employment; case management; substance use management; and peer and family support and advocacy.

¹⁵⁷ Srihari VH, Tek C, Kucukgoncu S, Phutane VH, Breitborde NJK, Pollard J, et al. (2015). First-Episode Services for Psychotic Disorders in the U.S. Public Sector: A Pragmatic Randomized Controlled Trial. *Psychiatric Services*, Feb. 2, 2015. doi:0.1176/appi.ps.201400236. 66(7), 705-712.

¹⁵⁸ Early Psychosis Program Directory, Stanford Medicine. Available at <https://med.stanford.edu/peppnet/interactivedirectory.html>.

Outcomes data show reductions in hospitalization rates and symptom severity as well as improvements in overall functioning after 12 months of care. UC Davis has supported the development of programs in nearby areas, including Solano, Napa, Sonoma, and Yolo Counties. With the support of multiple counties, the Mental Health Services Oversight and Accountability Commission and DHCS, UC Davis is leading the EPI-CAL Network, which seeks to provide statewide training and technical assistance as well as outcomes evaluation support to California’s early psychosis programs.

Figure 16. **Counties with First-Episode Psychosis Programs Available**¹⁵⁹



Eating Disorders

Eating disorders, especially among children, youth and young adults, present significant behavioral and medical issues. For instance, individuals living with anorexia nervosa have high mortality rates and higher costs of care than do individuals living with other behavioral health conditions.¹⁶⁰ Discussions with professionals who treat people experiencing eating disorders identified challenges in commercial and Medi-Cal coverage for treating these patients. Over the past several years, there have been additional efforts in selected areas of the state to address these disorders, including:

¹⁵⁹ Data provided by Stanford Medicine Psychosis-Risk and Early Psychosis Program Network via personal correspondence in October 2021.

¹⁶⁰ van Hoeken D, Hoek HW. Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Curr Opin Psychiatry*. 2020;33(6):521-527. doi:10.1097/YCO.0000000000000641.

- Identifying eating disorders earlier and providing consultation to medical and behavioral health staff on effective strategies and practices to address these disorders.
- Establishing training on family-based treatment for eating disorders in certain areas of the state.
- Providing ongoing consultation on a weekly or monthly basis for practitioners who treat individuals living with an eating disorder.

Despite these efforts, focus group participants identified barriers that have historically limited access to treatment of eating disorders. For example, some Medi-Cal plans offer single-case agreements (SCAs) for individuals experiencing an eating disorder. These SCAs are necessary but administratively burdensome for providers and MCPs, and families may not know this is an available treatment option for their loved ones. In addition, focus group participants indicated a dearth of professionals who can identify and treat children, youth and young adults living with eating disorders. National data indicate that close to one in ten people in the United States (9 percent) will have an eating disorder over the course of their lifetimes.¹⁶¹

6.2 Populations Who Are Justice-involved

In California, 36,000 individuals are released from prison and a million individuals enter and leave jails each year.¹⁶² Nearly all of these individuals are eligible for Medi-Cal.¹⁶³ Individuals who are justice-involved often experience high rates of behavioral health issues and, in fact, often are arrested and incarcerated due to behaviors arising from those issues (e.g., erratic behavior due to psychosis, possession of illicit drugs). Among incarcerated individuals in California, approximately 66 percent of inmates were identified as having a high or moderate need for SUD treatment.¹⁶⁴ In addition, the proportion of incarcerated people in California jails or prisons with an active mental health case has increased over the past decade.¹⁶⁵ Individuals who are justice-involved have a significantly higher likelihood of ED visits, hospitalizations, and overdose- and

¹⁶¹ Report: Economic Costs of Eating Disorders, Harvard School of Public Health, can be found at: <https://www.hsph.harvard.edu/stripped/report-economic-costs-of-eating-disorders/>.

¹⁶² "From Corrections to Community: Reentry Health Care," California Health Care Foundation, 2018. Available at <https://www.chcf.org/project/corrections-community-reentry-health-care/>.

¹⁶³ Ibid.

¹⁶⁴ "Improving In-Prison Rehabilitation Programs," Legislative Analyst's Office, 2017. Available at <https://lao.ca.gov/Publications/Report/3720>.

¹⁶⁵ "The Prevalence of Mental Illness in California Jails Is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019," California Health Policy Strategies, 2020. Available at https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

SUD-related death. And for people recently released from prison, overdose is the leading cause of death.¹⁶⁶

The incarceration of people living with mental health and substance use disorders intersects with systemic inequities in the way the criminal justice system treats people of color. Black and Latino individuals are not more likely to misuse alcohol or drugs than are white individuals, but they are more likely to be incarcerated for related behaviors. For instance:

- Approximately 29 percent of male prisoners in California are Black (as compared to 5.6 percent of California’s adult male population); nationally, 5 percent of illicit drug users are Black, yet they represent 29 percent of those arrested and 33 percent of those incarcerated for drug offenses.^{167,168}
- For Latino men, the imprisonment rate is 1,016 per 100,000 as compared to 314 per 100,000 for men of other races.¹⁶⁹
- There is also a large discrepancy in the incarceration rate of the AI/AN population relative to the general population; however, due to data collection challenges, AI/AN populations are generally lumped into the “Other” category, making it difficult to report on their incarceration rate.¹⁷⁰

¹⁶⁶ Binswanger, IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release From Prison — A High Risk of Death for Former Inmates, *New England Journal of Medicine*, January 2007.

¹⁶⁷ “Criminal Justice Factsheet,” NAACP. Accessed September 8, 2021. Available at <https://naacp.org/resources/criminal-justice-fact-sheet>.

¹⁶⁸ “California’s Prison Population,” Public Policy Institute of California, 2017. Available at <https://www.ppic.org/publication/californias-prison->

¹⁶⁹ Ibid.

¹⁷⁰ Daniel R, “Since you asked: What data exists about Native American people in the criminal justice system,” Prison Policy Initiative, April 22, 2020. Available at <https://www.prisonpolicy.org/blog/2020/04/22/native/>.



Incompetent to Stand Trial Backlog

The number of Californians deemed incompetent to stand trial (IST) on the basis of their mental illness for felony charges has increased significantly in recent years.¹⁷¹ A significant number of individuals—1,722 as of December 2021—who have not been convicted of crimes and are determined to be IST are waiting in jails—on average for several months—for state hospital beds to become available to restore individuals to competency. Once competency is restored individuals return from the state hospital to jail for their court case to be adjudicated. Counties are responsible for treating people facing misdemeanor charges who are deemed to be IST.¹⁷²

The state has taken a number of steps in recent years to address the IST backlog and invest in diversion and community-based restoration programs for individuals living with serious mental illness (SMI) who become justice-involved. CalHHS and the Department of State Hospitals (DSH) have convened an [IST Solutions Workgroup](#) to identify actionable solutions to address the growing number of individuals living with SMI who are deemed IST on felony charges.¹⁷³ The Workgroup has recently submitted recommendations for short-term, medium-term, and long-term solutions, and the state has appropriated \$75 million for DSH to begin implementation of these recommendations beginning in the 2021-22 budget. Examples of recommendations include implementing the CalAIM justice in-reach and re-entry proposal, expanding pre-booking diversion services, and expanding diversion programs with adequate housing supports, including enriched residential programs. In addition, the state's enacted 2021-2022 budget also includes funding for DSH to implement or expand a number of initiatives including:

- Expand community- and jail-based competency restoration funding.
- Contract for sub-acute bed capacity to expand treatment options to serve the increasing number of felony IST patient referrals to the department¹⁷⁴
- Reevaluate individuals deemed IST on a felony charge waiting in jail 60 days or more pending placement to a California Department of State Hospitals (DSH) treatment program

¹⁷¹ “Behavioral Health: Community Care Demonstration Project,” Legislative Analyst’s Office, February 19, 2021. Available at <https://lao.ca.gov/Publications/Report/4382>.

¹⁷² Ibid.

¹⁷³ Incompetent to Stand Trial (IST) Solutions Workgroup. CalHHS. More information available at <https://www.chhs.ca.gov/home/committees/ist-solutions-workgroup/>.

¹⁷⁴ 2021-22 Budget Summary for California Department of Health and Human Services. Available at <https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>.

- Expand the current IST/Pre-Trial Felony Mental Health Diversion to current and new counties.

Various approaches and services can effectively address behavioral health issues to divert individuals from entering the justice system, identify and plan for such services during the reentry process, and facilitate and engage individuals with these services as they reenter the community. These services and approaches include:

- Collaborative courts combining judicial supervision with rehabilitative services to support recovery, reduce recidivism and improve outcomes among individuals living with SUD or mental health conditions.¹⁷⁵
- Pre-release services and reentry planning such as enrolling individuals in Medi-Cal coverage prior to release, offering services and medications to stabilize individuals' physical and behavioral health conditions while incarcerated, and establishing a coordinated plan for their community-based care prior to release to support the reentry transition.
- Community-based reentry programs that connect individuals to community supports and treatment resources upon their release from criminal justice institutions.
- Law Enforcement Assisted Diversion programs, which establish treatment-based alternatives to criminal sanctions for individuals living with mental health, substance use and co-occurring disorders.

To address these issues, California has developed local and statewide initiatives for individuals who are justice-involved with behavioral health issues. Many of these programs aim to prevent unnecessary incarceration for individuals living with behavioral health conditions or to connect such individuals with treatment resources after release from jail or prison. Several initiatives focus efforts on ensuring Medi-Cal benefits upon release from prisons and, increasingly, jails. These existing initiatives include:

- Since 2015, state prisons are required to use a standardized process for gathering and processing pre-release applications to ensure that individuals who are justice-involved are enrolled in Medi-Cal before their return to the community. By January 1, 2023, all counties are mandated to implement pre-release Medi-Cal application processes in county jails and youth correctional facilities.¹⁷⁶
- As mandated by the federal SUPPORT Act and recent CMS guidance, California requires¹⁷⁷ counties to suspend—rather than terminate—the Medi-Cal eligibility

¹⁷⁵ Collaborative courts supporting individuals with behavioral health conditions were identified using data provided by the Judicial Council of California.

¹⁷⁶ CA Legislature. SB 1469.727 WIC. 2006. Available at http://www.leginfo.ca.gov/pub/05-06/bill/sen/sb_1451-1500/sb_1469_cfa_20060501_142757_sen_comm.html.

¹⁷⁷ CA Legislature. SB 1147. 2008. Available at http://leginfo.ca.gov/pub/07-08/bill/sen/sb_1101-1150/sb_1147_cfa_20080311_130324_sen_comm.html; see also CA Penal Code § 4011.11.

- of individuals under age 21 when they become an inmate in a public institution.¹⁷⁸
- DHCS requires jails and county juvenile facilities to implement a process to facilitate referrals to county specialty mental health services, the DMC-ODS and/or Medi-Cal MCPs for inmates who received behavioral health services while incarcerated, to allow for the continuation of behavioral health treatment.¹⁷⁹ At least 20 counties have existing processes for Medi-Cal enrollment prior to reentry.
 - Managed care plans are required to offer intensive, community-based care management for individuals transitioning to the community through the new statewide Enhanced Care Management and Community Supports benefit.
 - DHCS is also leveraging multiple federal funding streams to support the delivery of behavioral health services for individuals who are incarcerated, including, but not limited to, funding to expand MAT in county jails and drug courts, MAT training and technical assistance for the California Department of Corrections and Rehabilitation (CDCR), and Community Mental Health Services Block Grant funding.
 - While more can be done in this area, California is making strides in strengthening pre-release efforts, diversion programs and reentry activities, including:
 - Currently, 17 counties offer Whole Person Care (WPC) pilots dedicated to serving individuals reentering the community post-incarceration and have designed programs to directly engage local jails and/or probation departments.¹⁸⁰ These programs will be transitioned into Enhanced Care Management/Community Supports programs in CalAIM.
 - A significant percentage of counties developed and implemented adult drug courts (46 counties) and adult mental health courts (38 counties).
 - Almost all counties (92 percent, 55 respondents) report collaborating with jail or prison facilities to facilitate pre-release planning for incarcerated individuals reentering the community.
 - Most counties operate at least one pre-release reentry program and many counties have several. There are nearly 840 operational pre-release reentry programs serving nearly 13,000 individuals who are justice-involved at any given time.

¹⁷⁸ State Medicaid Director Letter re: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act), CMS, January 19, 2021. Available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>.

¹⁷⁹ Brief Overview of the Department of Health Care Services (DHCS)' California Advancing and Innovating Medi-Cal (CalAIM) Proposals that Impact the Criminal Justice Population, CCJBH, September 2021. Available at https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2021/09/CalAIM-Proposals-Relevant-to-Justice-System-Partners_September-2021.ADA_.pdf?label=Brief%20Overview%20of%20CalAIM%20Proposals&from=https://www.cdcr.ca.gov/ccjbh/publications/.

¹⁸⁰ Counties with justice-involved WPC pilots were identified through a review of WPC contracts and confirmed by targeted interviews and surveys conducted by DHCS and Manatt in May 2021.

As of November 2021, the month of this report's publication, the state is also pursuing authorization of pre-release services to improve care for individuals who are justice-involved through the CalAIM Section 1115 Demonstration waiver.¹⁸¹ Through its 1115 waiver request, California seeks to test the expectation that providing health care services to individuals for the 90 days prior to release will prevent avoidable use of health care services while improving health outcomes post-incarceration. Service provision in the pre-release period is designed to engage eligible individuals who are justice-involved and prepare them for return to the community and to mitigate gaps in services and medication. If approved by the federal government, covered services for eligible individuals will include in-reach care management/care coordination; in-reach physical and behavioral health clinical consultation services provided via telehealth or in person, as needed, via community-based providers; limited laboratory/ X-rays; and MAT and psychotropic medications. Services will also be provided within jails and prisons for post-release, including a 30-day supply of medications and durable medical equipment.



Pre-Trial Diversion for Individuals Determined Incompetent to Stand Trial

Enacted in 2018, **AB 1810** created a pre-trial diversion pathway for individuals with certain mental health diagnoses charged with a felony or misdemeanor and are determined to be unlikely to pose a significant safety risk if treated in the community.¹⁸² The law allows the court to grant diversion if a mental health treatment program agrees to accept responsibility for the treatment of the defendant. The diversion period can be up to two years and charges are dismissed upon the successful completion of the diversion program.

The 2018-19 State Budget included \$100 million one-time over three years and the Budget Act of 2021 allocated an additional \$47.6 million dollars one-time to support an expansion of the **California Department of State Hospitals Diversion Program**. The funds will be used for county pre-trial mental health diversion programs for individuals living with serious mental illness who are deemed incompetent to stand trial.¹⁸³ Currently, 24 counties have implemented diversion programs and these programs may expand to increase diversion opportunities and additional counties may implement new diversion programs with the funding allocated in the Budget Act of 2021. Funding for this program is not on-going.

¹⁸¹ California Section 1115 Waiver Demonstration Application, June 30, 2021. Available at <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Section-1115-Renewal-Application.pdf>.

¹⁸² A.B.1810 Chapter 34. June 2018. Available at https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB1810.

¹⁸³ DSH Diversion Program, California Department of State Hospitals. Available at https://www.dsh.ca.gov/Treatment/DSH_Diversion_Program.html.

Behavioral Health Services for Individuals Who Are Justice-involved

Many initiatives for individuals who are justice-involved are locally or county led, with limited geographic reach. Quantitative and qualitative information collected through this assessment indicated that more can be done to support mental health and SUD services statewide to adequately support individuals who are justice-involved during pre-sentencing, while incarcerated and after release. A foundational problem is that many providers simply will not work with clients with a history of incarceration, particularly if they have been convicted of crimes that could represent a threat to other patients or staff (e.g., assault, sex crimes, arson). This perpetuates health disparities as individuals who are justice-involved are disproportionately people of color who have considerable health care needs but who are often left without care and needed medications upon release.



Thirty-seven of California's counties are participating in the Stepping Up initiative, a collaborative effort between agency decision-makers and diverse stakeholders to develop action plans to reduce the number of people living with mental illnesses in jails.

This results in challenges across the continuum of care for individuals who are justice-involved with behavioral health issues, especially if they require assistance with housing. For instance:

- Sixty-eight percent of counties (40 respondents) reported a significant need for services across the continuum of care for populations who are justice-involved, including an urgent need for mental health residential services.
- Thirty-five counties (58 percent) reported a need for SUD residential services for populations who are justice-involved.
- Forty-two percent of counties (25 respondents) need acute inpatient hospital beds and WM services for individuals who are justice-involved.
- Ninety-three percent of counties (56 respondents) identified an urgent need for housing for individuals who are justice-involved.
- Approximately 58 percent of counties (35 respondents) reported providers are unwilling to accept individuals with felony convictions/forensic backgrounds, and 68 percent (41 respondents) reported providers are unwilling to accept individuals with a history of sex offense convictions.
- Fifty-five percent (33 respondents) reported that they lack staff and training to meet the needs of populations who are justice-involved in their counties.
- According to the California Courts Judicial Council, 48 counties operate juvenile drug courts and 19 counties operate adult drug courts.



“We struggle significantly to place incarcerated people into treatment beds—no one will take people out of jail. We need access to jail-based treatment or facilities willing to take jail inmates.”

– *County Behavioral Health Director*

Focus group participants also explained that because probation systems differ between counties, there currently are inconsistent pathways to connect individuals who are justice-involved with community-based services. In addition, stakeholders shared that there are few, if any, navigational supports for families of incarcerated individuals. These issues are compounded by stigma and discrimination. One county reported, “Many programs take longer to interview patients who are in jail, and there is significant stigma against jailed patients. There is often the assumption that these patients are more dangerous and violent than are patients coming from other places. Programs also think that they have a right to view patients’ criminal histories if they are incarcerated at the time of referral.”



“There should be no difference in the information required for referral for jail patients, as this perpetuates discrimination. Many programs lack training in working with the criminal justice population and the criminal justice and legal systems in which their clients are involved.”

– *County Behavioral Health Director*

Some counties have developed an array of innovative programs to better serve individuals who are justice-involved. Orange County has developed an approach that includes collaborative release planning, linkages to community resources and treatment (including MAT), and services for youth in juvenile hall. San Diego County requires that individuals released on probation have a “warm handoff” to community services, allowing individuals to receive treatment or housing services immediately upon release.

As discussed in Section 5.7 above, some counties also employ crisis intervention teams (CITs) that are designed to address the needs of individuals living with behavioral health conditions who enter the judicial system during a crisis state. Counties’ investments in alternative models of crisis response, such as CITs, are intended to help mitigate unnecessary contact with law enforcement and to divert people in crisis to treatment services instead of jails. Data from the University of Memphis Crisis Intervention Team

Resource Center indicate that CITs are operational in 24 counties across the state¹⁸⁴; in most cases, the CITs are small and may not be adequately resourced to fully implement the CIT model with fidelity.

6.3 AI/AN Communities

There are 109 federally recognized American Indian tribes in California¹⁸⁵ and 78 entities petitioning for federal recognition.¹⁸⁶ California is home to more AI/AN communities than any other state,¹⁸⁷ and these communities face high rates of behavioral health issues with little or no access to prevention or treatment services across both rural and urban communities. The prevalence and intensity of behavioral health conditions and the lack of access to services are driven by historical trauma as well as related social, policy and economic conditions that have limited access to health care and housing resources and resulted in poverty, unemployment and lower educational attainment.¹⁸⁸ Specifically:

- Nationally, among AI/AN individuals, 19 percent report experiencing mental illness in the past 12 months.¹⁸⁹
- In California, opioid overdose deaths in the AI/AN population are almost double that of white communities and 500 percent higher than in Latino communities.¹⁹⁰
- According to the most recent evaluation of the DMC-ODS, overdose death rates from psychostimulants are also higher for the AI/AN population (20.5 per 100,000) than for any other racial/ethnic group.¹⁹¹
- AI/AN youth and adolescents nation-wide face significantly higher rates of depression, suicide, and SUD than other young adult populations, but they have

¹⁸⁴ University of Memphis Crisis Intervention Team Resource Center. Available: <http://www.cit.memphis.edu/aboutCIT.php>.

¹⁸⁵ "California Tribal Communities," California Courts: The Judicial Branch of California, 2021. Available at <https://www.courts.ca.gov/3066.htm>.

¹⁸⁶ "Tribal Governments," Los Angeles City/County Native American Indian Commission, 2021. Available at <https://lanaic.lacounty.gov/resources/>.

¹⁸⁷ Ibid.

¹⁸⁸ "Tribal Affairs," SAMHSA, October 2021. Available at <https://www.samhsa.gov/tribal-affairs>.

¹⁸⁹ "Native And Indigenous Communities And Mental Health," Mental Health America, Accessed September 8, 2021. Available at <https://www.mhanational.org/issues/native-and-indigenous-communities-and-mental-health>.

¹⁹⁰ "California's Tribal ODS & Tribal Medication Assisted Treatment (MAT) Expansion Project Update," DHCS, October 2019. Available at https://www.dhcs.ca.gov/Documents/5_California%27s_Tribal_ODS_and_MAT_Expansion_Project_Update.pdf.

¹⁹¹ "Drug Medi-Cal Organized Delivery System FY 2020 Evaluation Report," DHCS, July 2021. Available at https://www.uclaisap.org/dmc-ods-eval/assets/documents/2020-DMC-ODS-Evaluation-Report-with-Appendices_revised_2021-07-09.pdf.

limited access to youth-focused treatment services and facilities.¹⁹²

- While there are limited data on ACEs among AI/AN youth and adolescents, research generally shows up to 74 percent of AI/AN youth experience at least one traumatic event during childhood.¹⁹³

DHCS recognizes the devastating outcomes among AI/AN individuals and is working with AI/AN communities through the Tribal MAT Project (TMAT) to address the OUD prevention, treatment and recovery needs of California's Tribal and Urban American Indian communities.¹⁹⁴ Specifically, TMAT and TMAT 2.0 are focused on sharing knowledge among Tribal and Urban Indian communities, health programs and community-based partners on OUD prevention, treatment and recovery in California Indian Country.¹⁹⁵ More information on the specific gaps in the behavioral health continuum for AI/AN individuals and communities is provided below.

Challenges and Opportunities in Behavioral Health Services for AI/AN Individuals and Communities

As noted, there are significant gaps in the behavioral health care continuum for both youth and adults in AI/AN communities in California, attributable to systemic discrimination against AI/AN individuals and communities. In this context, it is important to understand the gaps as well as to work in partnership with AI/AN communities to identify culturally appropriate responses and interventions. For instance, focus group participants emphasized the following:

- The importance of culturally responsive and trauma-informed care that recognizes the historical trauma experienced by AI/AN individuals and the deep distrust of health care and government institutions attributable to forced assimilation campaigns.
- The integration of traditional AI/AN practices into behavioral health services, which might include sharing AI/AN blessings and other traditional forms of healing practices, such as sweat lodges and talking circles.
- A significant lack of residential services for AI/AN youth, as well as for adults, who require stabilization for mental health conditions.
- Recognition of the unique needs of the isolated and rural communities in which some AI/AN individuals reside, necessitating greater use of telehealth,

¹⁹² "Native American Youth Depression and Suicide," Child Welfare Information Gateway, Department of Health and Human Services. Accessed September 8, 2021. Available at <https://www.childwelfare.gov/topics/systemwide/diverse-populations/americanindian/mentalhealth/depression/>.

¹⁹³ Bereiter J, "ACES and Why They Matter in Healthcare," Indian Health Service, 2017. Available at https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/slides/traumainformedcare/aces0617.pdf.

¹⁹⁴ "Tribal MAT Project," California MAT Expansion Project. Accessed September 8, 2021. Available at <http://www.californiamat.org/matproject/tribal-mat-program/>.

¹⁹⁵ Ibid.

community-driven solutions, and a willingness to support transportation to services that may be hours away.

- The importance of accounting for the complexity and intensity of need among AI/AN individuals, which may require more extended and expansive treatment to allow for stabilization and treatment of multilayered historical and family-based trauma.
- A strong focus on prevention and early intervention systems specific to AI/AN communities to prevent the need for higher levels of care, focusing on AI/AN-led initiatives that include participation and leadership from AI/AN youth.

In addition to the information gathered through the focus groups, DHCS recently worked with the University of Southern California Keck School of Medicine to complete a [needs assessment](#) that focused on OUD and AI/AN communities.¹⁹⁶ This needs assessment found:

- Family substance use is pervasive, necessitating multigenerational treatment strategies.
- While there has been a decrease in opioid prescriptions resulting from increased prescription oversight, AI/AN youth are found to have greater access to a variety of substances than in the past.
- Community and individual stressors are risk factors for opioid use, while historical and intergenerational trauma remain significant drivers of both mental health issues and substance use among AI/AN populations.
- Barriers to treatment include individual stigma and shame in seeking services and structural factors including cost, lack of or insufficient insurance coverage, unstable housing, fragmented service delivery, and a lack of residential treatment facilities for SUD.
- There is a lack of youth OUD prevention programs in AI/AN communities in California.

The OUD needs assessment recommended various program and policy changes DHCS should consider addressing OUD, including better access to MAT. These recommendations include:¹⁹⁷

- Removing prior authorization requirements and limits on insurance coverage.
- Providing financial incentives to providers to become MAT certified.
- Charging a fee on opioid sales, to be deposited into a recovery fund.
- Adopting policies supporting longer provider-patient interactions.
- Expanding access to Tribal Opioid Response Grants among Urban Indian Health Programs.

¹⁹⁶ Soto C, "Tribal MAT Statewide Needs Assessment & Recommendations," University of Southern California Keck School of Medicine, 2019. Available at https://www.uclaisap.org/slides/psattc/cod/2019/Day%202/02_Workshop_Y_Soto.pdf.

¹⁹⁷ Ibid.

Finally, there are coordination challenges between counties, the federal Indian Health Service (IHS) and DHCS. Stakeholders shared that AI/AN communities with behavioral health needs are faced with a patchwork of service providers, with some county-based services covered by Medi-Cal and other services provided by IHS. This fragmentation adds to an already challenging landscape for AI/AN individuals who experience behavioral health conditions.

VII. Highest-Priority Challenges and Opportunities

Stakeholders identified significant concerns across the board regarding the continuum of behavioral health care in California, but a handful of issues emerged as urgent priorities. Many of these already are a focus of DHCS' behavioral health agenda, offering an important opportunity to address the highest-priority challenges confronting California's behavioral health system. These challenges and opportunities may be incorporated into DHCS's more immediate efforts to reform Medi-Cal to better address adults living with SMI, children living with SED, individuals living with SUD and individuals who are involved in the justice system. As a point-in-time study completed in the midst of implementation of numerous large-scale changes, the Administration hopes to see changes in these outcomes in coming years as a result of recent significant investments.



California needs a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

California needs a comprehensive approach to crisis services that emphasizes community-based treatment and prevention, and connects people to ongoing services.

The assessment at the center of this report highlights the importance of a comprehensive, coordinated effort to develop a continuum of crisis services that leverages and builds on the many initiatives already underway, including implementation of the 988 hotline by July 16, 2022; the Behavioral Health Continuum Infrastructure Program (see Section 2 for more details); and the CalHOPE 24/7 warm lines and chat support; and the new enhanced federal funding for a Medi-Cal mobile crisis benefit (pending budget approval).

While a key piece of any crisis initiative should include who responds to crisis calls—ideally, peers and behavioral health professionals who are experts in de-escalation—it also needs to address what happens to people before and after such crises. Any crisis system should start with identifying ways to avert the escalation of mental health and substance use issues, including offering support through peer warm lines before stress turns into a crisis. If a crisis response team is necessary, it is important to have alternatives to hospitalization when appropriate or incarceration, including crisis stabilization units, crisis residential services, crisis respite services (including peer respite) and sobering centers. In the absence of crisis response teams, these same

services should be available to law enforcement and other first responders as alternative destinations.

Most important, the assessment illustrates the importance of viewing crisis services as part of the broader behavioral health continuum, ensuring people receive services at the least expensive, least restrictive level of care (preventing unnecessary use of limited institutional resources such as EDs and hospitals, and helping to reduce the criminalization of mental health and substance use issues). Crisis services should be sufficiently funded by all payers, including Medicaid and commercial insurance, to ensure they can maintain 24/7 availability and respond in a timely manner to all individuals in crisis, regardless of insurance status. While there will be regional variation in capacity and resources for delivering crisis services, warm lines and crisis call centers should perform comparably across the state. The many initiatives already underway in California are working toward this vision.



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

Bed capacity and long waits in the ED and inpatient psychiatric hospitals are the most apparent challenges in California's behavioral health care system. The assessment highlights the importance of responding to these urgent needs and developing a strategy for finding ways to assist people to live independent and meaningful lives in their communities. In line with DHCS' broader vision for CalAIM, this requires a fundamental shift toward considering Whole Person Care (WPC) that is rooted in the priorities of the people served by the behavioral health care system. The approach should be person centered, allowing the individual to define where they want to live, to connect with others, to become employed and to participate in meaningful activities that facilitate community integration.

For behavioral health care system reform, this imperative translates into the importance of addressing the basic issue of affordable housing for individuals who are likely to have little or inconsistent income. Affordable housing was repeatedly raised as the most important barrier to supporting individuals in living in the community. More broadly, it points to the promise of social rehabilitation models—both for shorter-term residential treatment and housing programs (e.g., ARFs)—that offer people community-based services in home-like environments that meets their needs, including life skills and activities, and look beyond their medical conditions to the key ingredients for a meaningful life and the opportunity to remain in the community.



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

Stakeholders across the board highlighted the dearth of services for youth experiencing substance use disorders and the importance of finding ways to help prevent risky behaviors. The most glaring gap in services is for young people who require substance use treatment; 75 percent of counties (45) reported a lack of residential beds for youth patients, and 68 percent (41) reported they did not have enough providers with training and experience to meet youth patients' needs. As a result, children and youth SUD treatment options, including residential care, are sometimes mixed in with adult treatment options, or in some instances, youth are sent out of state to receive care.

At the same time, there was little interest in building out residential beds for youth without making sure they are used as rarely as possible. This requires viable community-based alternatives for treatment. So much of how children and youth succeed is linked to their ability to remain in school and their relationship with parents or other caretakers. Therefore, it is particularly problematic to have them sent far away from their communities and families for treatment. The assessment highlights the importance of increasing access to outpatient and intensive outpatient services for youth that can be delivered locally in or linked to schools, via telehealth or through intensive in-home services. The assessment also identified the need for prevention and early intervention for substance use or misuse that could be provided by schools and other community-based organizations.

Fortunately, California is making unprecedented investments in behavioral health services for children and youth (see Emerging and Existing Initiatives to Improve the Behavioral Health of California's Children and Youth in Section 6.1), including, most notably, through the Children and Youth Behavioral Health Initiative. This creates the opportunity to invest in prevention, such as by reducing risky behaviors, as well as to address the treatment gaps identified in the assessment.



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

While gaps in care are evident throughout the behavioral health care continuum for children and youth, the biggest chasm is a lack of services and interventions that could prevent children from developing significant and long-term behavioral health issues. Children who experience adverse childhood experiences (ACEs) are more likely to exhibit negative behaviors and more likely to develop risky behaviors. Traditional payer approaches often do not recognize or pay for prevention or early intervention activities to address these behaviors and other issues that confront children and youth. The lack of resources has resulted in few staff having the necessary training and competencies to effectively identify and address behavioral health issues early in children and youth. While the Children and Youth Behavioral Health Initiative and recent investments in screening for and addressing ACEs will provide some support for prevention activities, there are a host of other issues that children and youth experience. Trauma, gender

identification issues and grief, as identified in the assessment, are some of the areas that would benefit from a well-organized and funded approach.

Schools can play an important role in these preventive and early intervention activities. They offer a safe, welcoming, and inclusive place where all students can thrive, regardless of circumstance or location. School-based health centers as well as county operated school-linked services may be in the best position to develop the capacity to spread and sustain efforts that ensure children have timely access to these activities and interventions. Financially supporting school-based and linked programs, such as is planned in the Children and Youth Behavioral Health initiative, will give educators the support and resources they need to be successful. School communities that engage in the development and support of all school staff can create a culture that builds resilience for all students.



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

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

California may be able to draw from its California Reducing Disparities Project (CRDP), a statewide policy initiative focusing on reducing mental health disparities among historically unserved, underserved, and inappropriately served communities, to inform its approach for the broader behavioral health system. Phase I of the project focused on development of a strategic plan for addressing mental health disparities along with population-specific assessments and recommendation reports for five priority populations -- Black, Asian and Pacific Islander, Latino, American Indian/Alaska Native and LGBTQ+. Now in Phase II, CRDP is in the process of implementing and evaluating 35 community-defined evidence practices (CDEPs) delivered by CBOs that provide culturally and linguistically competent prevention and early intervention mental health services to priority populations.



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

As the body of research on effective treatment for mental health and substance use disorder conditions continues to expand, the assessment highlights the importance of embracing and making full use of those initiatives and treatment options that are known to be effective. Evidence-based practices can greatly improve lives if implemented broadly and with fidelity, and that is why the Children and Youth Behavioral Health Initiative included a significant investment for this purpose. The specific evidence-based practices highlighted in this assessment include use of contingency management for stimulant use disorders and greater availability of fidelity-based practices such as supported employment, supportive housing, Assertive Community Treatment teams, first-episode psychosis initiatives and specialized eating disorder protocols. Even beyond these specific initiatives and programs, the behavioral health field continues to evolve and produce more research on effective ways for providers to deliver therapy and other behavioral health supports. For example, the research continues to grow on the value of CBT, DBT, contingency management and motivational interviewing.

While sustainable funding for these practices is important, supporting providers to provide services with fidelity is equally so. California has had success expanding the use of MAT in recent years, offering an example of how a combination of state and county requirements, provider education, ongoing support and funding can assist in disseminating evidence-based practices. According to the Addiction Free California Dashboard, the rate of buprenorphine prescribing in California increased over 70% from December 2009 to December 2017.¹⁹⁸ Other states have had considerable success setting up Centers of Excellence (COEs) that work with providers to help them understand and use evidence-based practices, such as New York’s Center for Culturally Competent Care, Ohio’s Child and Adolescent Behavioral Health Center of Excellence, and Pennsylvania’s Centers of Excellence for MAT. With its leading academic institutions, California is particularly well positioned to leverage and work with such institutions to support providers in deploying evidence-based practices with fidelity. A California approach to developing COEs should consider existing practice change efforts and regional models given the size and diversity of the State.

In addition to expanding coverage and access to EBPs across the state, DHCS also recognizes the importance of sustaining community defined practices for behavioral health interventions. Under this model, community-based practitioners develop interventions that are geared toward a specific community or population and are often culturally grounded.

¹⁹⁸ “Data Dashboard,” Addiction Free CA. Available at <https://addictionfreeca.org/data-dashboard>.



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

Stakeholders consistently raised the critical importance of improving mental health and substance use disorder services for individuals who are justice-involved, starting by reducing the arrest and incarceration of people because they are in crisis due to those conditions. Despite the current reality that vast numbers of people in California’s jails and prisons are experiencing a mental health and/or substance use disorder, it was universally agreed that jails and prisons generate more trauma and stress and are not the right place for individuals living with behavioral health conditions unless they engage in criminal activity that leaves no other option.

Practical implications include the importance of implementing a comprehensive crisis response system, per the discussion above, that reduces the unnecessary involvement of law enforcement and incarceration of people who are having a mental health or substance use–driven crisis; pursuing the new Medi-Cal initiative to offer selected pre-release services to individuals living with certain behavioral health conditions; offering training and support to providers to encourage more of them to work with individuals who are justice-involved; engaging peers who have experienced incarceration to offer services to people leaving jail or prison; and ensuring that CalAIM’s WPC approach reflects the unique challenges confronting individuals who are justice-involved, such as additional barriers to housing, employment and treatment.

VIII. Implications Across the Continuum of Care

Along with the highest-priority issues and opportunities described above, numerous additional actions and initiatives may help California strengthen its behavioral health care system. This section reviews some of the ideas and strategies that were identified by stakeholders, focus group participants, survey responses and additional data organized by the continuum of care outlined in Figure 1b. For each service area or challenge, there is generally a need to expand capacity, consider policy changes and address workforce issues contributing to the situation. For more details on strategies and efforts underway to strengthen the behavioral health workforce in California, readers may want to review some of the more in-depth analyses on this topic, including materials from the California Future Health Workforce Commission and the Department of Health Care Access and Information.¹⁹⁹

¹⁹⁹ More information about the recommendations from the California Future Health Workforce Commission is available at <https://futurehealthworkforce.org/about/>.

8.1 Preventive, Wellness and Outpatient Considerations

A strong theme from the assessment is the importance of expanding preventive and outpatient behavioral health services, particularly for children and youth, including integrating services to address substance use and misuse into school-based settings. Prevention and early intervention are needed to stave off or ameliorate emerging behavioral health conditions, reduce the impact on EDs and inpatient facilities, and support California's commitment to seeing care delivered in the least restrictive settings possible.

The assessment also identified a host of policy changes that could reduce barriers and increase access to preventive and outpatient services. These policy changes may provide new and/or more focused direction to several key initiatives DHCS is shaping, including revisions to the SUD 1115 and SMI/SED Medicaid demonstrations waivers and proposed value-based purchasing proposals. The State will work with other state agencies and stakeholders to review current policies as needed to increase access to these services.

Overall, the assessment reinforced the importance of strengthening and expanding the behavioral health care workforce for early intervention (especially in schools and through pediatric offices serving children prior to elementary school), wellness and traditional outpatient services. Stakeholders recommended programs that seek to encourage the existing workforce to remain in the field, increase their expertise, and enhance their efficiency and bandwidth. Stakeholders also encouraged efforts to diversify the types of practitioners and settings that can offer outpatient behavioral health services.

Policy opportunities suggested by stakeholders include (1) incentivizing providers to adopt a no-reject policy for outpatient and other behavioral health services for individuals who are justice-involved and (2) developing a model of on-call and telehealth mentoring from psychiatrists for pediatric providers and perinatal providers to help with psychotropic prescribing for children, their parents and pregnant/postpartum women, similar to programs in Massachusetts and other states.

8.2 Crisis Services Considerations

The assessment reinforced the importance of DHCS' existing and proposed crisis service initiatives, such as the plan to use the new federal option to expand mobile crisis services for Medi-Cal enrollees (pending budget approval) and grants to counties for planning and implementation of crisis services. Other findings identified potential new services or renewed approaches for ensuring a full continuum of crisis services.

DHCS will continue to work with other state agencies and stakeholders to examine access to crisis services. One issue identified by stakeholders was to review and identify regulatory barriers preventing the delivery of integrated crisis care and SUD treatment, including ensuring that crisis services offer access to MAT for those individuals who have both OUD and a mental health issue.

The assessment identified opportunities to enhance the workforce of crisis providers, such as including peer support service providers and trained law enforcement personnel

operating in partnership with behavioral health providers, when necessary for an intervention. In addition, focus group respondents identified the need for training and technical assistance on the new federal mobile crisis option in Medi-Cal, pending budget approval (e.g., trauma-informed care, de-escalation strategies and harm reduction training), as well as training call center and mobile crisis staff on issues related to substance use disorders.

8.3 Community, Peer and Recovery Support Considerations

The assessment identified opportunities to improve various community, peer and recovery supports for children, youth and adults, including building additional capacity for the peer workforce and leveraging work already underway to provide coordinated specialty care services to youth and young adults who experience an initial episode of psychosis. Additional workforce strategies identified by stakeholders include creating a process for recruiting and certifying youth peer supports, SUD recovery coaches and a family peer support workforce. Efforts to increase access to and the quality of various community, peer and recovery supports will have workforce implications.

The focus group participants identified the need to expand the capacity and ensure consistent standards for community-based, peer and recovery services, which will be addressed in July 2022, as DHCS implements its new peer support certification standards. Other potential strategies to ensure the quality of peer-delivered services would not need regulatory changes but could benefit from processes to review and monitor programs to ensure they meet existing standards. For instance, strategies to review programs that address first-episode psychosis could promote alignment with existing strategies from the California Mental Health Services Oversight and Accountability Commission. Other policies may focus on strategies to include supported employment and supported education in the Medi-Cal program.

8.4 Intensive Outpatient and Treatment Services Considerations

The assessment identified several potential gaps in intensive services (community- and facility-based) where additional capacity was recommended. Data regarding potential gaps in inpatient psychiatric care identified by the California Hospital Association and supported by outputs using the Crisis Resource Need Calculator showed variability in existing inpatient bed capacity. The assessment also identified the lack of “upstream” services (e.g., crisis services) that could be helpful in diverting individuals from EDs and potential admission to these facilities. Additionally, the assessment suggested additional capacity to divert individuals from incarceration. It also highlighted the current bottlenecks in services that are necessary to transition individuals out of these facilities in a timely manner.

Stakeholders also identified the need to develop additional capacity for existing services or, in some instances, new services (e.g., ASAM Level 4.0-WM), and recommended that DHCS educate managed care organizations and hospitals regarding the current Voluntary Inpatient Detoxification benefit (inpatient withdrawal management) to ensure broader availability of services. Stakeholders also identified the need for additional clinical programs and providers to address eating disorders and clarifying the mutual responsibilities of managed care plans and mental health plans.

Stakeholders identified the need for policy changes to address gaps in intensive outpatient and treatment services. Suggestions include leveraging the proposed SMI/SED 1115 Demonstration program to allow Medi-Cal coverage of high-fidelity ACT teams and forensic ACT teams, to support programs to divert individuals from arrest and incarceration into treatment, and/or expand treatment options for eating disorders, and (2) developing standards and admission criteria for inpatient withdrawal management (also known as voluntary inpatient detox), consistent with current ASAM criteria.

8.5 Selected SUD Services Considerations

Overall, there were many findings that were specific to enhancing services for individuals living with SUD. These included findings regarding specific services for adults living with SUD and findings related to services and approaches for specific substances or combinations of substances (e.g., methamphetamine, fentanyl), MAT for OUD, and unevenness of access to various ASAM Level 3.0 residential levels of care. For adolescents, the service gaps were more pronounced. Quantitative and qualitative data from county surveys and focus group members identified a lack of treatment services across all SUD levels of care. While the 2015 1115 SUD DMC-ODS waiver provided a major driver in expanding access to and the quality of SUD services across the state, little noticeable improvement occurred for adolescents with SUD. DHCS will be addressing some of these issues for adults and adolescents in the renewal of the SUD 1115 DMC-ODS waiver. In addition, SUD program enhancements were included in California's request for federal funding opportunities available through the American Rescue Plan Act (ARPA). The department's Tribal MAT program has supported AI/AN populations over the past several years, and findings from the assessment supported continued enhancements of MAT and other SUD services for this population.

The assessment identified various policy barriers that hindered access to treatment. Some of these barriers would require statutory changes to address, such as acting on [new federal guidance](#) to allow OUD medications to be dispensed through mobile narcotic treatment vans, to offer access to methadone in regions with no NTP access. Others could be addressed through regulatory changes, such as amending licensing and certification standards to increase oversight authority of treatment programs to ensure clients with OUD are offered MAT, either on-site or through referral. Other barriers will be addressed through CalAIM updates to the DMC-ODS program and the new pilot of contingency management for stimulant use disorder. These efforts will require that DHCS continue to work with stakeholders on a range of strategies planned for calendar year 2022 and beyond to implement these updates.

The assessment findings provided direction for various strategies to address the workforce. While DHCS recognizes that recruitment and retention efforts will be imperative across behavioral health and other social service areas, more targeted strategies may be necessary to enhance the capacity and competencies of the workforce serving individuals living with SUD. These strategies may focus on implementation efforts that result from capacity and policy changes specific to SUD services. Similar to these efforts, considerations for workforce development will be

driven by changes to the SUD 1115 DMC-ODS waiver, implementation efforts for addressing stimulant use disorder and other planned initiatives.

IX. Conclusion

In summary, DHCS collected data from multiple sources, including quantitative analysis and qualitative input from focus groups and surveys, aiming to document the state of behavioral health capacity in California, with a particular focus on Medi-Cal. DHCS has many major behavioral health initiatives underway to address issues surfacing in this report. The assessment will also help inform future work, including guidance for implementation of the Behavioral Health Continuum Infrastructure Program (BHCIP) and California's proposal for the SMI/SED Demonstration 1115 Waiver. Key findings include:

- It is critical to have a comprehensive approach to behavioral health services that emphasizes community-based treatment, diverts individuals from costly inpatient services and involvement with law enforcement and connects people to ongoing services, including housing and housing supports.
- More community based treatment options are essential for people living with serious mental illness and/or a substance use disorder, there is a profound need for more community-based living options to promote community inclusion.
- More treatment options are vital for children and youth living with significant mental health and substance use disorders.
- Prevention and early intervention provided through schools and other community-based organizations are critical for children and youth, especially those who are at high risk.
- Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.
- A large and diverse health workforce can support the expansion and sustainability of mental health and SUD services, including efforts to recruit and train peers support staff and recovery coaches.
- More can be done to encourage evidence-based practices are used consistently and with fidelity throughout California's behavioral health system.
- More effectively addressing the behavioral health issues—and related housing, economic and physical health issues—of individuals who are justice-involved is critical.

In the months and years ahead, DHCS will continue to review and update these findings to inform its process for implementing existing initiatives and developing new ones. This assessment is a substantial start and intended to serve as one source of information that DHCS can consult in its work. DHCS recommends more in depth work to understand and analyze the current state of play with respect to the role of commercial insurers in providing behavioral health services; the role of MHSA funding; the use of realignment funds and other issues. As it continues its work, DHCS looks forward to ongoing consultation with the people living with behavioral health conditions, their families and caretakers, counties, providers, plans and other stakeholders that share the commitment to improving California's behavioral health system.

Appendix A – List of Acronyms

| <u>Acronym</u> | <u>Definition</u> |
|-----------------------|---|
| ACA | Affordable Care Act |
| ACEs | adverse childhood experiences |
| ACF | Administration for Children and Families |
| ACT | Assertive Community Treatment |
| AI/AN | American Indian/Alaska Native |
| AMI | any mental illness |
| AOT | assisted outpatient treatment |
| ARPA | American Rescue Plan Act of 2021 |
| ASAM | American Society of Addiction Medicine |
| BHCIP | Behavioral Health Continuum Infrastructure Program |
| BSCC | Board of State and Community Corrections |
| CalAIM | California Advancing and Innovating Medi-Cal |
| CBHSQ | Center for Behavioral Health Statistics and Quality |
| CBO | Community-Based Organization |
| CBT | Cognitive Behavioral Therapy |
| CHIP | Children's Health Insurance Program |
| CDCR | California Department of Corrections and Rehabilitation |
| CIT | crisis intervention team |
| CMS | Centers for Medicare & Medicaid Services |
| CRAFFT | Car, Relax, Alone, Forget, Friends, Trouble Screening Tool |
| CRTPs | Crisis Residential Treatment Programs |
| CSOC | Children's System of Care |
| CSUs | crisis stabilization units |
| DBT | Dialectical Behavior Therapy |
| DEA | Drug Enforcement Administration |
| DHCS | Department of Health Care Services |
| DMC-ODS | Drug Medi-Cal Organized Delivery System |
| EDs | emergency departments |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment benefit |
| ERISA | Employee Retirement Income and Security Act of 1974 |

| <u>Acronym</u> | <u>Definition</u> |
|-----------------------|---|
| FEP | first-episode psychosis |
| FFS | fee-for-service |
| FPL | federal poverty Level |
| FQHCs | Federally Qualified Health Centers |
| FSP | Full-Service Partnership |
| FURS | Family Urgent Response System |
| HPSAs | health professional shortage areas |
| IHS | Indian Health Service |
| ILOS | In-lieu-of services |
| IMDs | Institutions for Mental Disease |
| IOPs | Intensive Outpatient Programs |
| LOS | lengths of stay |
| MAT | medications for addiction treatment (also known as medication-assisted treatment) |
| MCOs | managed care organizations |
| MCPs | managed care plans |
| MHPAEA | Mental Health Parity and Addiction Equity Act |
| MHRCs | mental health rehabilitation centers |
| MHSA | Mental Health Services Act |
| NASMHPD | National Association of State Mental Health Program Directors |
| NIMBY | “Not in my backyard” |
| NPs | nurse practitioners |
| NSDUH | National Survey of Drug Use and Health |
| NTPs | Narcotic Treatment Programs |
| OTPs | Opioid Treatment Programs |
| OD | opioid use disorder |
| PAs | physician assistants |
| PHF | psychiatric health Facility |
| PHPs | Partial Hospitalization Programs |
| PRTFs | Psychiatric Residential Treatment Facilities |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |

| <u>Acronym</u> | <u>Definition</u> |
|-----------------------|---|
| SCAs | single-case agreements |
| SED | serious emotional disturbance |
| SMHS | Specialty Mental Health Services |
| SMI | serious mental illness |
| SNF | Skilled Nursing Facilities |
| SSI | Supplemental Security Income |
| STRTPs | Short-term Residential Therapeutic Programs |
| SUD | Substance Use Disorder |
| TMAT | Tribal MAT Project |
| WIC | Welfare and Institutions Code |
| WM | Withdrawal management |
| WPC | Whole Person Care |

Appendix B – Data

Table 1. Rates of Behavioral Health Conditions Among Adults Aged 18+ from the 2019 National Survey of Drug Use and Health

| | Any Mental Illness | Serious Mental Illness (SMI) | Illicit Drug Use Disorder | Alcohol Use Disorder | Any Substance Use Disorder (SUD) |
|---------------------------------------|--------------------|------------------------------|---------------------------|----------------------|----------------------------------|
| Age Group | | | | | |
| Aged 18-25 | 29.4% | 8.6% | 7.5% | 9.3% | 14.1% |
| Aged 26-49 | 19.2% | 6.8% | 3.7% | 7.0% | 9.6% |
| Aged 50+ | 14.1% | 2.9% | 1.0% | 3.4% | 4.1% |
| Gender | | | | | |
| Male | 16.3% | 3.9% | 3.7% | 7.3% | 10.0% |
| Female | 24.5% | 6.5% | 2.3% | 4.0% | 5.6% |
| Race/Ethnicity | | | | | |
| Not Hispanic | 21.1% | 5.3% | 3.0% | 5.7% | 7.8% |
| White | 22.2% | 5.7% | 2.9% | 6.0% | 8.1% |
| Black | 17.3% | 4.0% | 3.3% | 5.1% | 7.6% |
| American Indian/Alaska Native (AI/AN) | 18.7% | 6.7% | 4.5% | 6.8% | 10.2% |
| Native Hawaiian/Pacific Islander | 16.6% | 2.6% | 2.9% | 5.7% | 8.3% |
| Asian | 14.4% | 3.1% | 1.7% | 3.6% | 4.6% |
| Two or more | 31.7% | 9.3% | 5.9% | 7.6% | 11.9% |
| Hispanic | 18.0% | 4.9% | 2.9% | 5.1% | 7.0% |
| Employment Status | | | | | |
| Full-time employed | 19.2% | 4.6% | 2.7% | 6.7% | 8.6% |
| Part-time employed | 25.0% | 6.8% | 3.8% | 5.7% | 8.1% |
| Unemployed | 27.7% | 8.4% | 9.9% | 9.5% | 16.1% |

| | Any Mental Illness | Serious Mental Illness (SMI) | Illicit Drug Use Disorder | Alcohol Use Disorder | Any Substance Use Disorder (SUD) |
|---|---------------------------|-------------------------------------|----------------------------------|-----------------------------|---|
| Other | 20.1% | 5.2% | 2.2% | 3.6% | 5.3% |
| Region | | | | | |
| Northeast | 19.7% | 4.7% | 2.9% | 5.2% | 7.2% |
| Midwest | 22.1% | 5.6% | 3.0% | 6.2% | 8.2% |
| South | 19.2% | 5.0% | 2.4% | 5.0% | 6.7% |
| West | 22.1% | 5.7% | 3.9% | 6.5% | 9.2% |
| Metro Area | | | | | |
| Large metro | 20.2% | 4.8% | 3.1% | 5.8% | 7.9% |
| Small metro | 20.9% | 5.7% | 2.9% | 5.6% | 7.6% |
| Nonmetro | 21.2% | 5.9% | 2.6% | 5.1% | 7.0% |
| Income Level | | | | | |
| Less than 100% federal poverty level (FPL) | 26.7% | 8.9% | 5.3% | 6.1% | 9.8% |
| 100%-199% FPL | 23.7% | 6.8% | 3.3% | 5.3% | 7.8% |
| 200% or more FPL | 18.5% | 4.3% | 2.4% | 5.6% | 7.2% |
| Educational Attainment | | | | | |
| < High school | 18.3% | 4.3% | 3.3% | 5.4% | 7.7% |
| High school graduate | 19.3% | 5.1% | 3.5% | 5.2% | 7.9% |
| Some college | 23.7% | 7.0% | 3.7% | 6.1% | 8.7% |
| College graduate | 19.5% | 4.1% | 1.7% | 5.4% | 6.8% |
| Health Insurance Coverage | | | | | |
| Private | 18.6% | 4.3% | 2.1% | 5.4% | 7.0% |
| Medicaid/CHIP | 31.2% | 10.1% | 5.9% | 6.3% | 10.9% |

| | Any Mental Illness | Serious Mental Illness (SMI) | Illicit Drug Use Disorder | Alcohol Use Disorder | Any Substance Use Disorder (SUD) |
|-------------|--------------------|------------------------------|---------------------------|----------------------|----------------------------------|
| Other | 16.8% | 3.8% | 1.3% | 3.3% | 4.0% |
| No coverage | 21.8% | 6.0% | 5.7% | 7.6% | 11.3% |

Sources:

[SAMHSA NSDUHD Adult SMI Data Tables 2018-19](#)

[SAMHSA NSDUHD Adult SUD Data Tables 2018-19](#)

Caveats: These results are pulled directly from the results of the 2019 National Survey of Drug Use and Health. These results are based on survey responses, which may be prone to underreporting. Additional details about the NSDUH and inherent limitations can be found on the NSDUH website.

Table 2. Rates of SMI, SED and SUD by County Among Medi-Cal Enrollees in 2019

| County | SED Rate | SMI Rate | SUD Rate Aged 18+ | SUD Rate Aged 12-17 |
|--------------|----------|----------|-------------------|---------------------|
| Alameda | 2.8% | 5.9% | 3.3% | 1.4% |
| Alpine | * | 8.3% | * | 0.5% |
| Amador | 3.1% | 10.4% | 4.6% | 0.0% |
| Butte | 5.1% | 9.1% | 6.3% | * |
| Calaveras | 4.7% | 10.0% | 3.5% | 0.9% |
| Colusa | 1.7% | 6.5% | 2.1% | 0.8% |
| Contra Costa | 3.1% | 6.5% | 3.5% | * |
| Del Norte | 7.8% | 10.2% | 4.9% | 0.6% |
| El Dorado | 3.9% | 8.5% | 5.6% | 1.7% |
| Fresno | 2.5% | 5.6% | 3.1% | 1.3% |
| Glenn | 3.8% | 7.3% | 4.2% | 0.8% |
| Humboldt | 4.7% | 8.8% | 6.7% | 0.8% |
| Imperial | 2.3% | 6.1% | 3.2% | 0.9% |
| Inyo | 3.2% | 7.4% | 4.5% | 1.6% |
| Kern | 2.5% | 5.9% | 3.4% | 1.8% |
| Kings | 2.2% | 6.6% | 3.9% | 0.6% |
| Lake | 3.5% | 9.9% | 7.2% | 1.4% |
| Lassen | 3.4% | 10.3% | 4.8% | 1.5% |
| Los Angeles | 3.0% | 5.7% | 2.3% | 1.5% |
| Madera | 2.6% | 5.0% | 2.4% | 0.7% |
| Marin | 3.9% | 8.3% | 4.5% | 0.9% |
| Mariposa | 6.0% | 10.4% | 4.6% | 1.1% |
| Mendocino | 5.8% | 9.1% | 6.1% | 2.4% |

| County | SED Rate | SMI Rate | SUD Rate Aged 18+ | SUD Rate Aged 12-17 |
|-----------------|----------|----------|-------------------|---------------------|
| Merced | 2.1% | 5.9% | 3.3% | 2.1% |
| Modoc | 3.9% | 9.8% | 6.0% | 0.8% |
| Mono | 0.8% | 5.0% | 2.4% | * |
| Monterey | 2.2% | 5.3% | 3.6% | * |
| Napa | 3.4% | 7.3% | 3.7% | 1.3% |
| Nevada | 4.7% | 9.9% | 6.6% | 0.9% |
| Orange | 2.4% | 5.2% | 2.6% | 1.2% |
| Placer | 2.3% | 8.3% | 4.6% | 0.9% |
| Plumas | 6.0% | 12.1% | 3.9% | 0.7% |
| Riverside | 2.6% | 7.1% | 3.9% | * |
| Sacramento | 2.5% | 7.1% | 3.7% | 1.0% |
| San Benito | 2.5% | 4.9% | 2.6% | 0.4% |
| San Bernardino | 2.9% | 6.9% | 3.5% | 0.9% |
| San Diego | 2.4% | 8.2% | 4.1% | 0.7% |
| San Francisco | 2.4% | 7.0% | 5.0% | 1.2% |
| San Joaquin | 1.9% | 5.4% | 4.2% | 0.5% |
| San Luis Obispo | 3.7% | 9.7% | 7.5% | 0.5% |
| San Mateo | 2.5% | 5.7% | 2.8% | 1.5% |
| Santa Barbara | 2.7% | 6.7% | 4.7% | 0.9% |
| Santa Clara | 3.0% | 4.9% | 2.5% | 1.2% |
| Santa Cruz | 3.2% | 8.7% | 5.4% | 1.2% |
| Shasta | 5.5% | 11.8% | 8.0% | 1.0% |
| Sierra | * | 4.1% | 3.3% | 1.1% |
| Siskiyou | 6.0% | 10.3% | 4.8% | 0.0% |
| Solano | 3.1% | 6.7% | 4.0% | 1.5% |
| Sonoma | 3.4% | 8.3% | 5.3% | 0.5% |
| Stanislaus | 2.3% | 6.0% | 4.1% | 1.0% |
| Sutter | 2.6% | 5.6% | 3.4% | 0.7% |
| Tehama | 3.4% | 9.8% | 4.6% | 0.6% |
| Trinity | 5.5% | 7.4% | 5.0% | 0.4% |
| Tulare | 2.8% | 5.4% | 2.8% | * |
| Tuolumne | 4.5% | 11.4% | 6.1% | 1.1% |
| Ventura | 2.6% | 6.6% | 3.8% | 1.2% |
| Yolo | 3.1% | 7.7% | 4.1% | 1.2% |
| Yuba | 2.7% | 8.2% | 5.9% | 0.7% |
| UNKNOWN | 2.6% | 5.0% | 1.5% | 0.3% |

Source: Analysis of Medi-Cal administrative claims data.

* Rates for these counties are censored due to small sample size.

Caveats: These results are based on analyses of California Medicaid administrative claims data. Diagnosis code– and utilization-based proxy measures were developed to

estimate rates of SED, SMI and SUD among the Medi-Cal population by county. A complete description of these proxy measures and their inherent limitations can be found in Appendix C, below. In general, these proxy measures are likely to underestimate the true prevalence of these conditions because they fail to capture individuals who do not actively engage with the health care system. Further, proxy measures based on diagnosis codes do not capture the full nuance of DSM-consistent diagnoses related to these conditions.

Table 3. Rates of Behavioral Health Conditions Among Individuals Aged 12-17 from the 2019 National Survey of Drug Use and Health

| | Major Depressive Episode | Major Depressive Episode with Impairment | Illicit Drug Use Disorder | Alcohol Use Disorder | Any SUD |
|-----------------------|--------------------------|--|---------------------------|----------------------|---------|
| Age Group | | | | | |
| Aged 12-13 | 10.5% | 6.8% | 0.8% | 0.2% | 0.9% |
| Aged 14-15 | 16.4% | 11.9% | 3.9% | 1.4% | 4.8% |
| Aged 16-17 | 20.1% | 14.5% | 6.1% | 3.4% | 7.9% |
| Gender | | | | | |
| Male | 8.8% | 6.0% | 3.4% | 1.3% | 4.0% |
| Female | 23.0% | 16.5% | 3.8% | 2.1% | 5.0% |
| Race/Ethnicity | | | | | |
| Not Hispanic | 15.2% | 11.0% | 3.4% | 1.7% | 4.3% |
| White | 15.9% | 11.4% | 3.5% | 2.2% | 4.7% |
| Black | 11.4% | 8.0% | 3.5% | 0.3% | 3.7% |
| AI/AN | 12.2% | 11.5% | 7.2% | 3.2% | 8.9% |
| Asian | 15.1% | 11.3% | 1.3% | 0.2% | 1.3% |
| Two or more | 20.9% | 14.9% | 4.3% | 1.4% | 5.1% |
| Hispanic | 17.3% | 11.7% | 4.2% | 1.7% | 5.0% |
| Region | | | | | |
| Northeast | 13.8% | 9.5% | 3.7% | 1.8% | 4.4% |
| Midwest | 16.4% | 11.8% | 3.5% | 1.9% | 4.7% |
| South | 15.1% | 10.9% | 3.0% | 1.3% | 3.7% |
| West | 17.5% | 22.9% | 4.6% | 1.9% | 5.6% |
| Metro Area | | | | | |
| Large metro | 15.9% | 11.3% | 3.9% | 1.6% | 4.6% |
| Small metro | 16.0% | 11.4% | 3.5% | 1.6% | 4.6% |
| Nonmetro | 14.6% | 9.9% | 2.6% | 2.1% | 4.0% |
| Income Status | | | | | |
| Less than 100% FPL | 14.0% | 10.0% | 3.9% | 1.4% | 4.7% |

| | Major Depressive Episode | Major Depressive Episode with Impairment | Illicit Drug Use Disorder | Alcohol Use Disorder | Any SUD |
|----------------------------------|--------------------------|--|---------------------------|----------------------|---------|
| 100%-199% FPL | 16.0% | 11.5% | 4.3% | 1.6% | 5.0% |
| 200% or more FPL | 16.2% | 11.4% | 3.2% | 1.8% | 4.2% |
| Health Insurance Coverage | | | | | |
| Private | 16.0% | 10.9% | 3.1% | 1.7% | 4.1% |
| Medicaid/CHIP | 15.3% | 11.2% | 4.2% | 1.7% | 5.0% |
| Other | 15.9% | 13.2% | 4.1% | 1.8% | 5.3% |
| No coverage | 16.3% | 10.5% | 4.2% | 1.4% | 5.0% |

Sources:

[SAMHSA NSDUHD Child/Youth Mental Health Data Tables 2018-19](#)

[SAMHSA NSDUHD Child/Youth SUD Data Tables 2018-19](#)

Caveats: These results are pulled directly from the results of the 2019 National Survey of Drug Use and Health. These results are based on survey responses, which may be prone to underreporting. Additional details about the NSDUH and inherent limitations can be found on the NSDUH website.

Table 4. Facilities Providing Outpatient Mental Health or SUD Treatment and Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plans, by County

| County | Community Mental Health Clinics | Federally Qualified Health Centers (FQHCs) | Other Outpatient Mental Health Treatment Facilities | Number of Outpatient SUD Treatment Facilities | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents |
|---------|---------------------------------|--|---|---|---|--|
| Alameda | 6 | 3 | 20 | 29 | 532 | 3.2 |
| Alpine | 0 | 0 | 1 | 1 | 4 | 38.5 |
| Amador | 0 | 0 | 1 | 1 | 14 | 3.6 |
| Butte | 1 | 0 | 4 | 8 | 124 | 5.5 |

| County | Community Mental Health Clinics | Federally Qualified Health Centers (FQHCs) | Other Outpatient Mental Health Treatment Facilities | Number of Outpatient SUD Treatment Facilities | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents |
|---------------|--|---|--|--|--|---|
| Calaveras | 0 | 0 | 1 | 1 | 21 | 4.6 |
| Colusa | 1 | 0 | 0 | 1 | 8 | 3.7 |
| Contra Costa | 3 | 1 | 10 | 21 | 681 | 6.0 |
| Del Norte | 0 | 0 | 3 | 2 | 11 | 4.0 |
| El Dorado | 1 | 0 | 2 | 4 | 70 | 3.7 |
| Fresno | 0 | 0 | 13 | 22 | 473 | 4.8 |
| Glenn | 0 | 0 | 0 | 3 | 22 | 7.9 |
| Humboldt | 0 | 1 | 4 | 7 | 88 | 6.5 |
| Imperial | 0 | 0 | 1 | 4 | 42 | 2.3 |
| Inyo | 1 | 0 | 0 | 2 | 9 | 5.0 |
| Kern | 0 | 1 | 11 | 21 | 339 | 3.8 |
| Kings | 0 | 0 | 0 | 3 | 50 | 3.3 |
| Lake | 0 | 1 | 0 | 4 | 25 | 3.9 |
| Lassen | 0 | 0 | 1 | 2 | 5 | 1.6 |
| Los Angeles | 38 | 10 | 128 | 195 | 4,490 | 4.5 |
| Madera | 0 | 0 | 3 | 2 | 53 | 3.4 |
| Marin | 2 | 0 | 6 | 13 | 107 | 4.1 |
| Mariposa | 0 | 0 | 1 | 1 | 22 | 12.6 |
| Mendocino | 0 | 2 | 3 | 6 | 56 | 6.4 |
| Merced | 0 | 0 | 5 | 4 | 146 | 5.4 |
| Modoc | 0 | 0 | 0 | 2 | 8 | 9.0 |
| Mono | 0 | 0 | 0 | 1 | 5 | 3.5 |
| Monterey | 0 | 1 | 7 | 12 | 253 | 5.8 |
| Napa | 0 | 0 | 4 | 3 | 49 | 3.5 |
| Nevada | 1 | 0 | 2 | 4 | 63 | 6.3 |

| County | Community Mental Health Clinics | Federally Qualified Health Centers (FQHCs) | Other Outpatient Mental Health Treatment Facilities | Number of Outpatient SUD Treatment Facilities | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents |
|-----------------|--|---|--|--|--|---|
| Orange | 0 | 5 | 40 | 73 | 831 | 2.6 |
| Placer | 0 | 0 | 5 | 8 | 125 | 3.2 |
| Plumas | 0 | 0 | 1 | 0 | 16 | 8.6 |
| Riverside | 1 | 1 | 17 | 37 | 652 | 2.7 |
| Sacramento | 3 | 3 | 19 | 18 | 336 | 2.2 |
| San Benito | 0 | 0 | 1 | 1 | 18 | 3.0 |
| San Bernardino | 3 | 5 | 20 | 30 | 812 | 3.8 |
| San Diego | 1 | 8 | 32 | 78 | 812 | 2.4 |
| San Francisco | 5 | 2 | 14 | 17 | 613 | 7.0 |
| San Joaquin | 1 | 0 | 3 | 11 | 164 | 2.2 |
| San Luis Obispo | 4 | 0 | 1 | 4 | 181 | 6.4 |
| San Mateo | 0 | 1 | 6 | 8 | 195 | 2.5 |
| Santa Barbara | 0 | 1 | 9 | 17 | 195 | 4.4 |
| Santa Clara | 1 | 2 | 22 | 22 | 599 | 3.1 |
| Santa Cruz | 0 | 0 | 2 | 6 | 119 | 4.3 |
| Shasta | 1 | 0 | 4 | 8 | 93 | 5.2 |
| Sierra | 0 | 0 | 2 | 2 | 3 | 9.9 |
| Siskiyou | 0 | 0 | 2 | 3 | 16 | 3.7 |
| Solano | 1 | 0 | 6 | 6 | 165 | 3.7 |
| Sonoma | 2 | 0 | 7 | 8 | 106 | 2.1 |
| Stanislaus | 0 | 1 | 3 | 10 | 189 | 3.5 |
| Sutter | 1 | 2 | 3 | 2 | 74 | 4.3 |
| Tehama | 0 | 0 | 0 | 2 | 25 | 3.9 |

| County | Community Mental Health Clinics | Federally Qualified Health Centers (FQHCs) | Other Outpatient Mental Health Treatment Facilities | Number of Outpatient SUD Treatment Facilities | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan | Number of Non-Psychiatrist Behavioral Health Providers Licensed with County SMHS Plan per 10,000 residents |
|--------------|---------------------------------|--|---|---|---|--|
| Trinity | 2 | 0 | 0 | 1 | 11 | 8.7 |
| Tulare | 0 | 0 | 4 | 8 | 170 | 3.7 |
| Tuolumne | 0 | 0 | 1 | 2 | 15 | 2.8 |
| Ventura | 0 | 0 | 14 | 15 | 312 | 3.7 |
| Yolo | 1 | 0 | 4 | 6 | 75 | 3.5 |
| Yuba | 0 | 1 | 1 | 3 | * | 3.2 |
| Total | 81 | 52 | 474 | 785 | 14,692 | 3.7 |

*Note: Yuba County submits workforce data jointly with Sutter County.

Sources: Data on CMHCs, FQHCs and outpatient mental health/SUD treatment facilities were extracted from the SAMHSA Behavioral Health Treatment Services Locator. Data on the number of non-psychiatrist behavioral health providers licensed with county SMHS plans were provided by DHCS.

Caveats: The numbers of outpatient mental health and SUD facilities documented in this table were identified using the SAMHSA Behavioral Health Treatment Services Locator. There likely are additional facilities providing outpatient mental health and SUD treatment services that are not documented in the SAMHSA treatment locator. The SAMHSA Behavioral Health Treatment Services Locator covers facilities funded by the state, facilities administered by the U.S. Department of Veterans Affairs, and/or private for-profit and nonprofit facilities that are licensed by the state or a national treatment accreditation organization such as The Joint Commission or the National Committee for Quality Assurance. However, the locator generally does not provide information on individuals in private practice or a small group practice unless they are licensed or certified as a clinic. Data on the number of non-psychiatrist behavioral health providers licensed with county SMHS plans were extracted from network adequacy data provided by DHCS. These counts only reflect the number of Medi-Cal-enrolled behavioral health providers licensed with county SMHS plans. Additional behavioral health providers in the state that are not licensed with county SMHS plans are not captured here.

Table 5. Facilities Providing Selected Intensive Treatment Services for Mental Health or SUD According to the SAMHSA Behavioral Health Treatment Services Locator

| County | Partial Hospitalization for Mental Health | Partial Hospitalization for SUD | Intensive Outpatient Services for SUD |
|----------------|--|--|--|
| Alameda | 1 | 6 | 19 |
| Alpine | 0 | 0 | 1 |
| Amador | 0 | 0 | 0 |
| Butte | 0 | 0 | 5 |
| Calaveras | 0 | 0 | 0 |
| Colusa | 0 | 0 | 0 |
| Contra Costa | 2 | 1 | 15 |
| Del Norte | 0 | 0 | 1 |
| El Dorado | 0 | 1 | 3 |
| Fresno | 0 | 2 | 10 |
| Glenn | 0 | 0 | 2 |
| Humboldt | 0 | 1 | 3 |
| Imperial | 0 | 0 | 2 |
| Inyo | 0 | 0 | 2 |
| Kern | 0 | 2 | 15 |
| Kings | 0 | 0 | 0 |
| Lake | 0 | 0 | 2 |
| Lassen | 0 | 0 | 0 |
| Los Angeles | 12 | 49 | 117 |
| Madera | 0 | 0 | 2 |
| Marin | 0 | 3 | 12 |
| Mariposa | 0 | 0 | 0 |
| Mendocino | 0 | 0 | 3 |
| Merced | 0 | 0 | 3 |
| Modoc | 0 | 0 | 1 |
| Mono | 0 | 0 | 1 |
| Monterey | 0 | 6 | 9 |
| Napa | 0 | 0 | 2 |
| Nevada | 0 | 1 | 3 |
| Orange | 5 | 51 | 61 |
| Placer | 0 | 1 | 6 |
| Plumas | 0 | 0 | 0 |
| Riverside | 1 | 16 | 25 |
| Sacramento | 0 | 5 | 7 |
| San Benito | 0 | 0 | 0 |
| San Bernardino | 0 | 10 | 19 |
| San Diego | 8 | 20 | 51 |

| County | Partial Hospitalization for Mental Health | Partial Hospitalization for SUD | Intensive Outpatient Services for SUD |
|------------------------|--|--|--|
| San Francisco | 0 | 1 | 5 |
| San Joaquin | 0 | 1 | 2 |
| San Luis Obispo | 0 | 2 | 3 |
| San Mateo | 0 | 1 | 6 |
| Santa Barbara | 1 | 2 | 11 |
| Santa Clara | 1 | 7 | 10 |
| Santa Cruz | 0 | 1 | 3 |
| Shasta | 0 | 0 | 3 |
| Sierra | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 1 |
| Solano | 0 | 2 | 3 |
| Sonoma | 0 | 1 | 4 |
| Stanislaus | 0 | 4 | 7 |
| Sutter | 0 | 0 | 2 |
| Tehama | 0 | 0 | 1 |
| Trinity | 0 | 0 | 0 |
| Tulare | 0 | 2 | 4 |
| Tuolumne | 0 | 0 | 1 |
| Ventura | 2 | 5 | 11 |
| Yolo | 0 | 0 | 3 |
| Yuba | 0 | 1 | 2 |
| Total | 33 | 205 | 484 |

Source: Data were extracted from the SAMHSA Behavioral Health Treatment Services Locator.

Caveats: These results are based on analysis of the SAMHSA Behavioral Health Treatment Services Locator. These results only capture facilities included in the treatment services locator that have flags indicating that the facilities provide partial hospitalization or intensive outpatient services for the treatment of mental health or SUD. As mentioned above, the SAMHSA Behavioral Health Treatment Services Locator may not capture all facilities providing outpatient mental health and SUD treatment services in the state. It is also possible that the treatment locator is missing relevant indicator variables for some facilities that are in fact providing partial hospitalization or intensive outpatient services.

Table 6. Narcotic Treatment Programs and DEA-Waivered Buprenorphine Prescribers by County

| Counties | NTP Facilities | Total DEA-waivered buprenorphine patient capacity | Buprenorphine Patient Capacity per 100,000 Residents |
|-----------------------|-----------------------|--|---|
| Alameda | 8 | 17,230 | 1,101 |
| Alpine | 0 | | |
| Amador | 1 | 1,535 | 4,077 |
| Butte | 1 | 3,040 | 1,367 |
| Calaveras | 0 | 220 | 486 |
| Colusa | 0 | 60 | 281 |
| Contra Costa | 4 | 14,965 | 1,382 |
| Del Norte | 0 | 310 | 1,107 |
| El Dorado | 1 | 3,030 | 1,661 |
| Fresno | 5 | 5,380 | 567 |
| Glenn | 0 | 130 | 465 |
| Humboldt | 1 | 3,910 | 2,902 |
| Imperial | 2 | 2,095 | 1,191 |
| Inyo | 0 | 580 | 3,163 |
| Kern | 5 | 5,845 | 683 |
| Kings | 0 | 1,875 | 1,241 |
| Lake | 0 | 1,075 | 1,673 |
| Lassen | 0 | 320 | 965 |
| Los Angeles | 44 | 88,615 | 890 |
| Madera | 0 | 580 | 381 |
| Marin | 1 | 5,205 | 2,034 |
| Mariposa | 0 | 365 | 2,036 |
| Mendocino | 0 | 2,140 | 2,445 |
| Merced | 1 | 1,150 | 440 |
| Modoc | 0 | 30 | 323 |
| Mono | 0 | 270 | 1,912 |
| Monterey | 2 | 6,210 | 1,467 |
| Napa | 0 | 2,540 | 1,835 |
| Nevada | 1 | 1,570 | 1,592 |
| Orange | 5 | 30,215 | 981 |
| Placer | 1 | 4,450 | 1,233 |
| Plumas | 0 | 150 | 774 |
| Riverside | 5 | 15,190 | 671 |
| Sacramento | 6 | 24,685 | 1,697 |
| San Benito | 4 | 465 | 816 |
| San Bernardino | 10 | 15,065 | 725 |
| San Diego | 13 | 35,615 | 1,120 |

| Counties | NTP Facilities | Total DEA-waivered buprenorphine patient capacity | Buprenorphine Patient Capacity per 100,000 Residents |
|-----------------|-----------------------|--|---|
| San Francisco | 7 | 29,565 | 3,554 |
| San Joaquin | 1 | 4,805 | 683 |
| San Luis Obispo | 1 | 4,165 | 1,518 |
| San Mateo | 2 | 8,530 | 1,154 |
| Santa Barbara | 4 | 5,540 | 1,284 |
| Santa Clara | 2 | 18,930 | 1,028 |
| Santa Cruz | 1 | 4,285 | 1,606 |
| Shasta | 0 | 4,495 | 2,522 |
| Sierra | 0 | 275 | 8,929 |
| Siskiyou | 0 | 600 | 1,359 |
| Solano | 2 | 5,330 | 1,258 |
| Sonoma | 2 | 8,600 | 1,754 |
| Stanislaus | 3 | 3,175 | 605 |
| Sutter | 0 | 510 | 537 |
| Tehama | 0 | 180 | 285 |
| Trinity | 0 | 100 | 748 |
| Tulare | 3 | 2,560 | 570 |
| Tuolumne | 0 | 1,055 | 1,930 |
| Ventura | 5 | 8,310 | 998 |
| Yolo | 1 | 1,090 | 530 |
| Yuba | 2 | 585 | 798 |

Sources: [Data on licensed NTPs are available via DHCS](#)

Data on DEA-waivered buprenorphine prescriber capacity from the US DEA.

Caveats: The US DEA collects data on all DEA-waivered buprenorphine prescribers, including the total patient capacity that an individual is permitted to treat with buprenorphine. Summaries of these data may be found on the Addiction Free California data dashboard produced as part of the California MAT expansion project. These data were provided by the Addiction Free California website administrators for the purpose of this assessment. These data capture the total potential buprenorphine case load by county rather than the number of patients who are actively receiving buprenorphine. Previous research suggests that many buprenorphine prescribers do not treat their full potential caseload of patients, and some providers do not prescribe buprenorphine at all despite having a DEA-waiver

Table 7. Residential SUD Treatment Facilities by County

| County | ASAM Level 3.1 | ASAM Level 3.3 | ASAM Level 3.5 | ASAM Level 3.7 |
|----------------|----------------|----------------|----------------|----------------|
| Alameda | 9 | 4 | 9 | 0 |
| Alpine | 0 | 0 | 0 | 0 |
| Amador | 0 | 0 | 0 | 0 |
| Butte | 0 | 0 | 0 | 0 |
| Calaveras | 0 | 0 | 0 | 0 |
| Colusa | 0 | 0 | 0 | 0 |
| Contra Costa | 12 | 2 | 4 | 0 |
| Del Norte | 0 | 0 | 0 | 0 |
| El Dorado | 3 | 0 | 0 | 0 |
| Fresno | 4 | 0 | 3 | 0 |
| Glenn | 0 | 0 | 0 | 0 |
| Humboldt | 0 | 1 | 1 | 0 |
| Imperial | 0 | 0 | 0 | 0 |
| Inyo | 0 | 0 | 0 | 0 |
| Kern | 5 | 0 | 5 | 0 |
| Kings | 0 | 0 | 0 | 0 |
| Lake | 2 | 0 | 1 | 0 |
| Lassen | 0 | 0 | 0 | 0 |
| Los Angeles | 78 | 18 | 65 | 1 |
| Madera | 0 | 0 | 0 | 0 |
| Marin | 3 | 0 | 3 | 0 |
| Mariposa | 0 | 0 | 0 | 0 |
| Mendocino | 1 | 0 | 0 | 0 |
| Merced | 2 | 0 | 0 | 0 |
| Modoc | 0 | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 | 0 |
| Monterey | 4 | 0 | 4 | 0 |
| Napa | 1 | 0 | 1 | 0 |
| Nevada | 2 | 0 | 2 | 0 |
| Orange | 8 | 1 | 5 | 0 |
| Placer | 1 | 0 | 1 | 0 |
| Plumas | 0 | 0 | 0 | 0 |
| Riverside | 11 | 2 | 19 | 0 |
| Sacramento | 9 | 0 | 6 | 0 |
| San Benito | 1 | 0 | 1 | 0 |
| San Bernardino | 8 | 0 | 8 | 0 |
| San Diego | 27 | 2 | 19 | 0 |

| County | ASAM Level 3.1 | ASAM Level 3.3 | ASAM Level 3.5 | ASAM Level 3.7 |
|------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| San Francisco | 7 | 3 | 3 | 0 |
| San Joaquin | 1 | 0 | 1 | 0 |
| San Luis Obispo | 1 | 0 | 0 | 0 |
| San Mateo | 9 | 0 | 7 | 0 |
| Santa Barbara | 6 | 0 | 2 | 0 |
| Santa Clara | 6 | 3 | 5 | 0 |
| Santa Cruz | 5 | 0 | 2 | 0 |
| Shasta | 5 | 0 | 4 | 0 |
| Sierra | 0 | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 0 | 0 |
| Solano | 4 | 0 | 0 | 0 |
| Sonoma | 0 | 0 | 0 | 0 |
| Stanislaus | 4 | 0 | 3 | 0 |
| Sutter | 1 | 0 | 1 | 0 |
| Tehama | 0 | 0 | 0 | 0 |
| Trinity | 0 | 0 | 0 | 0 |
| Tulare | 5 | 0 | 4 | 0 |
| Tuolumne | 0 | 0 | 0 | 0 |
| Ventura | 1 | 0 | 1 | 0 |
| Yolo | 1 | 0 | 1 | 0 |
| Yuba | 1 | 0 | 1 | 0 |
| Total | 256 | 36 | 191 | 1 |

Source: Data were extracted from DMC-ODS provider reports provided by DHCS.

Caveats: These data are based on DMC-ODS provider reports. These reports document the different types of services provided by DMC-ODS-licensed facilities. These reports do not capture facilities that are not licensed by DMC-ODS. Additional SUD treatment facilities in the state that are providing ASAM-consistent residential treatment services may not be documented here.

Table 8. Social Rehabilitation Programs by County

| County | Social Rehabilitation Programs licensed by DSS | Number of Available Beds Among Social Rehabilitation Programs Affiliated with California Association of Social Rehabilitation Agencies | | |
|-----------------|--|--|---------------------------------|------------------------------------|
| | | Crisis Residential Treatment | Long Term Residential Treatment | Transitional Residential Treatment |
| Alameda | 8 | 0 | 0 | 0 |
| Butte | 2 | 0 | 0 | 0 |
| Contra Costa | 5 | 0 | 0 | 0 |
| Fresno | 4 | 0 | 0 | 0 |
| Humboldt | 1 | 0 | 0 | 0 |
| Imperial | 1 | 0 | 0 | 0 |
| Kern | 2 | 0 | 0 | 0 |
| Los Angeles | 34 | 24 | 0 | 0 |
| Marin | 1 | 10 | 42 | 0 |
| Merced | 1 | 0 | 0 | 0 |
| Monterey | 3 | 28 | 0 | 1 |
| Napa | 2 | 8 | 0 | 1 |
| Nevada | 1 | 0 | 0 | 0 |
| Orange | 39 | 0 | 0 | 0 |
| Placer | 1 | 0 | 0 | 0 |
| Riverside | 6 | 0 | 0 | 0 |
| Sacramento | 9 | 45 | 0 | 0 |
| San Bernardino | 12 | 0 | 0 | 0 |
| San Diego | 15 | 0 | 0 | 0 |
| San Francisco | 17 | 48 | 0 | 13 |
| San Joaquin | 5 | 0 | 0 | 0 |
| San Luis Obispo | 1 | 0 | 0 | 1 |
| San Mateo | 5 | 16 | 0 | 2 |
| Santa Barbara | 4 | 0 | 0 | 0 |
| Santa Clara | 9 | 62 | 45 | 0 |
| Santa Cruz | 3 | 0 | 0 | 0 |
| Shasta | 2 | 0 | 0 | 0 |
| Solano | 2 | 0 | 0 | 0 |
| Sonoma | 6 | 20 | 0 | 1 |
| Ventura | 7 | 0 | 0 | 0 |
| Yolo | 2 | 0 | 0 | 0 |

Source: Social rehabilitation Licensure data were obtained from the California Department for Social Services. Data on the number of beds available among social rehabilitation programs affiliated with California Association of Social Rehabilitation Agencies were obtained via personal correspondence in November 2021

Caveats: California licenses transitional and long-term residential settings and crisis residential treatment programs as social rehabilitation programs and does not differentiate among the different settings. Data provided by California Association of Social Rehabilitation Agencies may not include complete information from all member organizations.

Table 9. **Mobile Crisis Teams Available by County in 2021**

| County | Number of Mobile Crisis Teams |
|---------------|--------------------------------------|
| Alameda | 5 |
| Alpine | 0 |
| Amador | 1 |
| Butte | 2 |
| Calaveras | 2 |
| Colusa | 1 |
| Contra Costa | 4.5 |
| Del Norte | 0 |
| El Dorado | 2 |
| Fresno | 1 |
| Glenn | 1 |
| Humboldt | 2 |
| Imperial | 1 |
| Inyo | 1 |
| Kern | 13 |
| Kings | 1 |
| Lake | 7 |
| Lassen | 0 |
| Los Angeles | 171 |
| Madera | 1 |
| Marin | 1 |
| Mariposa | 1 |
| Mendocino | 1 |

| County | Number of Mobile Crisis Teams |
|-----------------|--------------------------------------|
| Merced | 2 |
| Modoc | 0 |
| Mono | 0 |
| Monterey | 2 |
| Napa | 0 |
| Nevada | 2 |
| Orange | 25 |
| Placer | 3 |
| Plumas | 0 |
| Riverside | 12 |
| Sacramento | 8 |
| San Benito | 1 |
| San Bernardino | 18 |
| San Diego | 2 |
| San Francisco | 3 |
| San Joaquin | 4 |
| San Luis Obispo | 2 |
| San Mateo | 1 |
| Santa Barbara | 3 |
| Santa Clara | 10 |
| Santa Cruz | 7 |
| Shasta | 2 |
| Sierra | 0 |
| Siskiyou | 0 |
| Solano | 4 |
| Sonoma | 3 |
| Stanislaus | 0 |
| Sutter | 0 |
| Tehama | 0 |
| Trinity | 0 |
| Tulare | 2 |
| Tuolumne | 3 |

| County | Number of Mobile Crisis Teams |
|---------------|--------------------------------------|
| Ventura | 1 |
| Yolo | 4 |
| Yuba | 0 |
| Total | 343.5 |

Source: Data were obtained from a survey of county behavioral health directors.

Caveats: These results are based on surveys conducted with county behavioral health directors. Directors were asked to report the number of mobile crisis response teams operational in their county. Counties have varying definitions of what constitutes a mobile crisis response team. These teams may vary in size and scope (e.g., some may only serve selected populations or may only operate during limited days/times). It is also unclear how many individuals each team is able to serve.

Table 10. Facilities Providing Ambulatory or Residential Withdrawal Management by County

| Counties | Ambulatory Withdrawal Management | ASAM Level 3.2-WM | ASAM Level 3.7-WM | ASAM Level 4.0-WM |
|-----------------|---|--------------------------|--------------------------|--------------------------|
| Alameda | 0 | 1 | 0 | 0 |
| Alpine | 0 | 0 | 0 | 0 |
| Amador | 0 | 0 | 0 | 0 |
| Butte | 0 | 0 | 0 | 0 |
| Calaveras | 0 | 0 | 0 | 0 |
| Colusa | 0 | 0 | 0 | 0 |
| Contra Costa | 1 | 5 | 0 | 0 |
| Del Norte | 0 | 0 | 0 | 0 |
| El Dorado | 0 | 0 | 0 | 0 |
| Fresno | 1 | 2 | 0 | 0 |
| Glenn | 0 | 0 | 0 | 0 |
| Humboldt | 0 | 1 | 0 | 0 |
| Imperial | 1 | 0 | 0 | 0 |
| Inyo | 0 | 0 | 0 | 0 |
| Kern | 1 | 2 | 0 | 0 |
| Kings | 0 | 0 | 0 | 0 |
| Lake | 0 | 0 | 0 | 0 |

| Counties | Ambulatory Withdrawal Management | ASAM Level 3.2-WM | ASAM Level 3.7- WM | ASAM Level 4.0- WM |
|-----------------|---|------------------------------|-----------------------------------|-----------------------------------|
| Lassen | 0 | 0 | 0 | 0 |
| Los Angeles | 36 | 41 | 3 | 3 |
| Madera | 0 | 0 | 0 | 0 |
| Marin | 1 | 1 | 0 | 0 |
| Mariposa | 0 | 0 | 0 | 0 |
| Mendocino | 0 | 1 | 0 | 0 |
| Merced | 1 | 0 | 0 | 0 |
| Modoc | 0 | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 | 0 |
| Monterey | 0 | 3 | 0 | 0 |
| Napa | 0 | 1 | 0 | 0 |
| Nevada | 0 | 2 | 0 | 0 |
| Orange | 7 | 4 | 0 | 0 |
| Placer | 0 | 2 | 0 | 0 |
| Plumas | 0 | 0 | 0 | 0 |
| Riverside | 6 | 6 | 0 | 0 |
| Sacramento | 1 | 3 | 0 | 0 |
| San Benito | 0 | 1 | 0 | 0 |
| San Bernardino | 1 | 3 | 0 | 0 |
| San Diego | 8 | 5 | 0 | 0 |
| San Francisco | 0 | 4 | 0 | 0 |
| San Joaquin | 0 | 1 | 0 | 0 |
| San Luis Obispo | 2 | 0 | 0 | 0 |
| San Mateo | 1 | 0 | 0 | 0 |
| Santa Barbara | 0 | 4 | 0 | 0 |
| Santa Clara | 0 | 3 | 0 | 0 |
| Santa Cruz | 0 | 1 | 0 | 0 |
| Shasta | 0 | 1 | 0 | 0 |
| Sierra | 0 | 0 | 0 | 0 |
| Siskiyou | 0 | 1 | 0 | 0 |
| Solano | 0 | 2 | 0 | 0 |
| Sonoma | 0 | 0 | 0 | 0 |

| Counties | Ambulatory Withdrawal Management | ASAM Level 3.2-WM | ASAM Level 3.7- WM | ASAM Level 4.0- WM |
|-------------------|---|------------------------------|-----------------------------------|-----------------------------------|
| Stanislaus | 0 | 2 | 0 | 0 |
| Sutter | 0 | 1 | 0 | 0 |
| Tehama | 0 | 0 | 0 | 0 |
| Trinity | 0 | 0 | 0 | 0 |
| Tulare | 0 | 3 | 0 | 0 |
| Tuolumne | 0 | 0 | 0 | 0 |
| Ventura | 1 | 1 | 0 | 0 |
| Yolo | 0 | 0 | 0 | 0 |
| Yuba | 0 | 1 | 0 | 0 |
| Total | 69 | 108 | 3 | 3 |

Sources: Facilities providing ambulatory withdrawal management were identified using DHCS alcohol and drug program certification data, and facilities providing residential withdrawal management were identified using DMC-ODS provider reports from DHCS.

Caveats: Facilities providing residential withdrawal management services were identified using DMC-ODS provider reports provided by DHCS. As mentioned above, these reports only include facilities that are licensed by DMC-ODS. There may be additional facilities in the state providing ASAM-consistent withdrawal management services that are not licensed by DMC-ODS.

Table 11. **Availability of Inpatient Psychiatric Beds by Covered California Region**

| Covered California Region | Total Beds Available for Region | Net Bed Surplus/Gap per Region According to Crisis Now Resource Calculator |
|---|--|---|
| Northern Counties | 116 | -20 |
| North Bay Area | 235 | 75 |
| Greater Sacramento | 440 | 127 |
| San Francisco County | 175 | -85 |
| Contra Costa County | 116 | 3 |
| Alameda County | 339 | 160 |
| Santa Clara County | 246 | 6 |
| San Mateo County | 62 | -51 |
| Santa Cruz, San Benito, and Monterey Counties | 56 | -12 |
| Central Valley | 227 | 35 |
| Fresno, Kings and Madera Counties | 93 | -12 |
| Central Coast | 162 | 14 |
| Eastern Counties | 0 | -11 |
| Kern County | 37 | -57 |
| Los Angeles County | 2,143 | 854 |
| Inland Empire | 532 | 63 |
| Orange County | 442 | 3 |
| San Diego County | 661 | 166 |

Sources: Data on inpatient beds were obtained from DHCS licensure data. Net bed surplus/gap per region is based on an analysis of Crisis Now Resource Calculator results. Information on Covered California regions is available at [2021 QHP QDP Region Map 11022020.pdf \(coveredca.com\)](#).

Caveats: The number of inpatient psychiatric beds in each county was assessed using DHCS licensure data. Some licensed facilities may have beds that are suspended, which are not captured in these licensure data. The net bed surplus/gap per region was assessed based on an analysis of data from the Crisis Now Resource Calculator. This calculator estimates the number of beds that are needed to serve the population in a given region. This calculator does not take into account regional variation in rates of mental health conditions or availability of other downstream providers, both of which may affect local need for inpatient psychiatric beds.

Appendix C – Approach and Methodology

This assessment was prepared by the California Department of Health Care Services (DHCS) with the assistance of Manatt Health Strategies and Dr. Anton Nigusse Bland. It is based on a mixed-methods design, relying on both quantitative and qualitative data sources. With respect to quantitative data, the assessment primarily relied on secondary data and existing reports available from the state as well as external data sources (e.g., the National Survey of Drug Use and Health (NSDUH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) Behavioral Health Treatment Services Locator (henceforth, “the Treatment Locator”). Qualitative data were gathered through a survey, interviews and stakeholder focus groups between July and September 2021.

Establishing the Framework for a Core Continuum of Care

The key principles and core continuum of care used in this assessment were developed based on source documents from federal agencies and national organizations and associations that describe the array of services and other attributes (policies, quality of care and principles) that should exist in a comprehensive and robust behavioral health care system. These include:

- SAMHSA’s Description of a Good and Modern Addictions and Mental Health Service System²⁰⁰
- DHCS’ 2012 California Mental Health and Substance Use System Needs Assessment²⁰¹
- Various federal guidance regarding behavioral health services from CMS, SAMHSA, and the National Institute of Mental Health^{202,203,204}
- American Society of Addiction Medicine (ASAM) levels of care description²⁰⁵
- Administration for Children and Families Title IV-E Prevention Services Clearinghouse²⁰⁶

²⁰⁰ Description of a Good and Modern Addictions and Mental Health Service System, SAMHSA, April 2011. Available at https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

²⁰¹ Available at <https://www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf>.

²⁰² Behavioral Health Services, Medicaid.gov. Available at <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html>.

²⁰³ National Guidelines for Behavioral Health Crisis Care, SAMHSA. Available at <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

²⁰⁴ Available at <https://www.nimh.nih.gov/health>.

²⁰⁵ Available at <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>.

²⁰⁶ Available at <https://www.acf.hhs.gov/opre/project/title-iv-e-prevention-services-clearinghouse-2018-2023>.

These materials do not provide an exhaustive list of all behavioral health services that could be included in a continuum of care. However, federal and state agencies have relied on these documents to identify what services should be available for people living with mental health and SUD needs, regardless of payer source. Similar needs assessments conducted in other states and jurisdictions have relied on these sources to benchmark what core services “are” available versus what “should be” available. California-specific information gathered through the qualitative data sources was used to adapt the continuum of services to California’s unique environment. For example, the continuum includes services and provider types that are specific to California (e.g., the Crisis Residential Treatment Program). While the continuum of care is designed to help guide the assessment, it includes some services for which data are not yet available.

Quantitative Data Collection

The assessment used quantitative data to capture the prevalence of behavioral health conditions in California as well as to take stock of the availability of behavioral health treatment services in each county. Data from the NSDUH and Medi-Cal (the state’s Medicaid program) administrative claims data were used to quantify the prevalence of behavioral health conditions in each county in California. Licensure and certification data, the Treatment Locator, and other secondary reports from state agencies and stakeholder groups were used to identify the availability of different behavioral health treatment resources in each county. In general, data on the availability of treatment resources were analyzed by assessing the absence or presence of treatment programs in each county. In some cases, availability was quantified by calculating the number of treatment facilities (or slots/beds) per capita in each county. In many instances, county-level data were not readily available.

Additional information on the data sources and how they were used to inform the assessment is provided below:

- *The NSDUH.* SAMHSA administers the NSDUH to estimate the prevalence of mental health conditions, SUD, and other health-related behaviors. NSDUH survey data were used in this assessment to compare the prevalence of behavioral health conditions in California with national rates. These data were also used to examine demographic characteristics associated with behavioral health conditions at the national level. The NSDUH data used for this assessment are available in public-facing reports available on the [NSDUH website](#).
- *Medi-Cal Administrative Claims Data.* Medi-Cal administrative claims data from calendar year 2019 were used to quantify the number of Medicaid enrollees with SMI, SED and SUD in each county in California. While the NSDUH produces a statewide estimate for the total number of individuals living with SMI and SUD, it does not provide this information at the county level. The assessment uses claims data to supplement prevalence data from the NSDUH in order to understand county-level variations in the prevalence of behavioral health conditions. While these data are only inclusive of Medi-Cal enrollees, they still provide useful insight regarding the wide variation in rates of behavioral health conditions in different regions of the state.
 - *Calculating Rates of SMI, SED and SUD Using Administrative Claims Data.* Proxy measures were used to assess rates of SMI, SED and SUD using

Medi-Cal administrative claims data. These proxy measures were generally based on combinations of ICD-10 diagnosis codes as well as utilization of inpatient psychiatric services. Adults aged 18+ were identified as having SMI if they had at least one inpatient or outpatient claim with a primary ICD-10 diagnosis code corresponding to schizophrenia, bipolar disorder, or major depression. Individuals were also classified as having SMI if they had at least one inpatient claim with a revenue code corresponding to inpatient psychiatric treatment. Slightly different criteria were used to identify individuals aged less than 18 with SED. Individuals were classified as having SED if they had at least one claim with a primary ICD-10 diagnosis code corresponding to schizophrenia, bipolar disorder, posttraumatic stress disorder, obsessive compulsive disorder or eating disorders. Individuals were also considered as having SED if they had at least one inpatient claim with a revenue code corresponding to inpatient psychiatric treatment. Finally, individuals were identified as having SUD if they had at least one claim with a primary ICD-10 diagnosis code corresponding to alcohol use disorder, opioid use disorder, stimulant use disorder or other substance use disorders.

- *Limitations of proxy measures used to calculate rates of SMI, SED and SUD using administrative claims data.* The proxy measures described above are prone to several noteworthy limitations. For one, there are many cases where these proxy measures may only identify individuals as having SMI/SED/SUD if they are actively receiving treatment for one of these conditions. An individual must have some interaction with the health care system in order for a Medicaid claim with an ICD-10 diagnosis code to be generated. In many cases, this interaction often implies receipt of a treatment or service related to the primary diagnosis code. With this in mind, diagnosis-based proxy measures may underestimate the true prevalence of a condition by only capturing individuals who have interactions with the health care system related to that condition. Conversely, these diagnosis-based proxy measures may also overestimate the population prevalence of these conditions. For example, the NSDUH defines individuals living with SMI as those who have diagnosable mental health conditions of “sufficient duration to meet diagnosis criteria in the DSM-IV.” ICD-10 codes related to bipolar disorder, schizophrenia, etc., do not necessarily imply DSM-IV-consistent diagnoses. In many cases, the threshold for receiving a DSM-IV-consistent diagnosis is higher than the threshold for receiving an ICD-10 diagnosis code. ICD-10 diagnosis codes also do not allow us to assess duration, so individuals with ICD-10 diagnosis codes related to SMI may not have mental health conditions for a sufficient-enough duration to meet the DSM-IV threshold for an SMI.
- *Licensure and Certification Data.* This assessment employed an array of licensure and certification data from DHCS, the Department of Social Services, the Department of Public Health, the Department of State Hospitals, the Office of Statewide Health Planning and Development, and the Medical Board of California to quantify the availability of behavioral health treatment resources in each county in California. Specifically, these data were used to identify psychiatrists and other behavioral health practitioners as well as treatment facilities providing crisis services,

inpatient mental health treatment, SUD treatment and withdrawal management (WM). The majority of these licensure and certification data are available through public reports published on the [California Health and Human Services Open Data Portal](#).

- *SAMHSA Treatment Locator*. The Treatment Locator is a tool developed by SAMHSA to assist individuals with identifying available mental health and SUD treatment resources. The Treatment Locator is compiled from responses to SAMHSA's National Survey of Substance Abuse Treatment Services and the National Mental Health Services Survey. These data include information on facilities that provide behavioral health treatment and are funded by a state agency. These data also include information on private and non-profit facilities that are licensed by a state or national agency to provide behavioral treatment services. These data were used to identify the availability of treatment resources that are not easily identifiable using licensure and certification data from the state. Specifically, the Treatment Locator was used to quantify the following types of facilities at the county level:
 - Community Mental Health Centers
 - Federally Qualified Health Centers
 - Facilities providing outpatient mental health treatment
 - Facilities providing intensive outpatient treatment or partial hospitalization services
 - Facilities providing Assertive Community Treatment
- Data from the Treatment Locator may be downloaded for free from the [SAMHSA website](#). While the Treatment Locator data are very valuable, they are not without limitations. In particular, it should be noted that this tool may not include all behavioral health providers. For example, the tool may not include unlicensed treatment facilities or license-exempt facilities. The locator also generally does not provide information on individuals in private practice or a small group practice unless they are licensed or certified as a clinic. Although the Treatment Locator is not a comprehensive database of every behavioral health treatment provider, it provides useful information regarding the general availability of outpatient treatment services at the county level. For example, the SAMHSA Treatment Locator includes information on availability of DEA-waivered buprenorphine prescribers that is generally consistent with data provided directly from the DEA. The Treatment Locator data indicate that there are two counties in California that do not have any DEA-waivered buprenorphine prescribers available. Comparatively, data from the US DEA suggest that there is only one county that does not have any buprenorphine prescribers available. Additional information regarding the treatment facilities that are included in the Treatment Locator may be found on the SAMHSA webpage.
- *Other Secondary Reports*. This assessment also relied on a variety of other secondary reports and data that were developed by California state agencies and other stakeholder groups. For example, the availability of school-based health services in each county was quantified using data collected by the California School-Based Health Alliance. Behavioral health treatment services for the populations who are justice-involved were generally identified using reports

shared by the California Department of Corrections and Rehabilitation as well as information found online. SUD treatment facilities providing residential or inpatient SUD treatment or withdrawal management were identified using Drug Medi-Cal Organized Delivery System (DMC-ODS) provider reports shared by DHCS. Data on average length of stay for inpatient psychiatric admissions were provided by the California Hospital Association. Other instances where data were gleaned from miscellaneous sources are referenced throughout the report.

Qualitative Data Collection

The assessment used qualitative data to identify gaps in the availability of behavioral health treatment services as well as to understand needs and priorities from counties' and other stakeholders' perspectives. Qualitative data were collected through:

- *A Survey of County Behavioral Health Directors.* Developed in collaboration with DHCS and the County Behavioral Health Directors Association of California, the survey sought to understand the perspectives of county behavioral health directors on the current continuum of care and their priorities for change. All 58 counties and the two city jurisdictions that operate behavioral health departments responded to the survey, as completion is a prerequisite to the receipt of future infrastructure grant funding.
- *Stakeholder Focus Groups and Interviews.* The authors facilitated seven focus groups to gather input on gaps in the continuum of care for mental health and SUD services as well as to learn more about success stories and innovative solutions that the state may consider for spread and sustainability. Focus groups were conducted with representatives from community behavioral health agencies; peer support advocacy groups; social rehabilitation agencies; alcohol and drug program executives; medical associations, including psychiatric and psychiatrist associations; urban and rural tribal behavioral health organizations; children and youth advocates and providers; individuals with lived experience; and community mental health advocates. The authors also facilitated 14 interviews to gather key insights from stakeholders and behavioral health experts in California about current gaps in the continuum of care as well as available data to inform the assessment.

The qualitative data were a critical supplement to the quantitative data collected, given the quantitative data's limitations. Manatt analyzed information collected through the survey as well as through stakeholder focus groups and interviews to inform the themes and recommendations in this report. Specifically, Manatt drew from these sources case studies to illustrate the report's themes, examples of innovations within and across counties, and quotes from individuals with both lived experience and important insights based on their roles as behavioral health directors, program administrators, state officials, providers, caregivers and individuals.

Assessment Limitations

Certain gaps and limitations affected this assessment. As discussed above, the broad nature of the assessment as well as the short time frame for its preparation prevented DHCS from examining every aspect of the continuum of care. Other limitations included the following:

- There were challenges in assessing the prevalence of behavioral health conditions and the need for services among California’s population due to lack of consistent data collection and availability, particularly among those individuals who are involved in the criminal justice system, individuals experiencing homelessness and AI/AN individuals.
- The assessment was not able to methodically evaluate access to and utilization of behavioral health services, except with respect to some of the claims data available on Medi-Cal enrollees.
- The assessment does not evaluate the integration of physical and mental health services across the state.
- The assessment does not examine the quality of behavioral health services and facilities; this was deemed out of scope given both the data and time limitations.
- While the assessment attempted to engage a wide range of stakeholders through the survey, interviews, and focus groups, DHCS acknowledges that stakeholder engagement could not be as comprehensive as desired due to the truncated timeframe for the report’s development.

Appendix D – Assessing the Need

To assess the adequacy of California’s current behavioral health care system, it is important to understand the prevalence of mental health and substance use disorders in the state. How many children and adults in California face such issues? How much does prevalence vary across counties and by characteristics such as race and ethnicity? There is not a perfect data source that captures the true population prevalence of mental health conditions or substance use disorders. Many data sources calculate rates of these conditions using self-reported surveys, which may be prone to underreporting. Other data sources rely on administrative claims data that fail to capture individuals who are not actively using health care services.

For the purposes of this assessment, rates of mental health conditions and substance use disorders were primarily assessed using data from the National Survey of Drug Use and Health (NSDUH). Administered by SAMHSA, the NSDUH can be used to estimate the prevalence of mental health conditions, SUDs, and other health-related behaviors.²⁰⁷ It can provide state-level information but not county-specific data. To provide some county-specific data, this assessment also draws from Medi-Cal administrative claims data and other California-specific sources of information.

Overall, as described in detail below, these data suggest that:

- Close to one in 20 California adults (4.5 percent) has SMI, and more than twice as many have SUD (9.2 percent).
- California has a marginally higher rate of SUD and lower rate of SMI compared with the overall U.S. population aged 18+.
- Rates of SMI nationally tend to be higher among AI/AN individuals and individuals who report being of two or more races.
- In California, rates of SMI and SUD are highest among individuals aged 18-25.
- Rates of SED among Black and Latino children in California are higher relative to other racial/ethnic groups, and SED rates among children are higher among lower-income groups.²⁰⁸
- Among individuals who are justice-involved in California and nationwide, rates of SMI and SUD are markedly higher relative to the general population. For example, reports from the California Department of Corrections and Rehabilitation (CDCR) suggest that 6.4 percent and 80 percent of individuals in prison in California have SMI or SUD, respectively, compared with only 4.5 percent and 9.2 percent among the general population, respectively.

²⁰⁷ NSDUH. About the Survey. Accessed September 8, 2021. https://nsduhweb.rti.org/respweb/about_nsduh.html.

²⁰⁸ “Mental Health in California. For Too Many, Care Not There. California Health Care Foundation, 2018. Available at <https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf>.

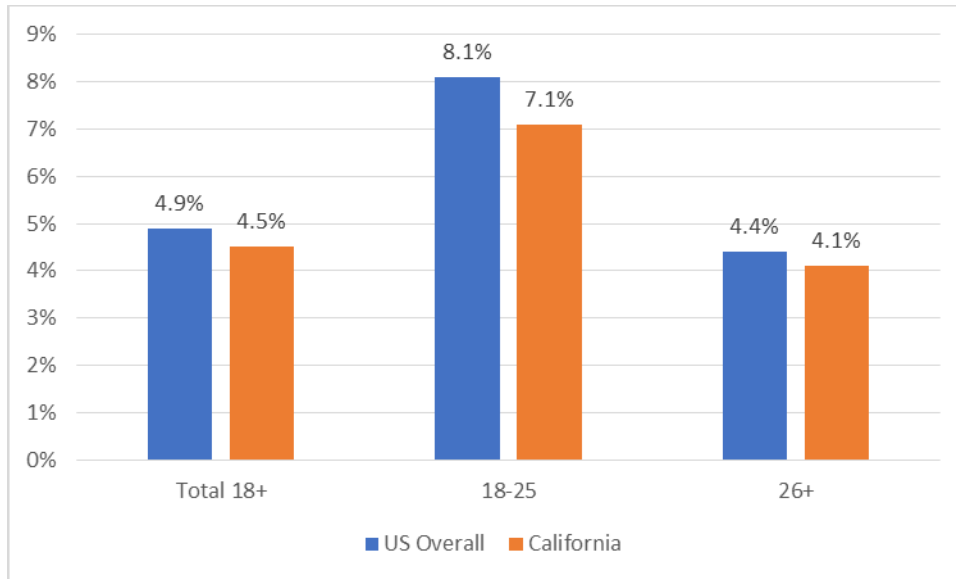
SMI Among Adults

The estimated percentage of adults living with SMI in the United States has increased steadily in recent years, from 3.7 percent in 2008 to 5.2 percent in 2019.²⁰⁹ In Appendix B, Table 1 displays nationwide rates of SMI among adults aged 18+ stratified by various demographic characteristics of interest. The NSDUH results suggest that the rate of SMI from 2018 to 2019 in California was marginally lower (4.5 percent) than the overall rate among the U.S. adult population (4.9 percent) for that period.²¹⁰

²⁰⁹ Lipari RN. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health.” Published online 2019:114.

²¹⁰ <https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf>.

Figure D-1. **Percentage of Individuals Aged 18+ with SMI in California Relative to U.S. Overall from 2018 and 2019 from Pooled NSDUH Data²¹¹**



According to the NSDUH, the rate of SMI among Medicaid enrollees nationally (8.1 percent) is substantially higher than the rate among individuals with any other type of insurance and is also higher than the rate among individuals who are uninsured.²¹²

California Medicaid administrative claims data also provided a picture of the number of Medi-Cal enrollees who had SMI in 2019. Proxy measures based on ICD-10 diagnosis codes and utilization of inpatient psychiatric services were used to estimate the rate of SMI among adult Medi-Cal enrollees aged 18+. Additional information on these proxy measures can be found in Appendix C. This analysis suggests that 6.3 percent of adult Medi-Cal enrollees had SMI in 2019. This rate differs from those reported by the NSDUH above because those rates are based on proxy measures calculated using administrative claims data. Limitations associated with these proxy measures are further described in Appendix C. At the county level, rates of SMI among Medi-Cal enrollees ranged from a high of 12.1 percent in Plumas County to a low of 4.1 percent in Sierra County. Figure D-2 below displays the percentages of adult Medi-Cal enrollees with SMI in each county in 2019. These data are also displayed in Appendix B, Table 2.

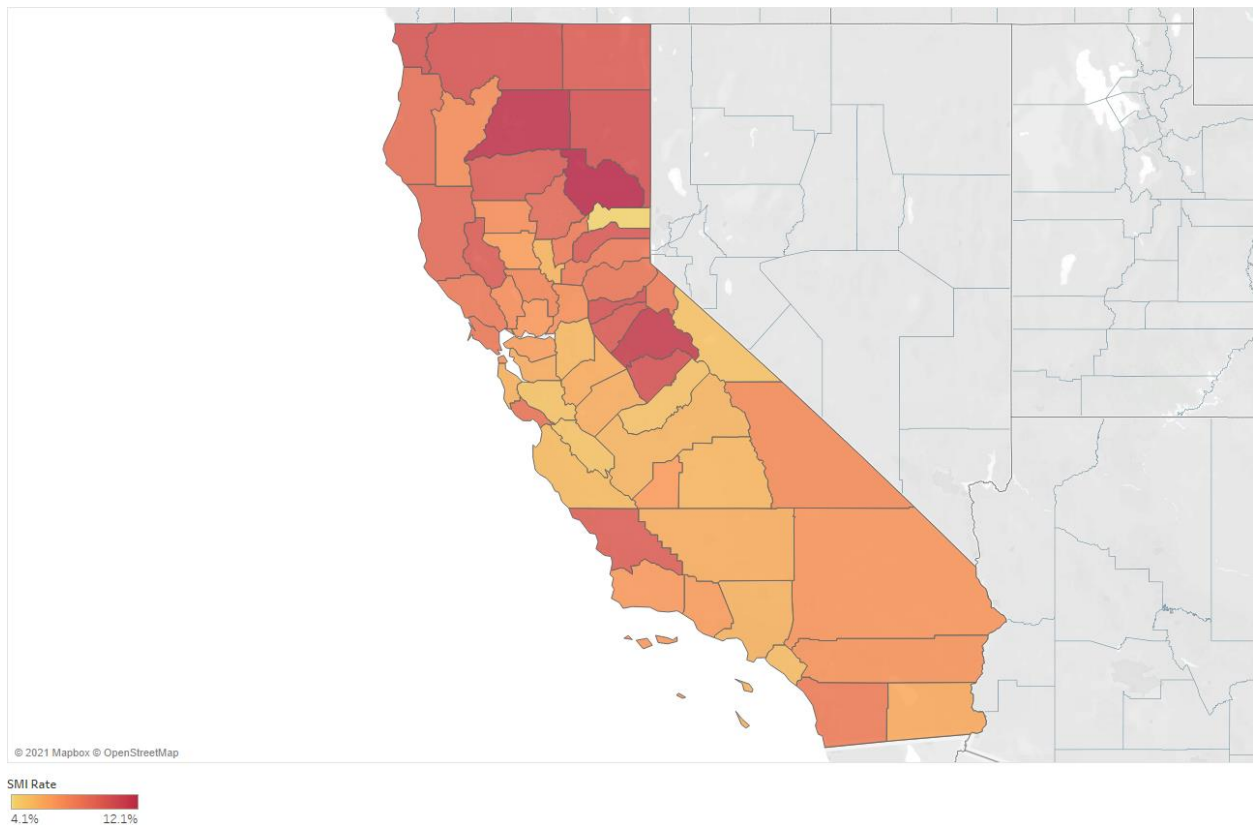
Adults living with SMI often receive treatment via county-contracted specialty mental health plans. DHCS produces publicly available reports that document the number of

²¹¹ Ibid.

²¹² Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. Accessed September 8, 2021. <https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf>.

Medi-Cal enrollees receiving specialty mental health services.²¹³ These data indicate that approximately 3.8 percent of adult Medi-Cal enrollees received a specialty mental health service in 2019. The discrepancy between the number of individuals receiving specialty mental health services (3.8 percent) and the number of Medi-Cal enrollees identified as having SMI using proxy measures (6.5 percent) implies that many enrollees with SMI fail to receive Medi-Cal SMHS services.

Figure D-2. **Percentage of Adult Medi-Cal Enrollees Identified as Having SMI Using California Medicaid Claims Data–Based Proxy Measures in 2019**



SUD Among Adults

In Appendix B, Table 1 also displays NSDUH data estimating nationwide rates of alcohol use disorder and SUD among adults aged 18+ stratified by demographic characteristics of interest. Rates of SUD tended to be higher among males, AI/AN individuals, individuals who are unemployed and individuals who are uninsured.²¹⁴ The NSDUH estimates suggest that the rate of SUD among adults in California (9.2 percent) is marginally higher than the rate among the overall U.S. population (7.7 percent).²¹⁵

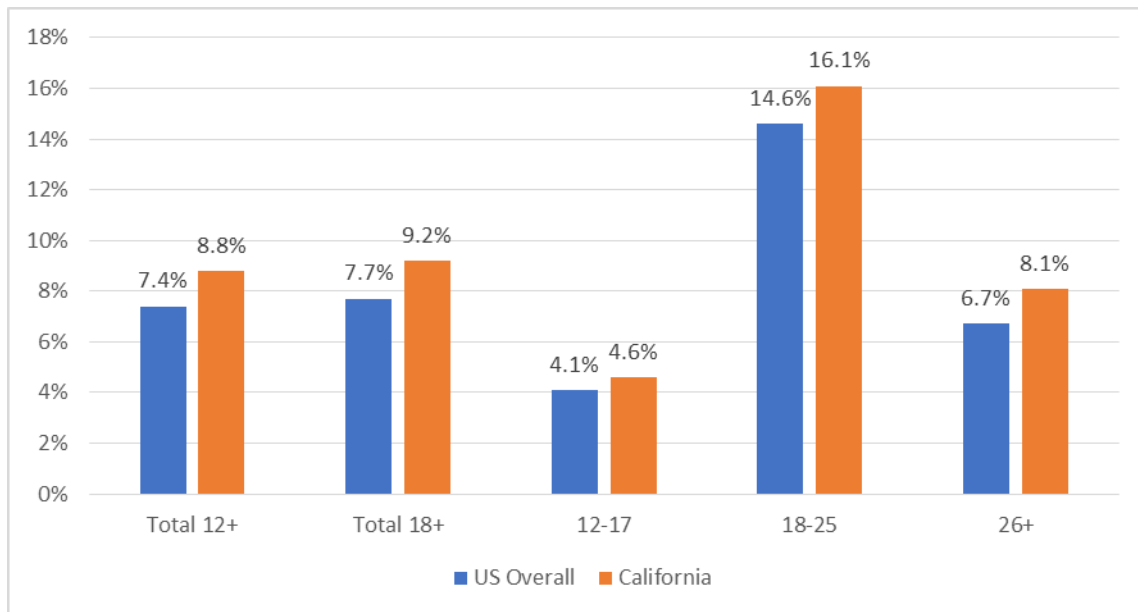
²¹³ Adult Population Performance Dashboard, CHHS Open Data. Available at <https://data.chhs.ca.gov/dataset/adult-population-performance-dashboard>.

²¹⁴ Ibid.

²¹⁵ Ibid.

In addition to capturing the prevalence of SUD, older versions of the NSDUH also estimated the percentage of individuals who received treatment. These data suggest that from 2010 to 2014, on average, only 7 percent of adults in California with alcohol use disorder and 12 percent of adults living with illicit drug use disorder received treatment.^{216,217} Although dated, these data suggest that a significant proportion of the overall population with SUD likely fail to receive treatment.

Figure D-3. Percentage of Individuals Aged 12+ with SUD in California Relative to U.S. Overall from 2018 and 2019 Pooled NSDUH Data²¹⁸



Analyses of Medicaid claims data revealed that 3.3 percent of Medi-Cal enrollees aged 18+ had an SUD diagnosis in 2019. This rate is lower than rates reported by the NSDUH above because it is based on diagnosis code-based proxy measures calculated using administrative claims data. Despite the fact that there are effective evidence-based treatments for some SUDs, only about one in five people who currently need treatment for this condition actually receive it.²¹⁹ Additional details on these proxy measures and their inherent limitations can be found in Appendix C. These proxy measures likely underreport the true prevalence of SUD because they fail to capture individuals who do not receive SUD treatment or otherwise interact with the health care system. As documented by NSDUH, the majority of individuals living with SUD have

²¹⁶ <https://www.chcf.org/wp-content/uploads/2018/09/SubstanceUseDisorderAlmanac2018.pdf>.

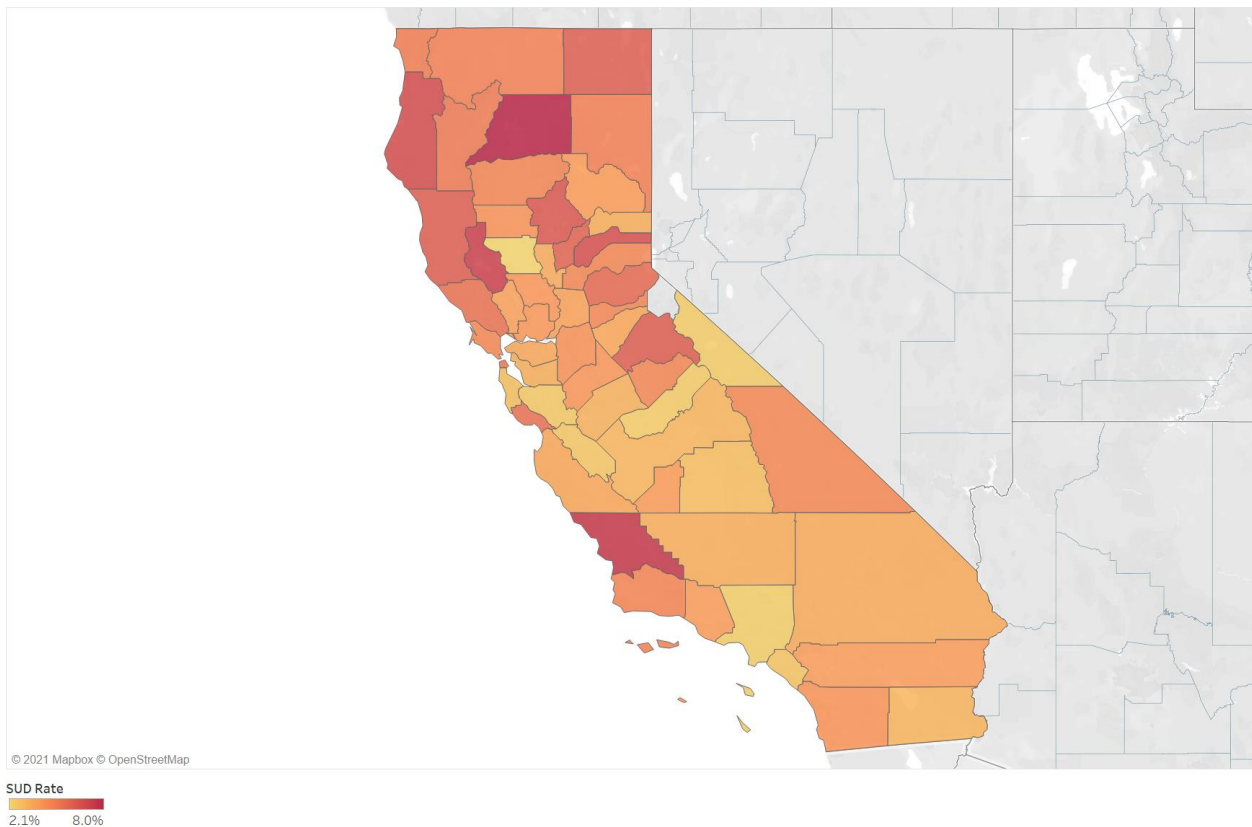
²¹⁷ Illicit drug use disorder includes use of marijuana, cocaine, heroin, hallucinogens, inhalants and methamphetamine, and nonmedical use of prescription drugs.

²¹⁸ Ibid.

²¹⁹ Saloner B, Karthikeyan S. National Changes in 12-Month Substance Abuse Treatment Utilization Among Individuals with 2 Opioid Use Disorders, 2004-2013, JAMA, Oct. 13, 2015.

historically not participated in treatment.²²⁰ Observed county-level rates of SUD among Medi-Cal enrollees ranged from a high of 8.0 percent in Shasta County to a low of 2.1 percent in Colusa County. Figure E-4 below displays the percentage of adult Medi-Cal enrollees with an SUD diagnosis in each county in 2019. These data are also displayed in Appendix B, Table 2.

Figure D-4. Percentage of Adult Medi-Cal Enrollees Identified as Having SUD Using California Medicaid Claims Data–Based Proxy Measures in 2019



*Note: Alpine County is excluded due to having a count less than 10.

Data from the California Department of Public Health on opioid-related overdose deaths were also used as a proxy to assess county-level variation in SUD prevalence.²²¹ These data show wide variation in rates of opioid-related overdose deaths at the county level. In 2020, rates ranged from a low of zero in six counties (Alpine, Mariposa, Modoc, Mono, Sierra, and Trinity) to a high of 43.68 per 100,000 in San Francisco. The age-adjusted opioid-related overdose death rate in San Francisco was over three times higher than the overall rate for the state. These data also suggest there is significant overlap between counties with high rates of SUD among Medi-Cal enrollees and

²²⁰ "California Health Care Almanac," California Health Care Foundation, October 2018. Available at <https://www.chcf.org/wp-content/uploads/2018/09/SubstanceUseDisorderAlmanac2018.pdf>.

²²¹ "California Overdose Surveillance Dashboard," California Department of Public Health. Available at <https://skylab.cdph.ca.gov/ODdash>.

counties with high rates of opioid-related overdose deaths. Five of the top 10 counties in terms of rates of SUD among Medi-Cal enrollees in 2019 were also among the top 11 counties in terms of overall opioid-related overdose death rates in 2020.

SED Among Children/Youth

Federal regulations use the term “serious emotional disturbance” to refer to youth living with psychiatric disorders that cause substantial functional impairment.^{222,223} Rates of SED among youth are less well documented than are rates of SMI among adults, and the methodological challenges associated with estimating rates of SED among youth are well established.²²⁴ The NSDUH does not provide estimates for nationwide rates of SED. However, a recent meta-analysis assessing 12 nationwide and regional studies that estimated rates of SED found a pooled prevalence rate of 10.06 percent among the studies examined.²²⁵ A previous study from California estimated that 7.6 percent of children in the state had SED in 2014.²²⁶ The California study estimated higher rates of SED among Black and Latino children relative to other racial/ethnic groups and higher rates among children in lower-income groups.²²⁷

²²² 34 CFR § 300.8 – Child with a disability. Available at <https://www.law.cornell.edu/cfr/text/34/300.8>.

²²³ Williams NJ, Scott L, Aarons GA. Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis. *Psychiatr Serv Wash DC*. 2018;69(1):32-40. doi:10.1176/appi.ps.201700145.

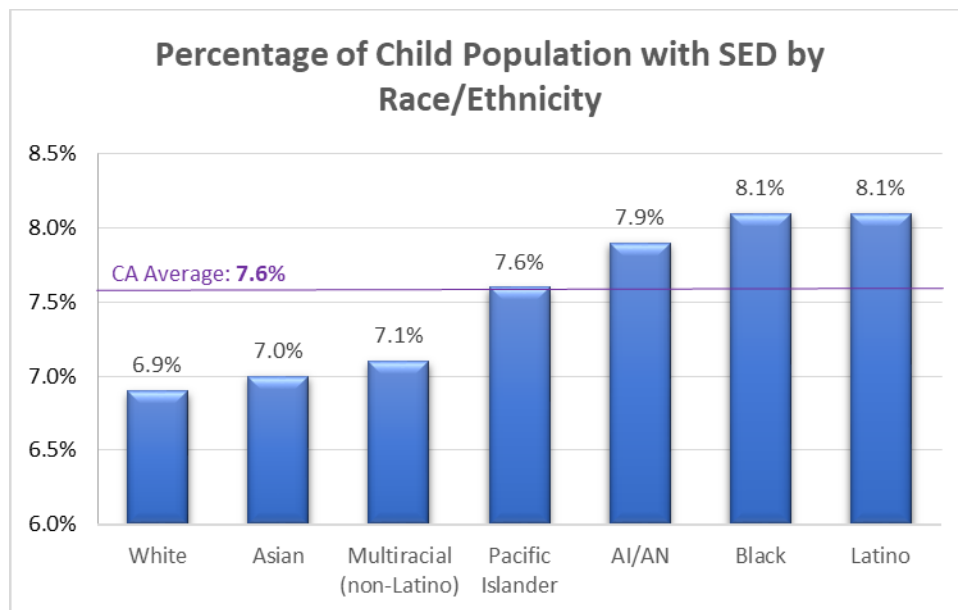
²²⁴ Existing measures and data. “Measuring Serious Emotional Disturbance in Children: Workshop Summary.” Committee on National Statistics; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; Board on Health Sciences Policy; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine; 2016. <https://www.ncbi.nlm.nih.gov/books/NBK368059/>.

²²⁵ Williams NJ, Scott L, Aarons GA. Prevalence of Serious Emotional Disturbance Among U.S. Children: A Meta-Analysis. *Psychiatr Serv Wash DC*. 2018;69(1):32-40. doi:10.1176/appi.ps.201700145.

²²⁶ “Mental Health in California. For Too Many, Care Not There.” California Health Care Foundation; 2018. Available at <https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf>.

²²⁷ Ibid.

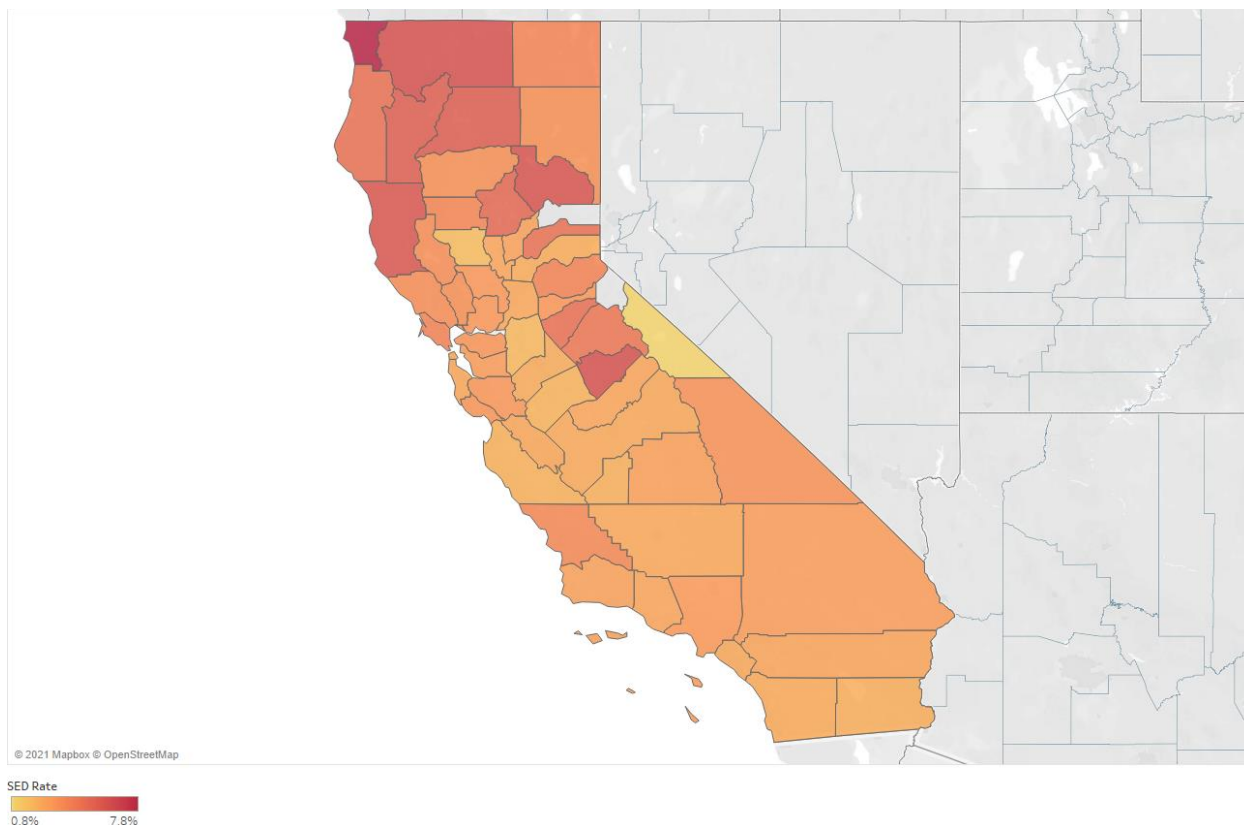
Figure D-5. **Percentage of California Child Population with SED by Race/Ethnicity in 2014**²²⁸



Analyses of California Medicaid administrative claims data were used to provide additional estimates of the rate of SED among Medi-Cal enrollees. These analyses indicate that 2.8 percent of Medi-Cal enrollees under age 18 had SED in 2019, with rates ranging from a low of 0.8 percent in Mono County to a high of 7.8 percent in Del Norte County. Note that these rates are not directly comparable to rates reported in other sources because they were calculated using proxy measures that do not capture the true population prevalence of SED. Figure E-6 below displays the percentage of Medi-Cal enrollees with SED in each county in 2019. These data are also presented in Appendix B, Table 2. Additional information on how these SED proxy measures were operationalized, as well as their inherent limitations, can be found in Appendix C.

²²⁸ Holzer C, Nguyen H, “Estimation of Need for Mental Health Services.” Accessed October 2021. Available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Joint%20Health%2002_26_19%20Teare%20to%20Ctte.pdf.

Figure D-6. Percentage of Medi-Cal Enrollees Identified as Having SED Using California Medicaid Claims Data–Based Proxy Measures in 2019



Note: Sierra and Alpine Counties are excluded due to having counts less than 10.

Adolescents with SUD

In Appendix B, Table 3 displays results from the NSDUH estimating the nationwide rate of SUD among youth aged 12-17 stratified by various demographic characteristics. Rates of SUD among this population were higher for females and AI/AN individuals. Pooled NSDUH data from 2018 to 2019 suggest that California has a higher rate of SUD (4.55 percent) among individuals aged 12-17 relative to the overall U.S. population (4.08 percent).²²⁹

Analyses of Medi-Cal claims data found that only 0.8 percent of youth Medi-Cal enrollees (aged 12-17) received an SUD diagnosis during calendar year 2019. This rate is lower than rates reported by the NSDUH above because it is based on proxy measures calculated using administrative claims data. Again, these rates likely underestimate the true prevalence of SUD because they fail to capture individuals who

²²⁹ Results from the 2019 National Survey on Drug Use and Health: Detailed Tables, SAMHSA, CBHSQ. Accessed September 8, 2021. <https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf>.

do not engage with the health care system. Additional detail on these proxy measures and their inherent limitations can be found in Appendix C. County-specific rates of SUD among youth Medi-Cal enrollees ranged from a high of 2.4 percent in Mariposa County to a low of 0 percent in Alpine and Sierra Counties. In Appendix B, Table 2 displays rates of SUD among youth Medi-Cal enrollees in each county in 2019.

Behavioral Health Conditions Among the Justice-involved Population

Rates of behavioral health conditions among the justice-involved population tend to be substantially higher than rates among the overall U.S. population.²³⁰ There is not a comprehensive data source similar to the NSDUH that captures rates of mental health conditions or SUD among individuals in jails and prisons, and previous nationwide estimates vary considerably. Figure D-7 below presents estimates from multiple disparate data sources to compare rates of any mental illness (AMI), SMI and SUD among individuals in prisons and jails relative to the overall U.S. population (e.g., different data sources were used to assess the rate of AMI in jails versus prisons versus the general population).

A previous report by the Bureau of Justice Statistics suggested that up to 14 percent of individuals in federal prisons and 26 percent of individuals in jails reported symptoms consistent with SMI.²³¹ The Bureau of Justice Statistics has also reported that approximately 58 percent and 63 percent of individuals in prisons and jails, respectively, met the criteria for substance abuse or dependence.²³²

The prevalence of behavioral health conditions in jails and prisons in California specifically may be estimated using proxy measures that are routinely reported by the Board of State and Community Corrections (BSCC) as well as the CDCR. According to the BSCC Jail Profile Survey, the number of individuals in California jails with an active mental health case rose from 19 percent in 2009 to 31 percent in 2019.²³³ Over the

²³⁰ Lamb HR, Weinberger LE. Persons With Severe Mental Illness in Jails and Prisons: A Review. *Psychiatry Serv.* 1998;49(4):483-492. doi:10.1176/ps.49.4.483. Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics. Accessed September 8, 2021. <https://bjs.ojp.gov/library/publications/mental-health-problems-prison-and-jail-inmates>.

²³¹ Bronson J, Berzofsky M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. Bureau of Justice Statistics; 2017. <https://bjs.ojp.gov/content/pub/pdf/imhprpj1112.pdf>.

²³² Bronson, Jennifer and Jessica Stroop, "Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates," US Department of Justice. Available at <https://bjs.ojp.gov/content/pub/pdf/dudaspi0709.pdf>.

²³³ "California Jail Profile Survey 1995-2020." Available at <https://www.openicpsr.org/openicpsr/project/104560/version/V7/view;jsessionid=9028C59D95C1C3DCF30613F070226456>.

same period, the percentage of individuals in jail with a psychotropic medication prescription increased from 13 percent in 2009 to 26 percent in 2019.²³⁴

Notably, the BSCC Jail Profile Survey captures wide variability in these measures across counties (e.g., the percentage of individuals with open mental health cases ranges from 6 percent in Trinity County to 88 percent in Santa Clara County), which suggests that these measures may not reliably capture the true underlying prevalence of mental health conditions. The BSCC Jail Profile Survey does not report proxy measures that can be used to estimate the percentage of individuals living with SUD.

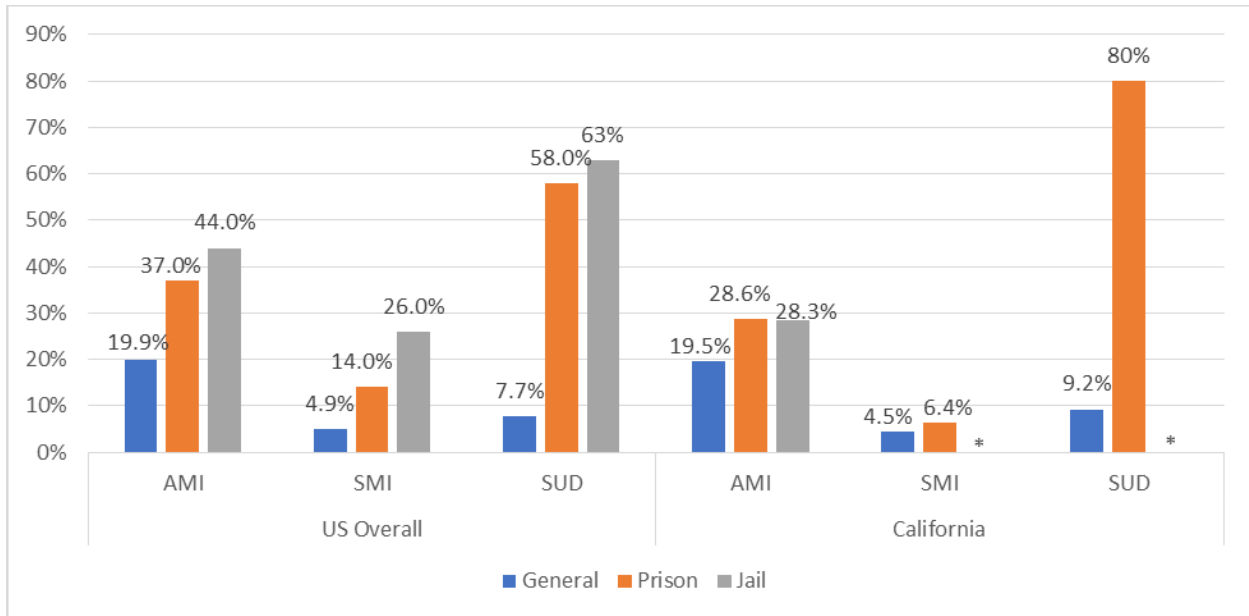
The CDCR uses rates of mental health treatment in prisons as a proxy measure for rates of mental health conditions. According to the Council on Criminal Justice and Behavioral Health's *19th Annual Legislative Report*, approximately 22 percent of prison inmates received treatment consistent with mild-to-moderate mental health conditions, while 6.4 percent received higher levels of care comparable to treatment for SMI.²³⁵ The report does not present statewide data that may be used to estimate rates of SUD among individuals in prisons. However, a previous report from California Correctional Health Care Services estimates that up to 80 percent of individuals in prison in California may have SUD.²³⁶

²³⁴ "The Prevalence of Mental Illness in California Jails Is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions, 2009-2019." California Health Policy Strategies LLC; 2020. https://calhps.com/wp-content/uploads/2020/02/Jail_MentalHealth_JPSReport_02-03-2020.pdf.

²³⁵ 19th Annual Legislative Report. Council on Criminal Justice and Behavioral Health; 2020.

²³⁶ Kelso C. Treatment to Reduce the Burden of Disease and Deaths from Opioid Use Disorder. California Correctional Health Care Services; 2018. <https://cchcs.ca.gov/wp-content/uploads/sites/60/Reports/Drug-Treatment-Program.pdf>.

Figure D-7. Rates of AMI, SMI and SUD Among Populations who are justice-involved in California and the U.S. Overall²³⁷



[*Note: The rate of SMI or SUD in jails could not be determined from available data sources.](#)

²³⁷ Justice-involved prevalence data were available from the CDCR legislative report. <https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2021/01/CCJBH-2020-Annual-Report-Final.pdf>. AMI, SMI and SUD data were available from the NSDUH. <https://www.samhsa.gov/data/sites/default/files/reports/rpt32805/2019NSDUHsaeExcelPercents/2019NSDUHsaeExcelPercents/2019NSDUHsaePercents.pdf>.

Appendix E – Additional Tables with County-Specific Information

Table E-1. Number of Facilities Providing Assertive Community Treatment by County

| County | Facilities Providing ACT |
|-----------------|---------------------------------|
| Alameda | 5 |
| Alpine | 0 |
| Amador | 0 |
| Butte | 2 |
| Calaveras | 0 |
| Colusa | 1 |
| Contra Costa | 3 |
| Del Norte | 0 |
| El Dorado | 1 |
| Fresno | 8 |
| Humboldt | 2 |
| Imperial | 0 |
| Inyo | 0 |
| Kern | 0 |
| Lake | 0 |
| Lassen | 0 |
| Los Angeles | 28 |
| Madera | 3 |
| Marin | 3 |
| Mariposa | 0 |
| Mendocino | 1 |
| Merced | 1 |
| Monterey | 5 |
| Napa | 0 |
| Nevada | 2 |
| Orange | 12 |
| Placer | 1 |
| Plumas | 0 |
| Riverside | 5 |
| Sacramento | 4 |
| San Benito | 0 |
| San Bernardino | 3 |
| San Diego | 12 |
| San Francisco | 8 |
| San Joaquin | 1 |
| San Luis Obispo | 0 |

| County | Facilities Providing ACT |
|---------------|---------------------------------|
| San Mateo | 2 |
| Santa Barbara | 0 |
| Santa Clara | 8 |
| Santa Cruz | 0 |
| Shasta | 1 |
| Sierra | 0 |
| Siskiyou | 1 |
| Solano | 2 |
| Sonoma | 0 |
| Stanislaus | 1 |
| Sutter | 0 |
| Trinity | 0 |
| Tulare | 1 |
| Tuolumne | 0 |
| Ventura | 0 |
| Yolo | 1 |
| Yuba | 0 |

Source: SAMHSA Behavioral Health Treatment Services Locator.

Table E-2. Sobering Centers and Sobering Center Capacity by County

| County | Sobering Centers | Capacity |
|----------------|-------------------------|-----------------|
| Alameda | 1 | 17 |
| Alpine | 0 | 0 |
| Amador | 0 | 0 |
| Butte | 0 | 0 |
| Calaveras | 0 | 0 |
| Colusa | 0 | 0 |
| Contra Costa | 0 | 0 |
| Del Norte | 0 | 0 |
| El Dorado | 0 | 0 |
| Fresno | 0 | 0 |
| Glenn | 0 | 0 |
| Humboldt | 0 | 0 |
| Imperial | 0 | 0 |
| Inyo | 0 | 0 |
| Kern | 2 | 16 |
| Kings | 0 | 0 |
| Lake | 0 | 0 |
| Lassen | 0 | 0 |
| Los Angeles | 1 | 50 |
| Madera | 0 | 0 |
| Marin | 0 | 0 |
| Mariposa | 0 | 0 |
| Mendocino | 0 | 0 |
| Merced | 0 | 0 |
| Modoc | 0 | 0 |
| Mono | 0 | 0 |
| Monterey | 1 | 10 |
| Napa | 0 | 0 |
| Nevada | 0 | 0 |
| Orange | 0 | 0 |
| Placer | 0 | 0 |
| Plumas | 0 | 0 |
| Riverside | 0 | 0 |
| Sacramento | 0 | 0 |
| San Benito | 0 | 0 |
| San Bernardino | 0 | 0 |
| San Diego | 1 | 15 |
| San Francisco | 1 | 13 |
| San Joaquin | 0 | 0 |

| County | Sobering Centers | Capacity |
|------------------------|-------------------------|-----------------|
| San Luis Obispo | 0 | 0 |
| San Mateo | 1 | 14 |
| Santa Barbara | 1 | 10 |
| Santa Clara | 1 | 20 |
| Santa Cruz | 0 | 0 |
| Shasta | 1 | 3 |
| Sierra | 0 | 0 |
| Siskiyou | 0 | 0 |
| Solano | 0 | 0 |
| Sonoma | 0 | 0 |
| Stanislaus | 0 | 0 |
| Sutter | 0 | 0 |
| Tehama | 0 | 0 |
| Trinity | 0 | 0 |
| Tulare | 0 | 0 |
| Tuolumne | 0 | 0 |
| Ventura | 0 | 0 |
| Yolo | 0 | 0 |
| Yuba | 0 | 0 |

Source: Provided by National Sobering Collaborative via personal correspondence in July 2021.

Table E-3. Inpatient Psychiatric Units and Bed Capacity by County

| Counties | Psychiatric Units Within General Acute Care Hospitals | Psychiatric Units Within General Acute Care Hospitals (Number of Beds) | Psychiatric Acute Care Hospital Facilities | Psychiatric Acute Care Hospital Facilities (Number of Beds) | Psychiatric Health Facilities | Psychiatric Health Facilities (Number of Beds) |
|--------------|---|--|--|---|-------------------------------|--|
| Alameda | 3 | 203 | 1 | 96 | 2 | 40 |
| Alpine | 0 | 0 | 0 | 0 | 0 | 0 |
| Amador | 0 | 0 | 0 | 0 | 0 | 0 |
| Butte | 0 | 0 | 0 | 0 | 1 | 16 |
| Calaveras | 0 | 0 | 0 | 0 | 0 | 0 |
| Colusa | 0 | 0 | 0 | 0 | 0 | 0 |
| Contra Costa | 1 | 43 | 1 | 73 | 0 | 0 |
| Del Norte | 0 | 0 | 0 | 0 | 0 | 0 |
| El Dorado | 0 | 0 | 0 | 0 | 1 | 10 |
| Fresno | 1 | 61 | 0 | 0 | 2 | 32 |
| Glenn | 0 | 0 | 0 | 0 | 0 | 0 |
| Humboldt | 0 | 0 | 0 | 0 | 1 | 16 |
| Imperial | 0 | 0 | 0 | 0 | 0 | 0 |
| Inyo | 0 | 0 | 0 | 0 | 0 | 0 |
| Kern | 3 | 21 | 0 | 0 | 1 | 16 |
| Kings | 0 | 0 | 0 | 0 | 0 | 0 |
| Lake | 0 | 0 | 0 | 0 | 0 | 0 |
| Lassen | 0 | 0 | 0 | 0 | 0 | 0 |
| Los Angeles | 28 | 1,176 | 10 | 919 | 3 | 48 |
| Madera | 0 | 0 | 0 | 0 | 0 | 0 |
| Marin | 1 | 17 | 0 | 0 | 0 | 0 |
| Mariposa | 0 | 0 | 0 | 0 | 0 | 0 |

| Counties | Psychiatric Units Within General Acute Care Hospitals | Psychiatric Units Within General Acute Care Hospitals (Number of Beds) | Psychiatric Acute Care Hospital Facilities | Psychiatric Acute Care Hospital Facilities (Number of Beds) | Psychiatric Health Facilities | Psychiatric Health Facilities (Number of Beds) |
|------------------------|--|---|---|--|--------------------------------------|---|
| Mendocino | 0 | 0 | 0 | 0 | 0 | 0 |
| Merced | 0 | 0 | 0 | 0 | 1 | 16 |
| Modoc | 0 | 0 | 0 | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 | 0 | 0 | 0 |
| Monterey | 2 | 40 | 0 | 0 | 0 | 0 |
| Napa | 1 | 21 | 1 | 45 | 0 | 0 |
| Nevada | 0 | 0 | 0 | 0 | 0 | 0 |
| Orange | 9 | 408 | 1 | 34 | 0 | 0 |
| Placer | 0 | 0 | 0 | 0 | 1 | 16 |
| Plumas | 0 | 0 | 0 | 0 | 0 | 0 |
| Riverside | 2 | 114 | 1 | 62 | 1 | 16 |
| Sacramento | 0 | 0 | 3 | 314 | 3 | 82 |
| San Benito | 0 | 0 | 0 | 0 | 0 | 0 |
| San Bernardino | 3 | 145 | 2 | 195 | 0 | 0 |
| San Diego | 13 | 376 | 5 | 285 | 0 | 0 |
| San Francisco | 4 | 141 | 2 | 34 | 0 | 0 |
| San Joaquin | 1 | 2 | 1 | 35 | 1 | 28 |
| San Luis Obispo | 0 | 0 | 0 | 0 | 1 | 16 |
| San Mateo | 2 | 62 | 0 | 0 | 0 | 0 |
| Santa Barbara | 0 | 0 | 0 | 0 | 1 | 16 |
| Santa Clara | 4 | 126 | 1 | 80 | 2 | 40 |
| Santa Cruz | 0 | 0 | 0 | 0 | 1 | 16 |
| Shasta | 1 | 20 | 0 | 0 | 1 | 16 |

| Counties | Psychiatric Units Within General Acute Care Hospitals | Psychiatric Units Within General Acute Care Hospitals (Number of Beds) | Psychiatric Acute Care Hospital Facilities | Psychiatric Acute Care Hospital Facilities (Number of Beds) | Psychiatric Health Facilities | Psychiatric Health Facilities (Number of Beds) |
|-------------------|--|---|---|--|--------------------------------------|---|
| Sierra | 0 | 0 | 0 | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 0 | 0 | 0 | 0 |
| Solano | 0 | 0 | 1 | 61 | 1 | 16 |
| Sonoma | 3 | 75 | 0 | 0 | 0 | 0 |
| Stanislaus | 1 | 67 | 0 | 0 | 1 | 16 |
| Sutter | 0 | 0 | 0 | 0 | 2 | 32 |
| Tehama | 0 | 0 | 0 | 0 | 1 | 16 |
| Trinity | 0 | 0 | 0 | 0 | 0 | 0 |
| Tulare | 1 | 63 | 0 | 0 | 0 | 0 |
| Tuolumne | 0 | 0 | 0 | 0 | 0 | 0 |
| Ventura | 1 | 43 | 1 | 87 | 0 | 0 |
| Yolo | 1 | 18 | 0 | 0 | 0 | 0 |
| Yuba | 0 | 0 | 0 | 0 | 0 | 0 |

Source: DHCS licensure data.

Table E-4. Services for Children/Youth and Young Adults by County

| County | Outpatient Programs for Children / youth | Outpatient treatment programs for young adults | Number of Child psychiatrists | Child psychiatrists per 100,000 individuals below age 18 | School based health programs with mental health services |
|--------------|--|--|-------------------------------|--|--|
| Alameda | 20 | 22 | 36 | 10.6 | 31 |
| Alpine | 1 | 1 | 0 | 0.0 | 0 |
| Amador | 1 | 1 | 2 | 33.3 | 0 |
| Butte | 2 | 5 | 2 | 4.5 | 0 |
| Calaveras | 1 | 1 | 0 | 0.0 | 0 |
| Colusa | 1 | 1 | 0 | 0.0 | 0 |
| Contra Costa | 10 | 11 | 39 | 15.1 | 13 |
| Del Norte | 2 | 3 | 0 | 0.0 | 0 |
| El Dorado | 3 | 3 | 2 | 5.2 | 0 |
| Fresno | 11 | 12 | 13 | 4.6 | 5 |
| Glenn | 0 | 0 | 0 | 0.0 | 0 |
| Humboldt | 4 | 5 | 0 | 0.0 | 1 |
| Imperial | 1 | 0 | 1 | 1.9 | 0 |
| Inyo | 1 | 1 | 0 | 0.0 | 0 |
| Kern | 7 | 10 | 15 | 5.8 | 5 |
| Kings | 0 | 0 | 0 | 0.0 | 1 |
| Lake | 1 | 1 | 0 | 0.0 | 1 |
| Lassen | 1 | 1 | 0 | 0.0 | 0 |
| Los Angeles | 121 | 157 | 305 | 14.2 | 45 |
| Madera | 3 | 3 | 0 | 0.0 | 2 |
| Marin | 5 | 6 | 25 | 48.7 | 2 |
| Mariposa | 1 | 1 | 0 | 0.0 | 1 |
| Mendocino | 4 | 3 | 0 | 0.0 | 0 |
| Merced | 4 | 5 | 1 | 1.2 | 1 |
| Modoc | 0 | 0 | 0 | 0.0 | 0 |
| Mono | 0 | 0 | 0 | 0.0 | 0 |
| Monterey | 6 | 7 | 9 | 8.0 | 2 |
| Napa | 3 | 3 | 7 | 25.2 | 4 |
| Nevada | 2 | 3 | 1 | 5.9 | 0 |
| Orange | 26 | 41 | 78 | 11.3 | 4 |
| Placer | 3 | 5 | 9 | 10.2 | 0 |
| Plumas | 1 | 1 | 0 | 0.0 | 0 |
| Riverside | 12 | 13 | 26 | 4.2 | 3 |
| Sacramento | 16 | 22 | 42 | 11.6 | 1 |

| County | Outpatient Programs for Children / youth | Outpatient treatment programs for young adults | Number of Child psychiatrists | Child psychiatrists per 100,000 individuals below age 18 | School based health programs with mental health services |
|------------------------|---|---|--------------------------------------|---|---|
| San Benito | 1 | 1 | 0 | 0.0 | 0 |
| San Bernardino | 23 | 28 | 27 | 4.7 | 2 |
| San Diego | 16 | 39 | 125 | 17.5 | 11 |
| San Francisco | 13 | 19 | 62 | 52.5 | 19 |
| San Joaquin | 2 | 4 | 10 | 4.9 | 7 |
| San Luis Obispo | 3 | 5 | 6 | 12.1 | 1 |
| San Mateo | 6 | 7 | 24 | 15.5 | 2 |
| Santa Barbara | 5 | 10 | 8 | 8.1 | 1 |
| Santa Clara | 19 | 21 | 101 | 24.3 | 13 |
| Santa Cruz | 2 | 2 | 8 | 15.4 | 1 |
| Shasta | 3 | 5 | 2 | 5.2 | 0 |
| Sierra | 2 | 2 | 0 | 0.0 | 0 |
| Siskiyou | 2 | 2 | 0 | 0.0 | 0 |
| Solano | 6 | 7 | 7 | 7.1 | 1 |
| Sonoma | 4 | 8 | 16 | 16.8 | 4 |
| Stanislaus | 2 | 3 | 2 | 1.3 | 5 |
| Sutter | 4 | 6 | 1 | 4.0 | 0 |
| Tehama | 0 | 0 | 0 | 0.0 | 0 |
| Trinity | 2 | 2 | 0 | 0.0 | 0 |
| Tulare | 1 | 4 | 4 | 2.8 | 2 |
| Tuolumne | 1 | 1 | 1 | 10.9 | 0 |
| Ventura | 9 | 14 | 15 | 7.9 | 1 |
| Yolo | 4 | 5 | 14 | 30.6 | 1 |
| Yuba | 1 | 2 | 0 | 0.0 | 0 |

Sources- Outpatient programs for children / youth and young adults identified from SAMHSA Behavioral Health Services Treatment Locator. Data on child psychiatrists provided by California Medical Board. Data on school-based health programs with mental health services.

Table E-5. Housing Units Available by Housing and Urban Development Continuum of Care

| Continuum of Care | Permanent Supportive Housing: Total Year-Round Beds | Other Permanent Housing: Total Year-Round Beds | Transitional Housing: Total Year-Round Beds | Rapid Rehousing: Total Year-Round Beds |
|---|--|---|--|---|
| San Jose/Santa Clara City and County | 3,829 | 126 | 559 | 1,486 |
| San Francisco | 5,897 | 4,154 | 627 | 1,187 |
| Oakland, Berkeley/Alameda County | 3,545 | - | 617 | 633 |
| Sacramento City and County | 3,251 | 91 | 590 | 772 |
| Santa Rosa, Petaluma/Sonoma County | 823 | 145 | 375 | 630 |
| Richmond/Contra Costa County | 1,156 | 6 | 194 | 231 |
| Salinas/Monterey, San Benito Counties | 301 | - | 509 | 226 |
| Marin County | 514 | 90 | 180 | 48 |
| Watsonville/Santa Cruz City and County | 658 | - | 182 | 420 |
| Mendocino County | 363 | - | 124 | 41 |
| Turlock, Modesto/Stanislaus County | 555 | - | 248 | 12 |
| Stockton/San Joaquin County | 726 | - | 360 | 364 |
| Daly City/San Mateo County | 1,218 | 47 | 172 | 367 |
| Visalia/Kings, Tulare Counties | 235 | 65 | 184 | 139 |
| Fresno City and County/Madera County | 1,338 | 44 | 148 | 767 |
| Roseville, Rocklin/Placer, Nevada Counties | 61 | - | 166 | 74 |
| Redding/Shasta County | 55 | - | 189 | 251 |
| Napa City and County | 50 | - | 22 | 59 |
| Vallejo/Solano County | 228 | - | 109 | 177 |
| Chico, Paradise/Butte County | 176 | 115 | 254 | 21 |
| Merced City and County | 163 | - | 144 | 46 |
| Davis, Woodland/Yolo County | 242 | - | 51 | 334 |
| Humboldt County | 57 | - | 85 | 213 |

| Continuum of Care | Permanent Supportive Housing: Total Year-Round Beds | Other Permanent Housing: Total Year-Round Beds | Transitional Housing: Total Year-Round Beds | Rapid Rehousing: Total Year-Round Beds |
|---|--|---|--|---|
| Colusa, Glen, Trinity Counties | - | - | 58 | - |
| Yuba City/Sutter County | 18 | 4 | 42 | 213 |
| El Dorado County | 5 | - | 66 | 85 |
| Tuolumne, Amador, Calaveras, Mariposa Counties | 58 | - | 51 | 100 |
| Tehama County | - | - | 38 | 188 |
| Lake County | 210 | 24 | 38 | - |
| Alpine, Inyo, Mono Counties | - | - | 21 | 7 |
| Nevada County | 42 | 2 | 12 | 97 |
| Los Angeles City and County | 22,683 | 2,030 | 4,111 | 6,045 |
| San Diego City and County | 4,901 | 939 | 1,700 | 1,846 |
| Santa Ana, Anaheim/Orange County | 2,496 | 295 | 1,017 | 663 |
| Santa Maria/Santa Barbara County | 707 | 277 | 163 | 186 |
| Bakersfield/Kern County | 2,308 | 9 | 264 | 602 |
| Long Beach | 1,662 | 240 | 317 | 378 |
| Pasadena | 434 | - | 51 | 25 |
| Riverside City and County | 1,744 | - | 92 | 318 |
| San Bernardino City and County | 1,603 | - | 186 | 2,101 |
| Oxnard, San Buenaventura/Ventura County | 693 | - | 205 | 683 |
| Glendale | 189 | - | 54 | 15 |
| Imperial County | 321 | - | 154 | 157 |
| San Luis Obispo County | 357 | 4 | 31 | 404 |

Source: U.S. Department of Housing and Urban Development.

Table E-6. Psychiatrists by County

| County | Number of Psychiatrists | Psychiatrists per 100,000 |
|----------------|--------------------------------|----------------------------------|
| Alameda | 350 | 21.1 |
| Alpine | 0 | 0.0 |
| Amador | 6 | 15.6 |
| Butte | 13 | 5.8 |
| Calaveras | 2 | 4.4 |
| Colusa | 0 | 0.0 |
| Contra Costa | 188 | 16.5 |
| Del Norte | 2 | 7.3 |
| El Dorado | 19 | 10.1 |
| Fresno | 93 | 9.4 |
| Glenn | 0 | 0.0 |
| Humboldt | 14 | 10.3 |
| Imperial | 12 | 6.6 |
| Inyo | 1 | 5.6 |
| Kern | 68 | 7.7 |
| Kings | 11 | 7.3 |
| Lake | 3 | 4.7 |
| Lassen | 1 | 3.2 |
| Los Angeles | 1882 | 18.7 |
| Madera | 4 | 2.6 |
| Marin | 177 | 68.1 |
| Mariposa | 1 | 5.7 |
| Mendocino | 8 | 9.2 |
| Merced | 7 | 2.6 |
| Modoc | 0 | 0.0 |
| Mono | 0 | 0.0 |
| Monterey | 63 | 14.5 |
| Napa | 86 | 61.6 |
| Nevada | 15 | 15.1 |
| Orange | 496 | 15.7 |
| Placer | 73 | 18.9 |
| Plumas | 0 | 0.0 |
| Riverside | 192 | 8.0 |
| Sacramento | 322 | 21.1 |
| San Benito | 1 | 1.7 |
| San Bernardino | 249 | 11.6 |
| San Diego | 725 | 21.9 |
| San Francisco | 567 | 64.8 |

| County | Number of Psychiatrists | Psychiatrists per 100,000 |
|------------------------|--------------------------------|----------------------------------|
| San Joaquin | 65 | 8.8 |
| San Luis Obispo | 91 | 32.3 |
| San Mateo | 214 | 27.9 |
| Santa Barbara | 61 | 13.7 |
| Santa Clara | 547 | 28.4 |
| Santa Cruz | 52 | 19.0 |
| Shasta | 12 | 6.7 |
| Sierra | 0 | 0.0 |
| Siskiyou | 4 | 9.2 |
| Solano | 59 | 13.4 |
| Sonoma | 88 | 17.6 |
| Stanislaus | 35 | 6.4 |
| Sutter | 11 | 11.4 |
| Tehama | 0 | 0.0 |
| Trinity | 1 | 7.9 |
| Tulare | 16 | 3.5 |
| Tuolumne | 4 | 7.4 |
| Ventura | 108 | 12.7 |
| Yolo | 52 | 23.9 |
| Yuba | 2 | 2.6 |

Source: California Medical Board.

Table E-7. Mental Health Rehabilitation Centers by County

| Counties | Total Facilities | Total Beds |
|-----------------|-------------------------|-------------------|
| Alameda | 3 | 154 |
| Alpine | 0 | 0 |
| Amador | 0 | 0 |
| Butte | 0 | 0 |
| Calaveras | 0 | 0 |
| Colusa | 0 | 0 |
| Contra Costa | 0 | 0 |
| Del Norte | 0 | 0 |
| El Dorado | 0 | 0 |
| Fresno | 2 | 81 |
| Glenn | 0 | 0 |
| Humboldt | 1 | 42 |
| Imperial | 0 | 0 |
| Inyo | 0 | 0 |
| Kern | 1 | 55 |
| Kings | 0 | 0 |
| Lake | 0 | 0 |
| Lassen | 0 | 0 |
| Los Angeles | 2 | 196 |
| Madera | 0 | 0 |
| Marin | 1 | 89 |
| Mariposa | 0 | 0 |
| Mendocino | 0 | 0 |
| Merced | 1 | 98 |
| Modoc | 0 | 0 |
| Mono | 0 | 0 |
| Monterey | 0 | 0 |
| Napa | 1 | 54 |
| Nevada | 0 | 0 |
| Orange | 1 | 80 |
| Placer | 0 | 0 |
| Plumas | 0 | 0 |
| Riverside | 1 | 38 |
| Sacramento | 1 | 54 |
| San Benito | 0 | 0 |
| San Bernardino | 0 | 0 |
| San Diego | 4 | 406 |
| San Francisco | 2 | 101 |
| San Joaquin | 0 | 0 |
| San Luis Obispo | 0 | 0 |

| Counties | Total Facilities | Total Beds |
|----------------------|-------------------------|-------------------|
| San Mateo | 1 | 68 |
| Santa Barbara | 0 | 0 |
| Santa Clara | 1 | 100 |
| Santa Cruz | 1 | 99 |
| Shasta | 0 | 0 |
| Sierra | 0 | 0 |
| Siskiyou | 0 | 0 |
| Solano | 1 | 92 |
| Sonoma | 0 | 0 |
| Stanislaus | 0 | 0 |
| Sutter | 1 | 44 |
| Tehama | 0 | 0 |
| Trinity | 0 | 0 |
| Tulare | 0 | 0 |
| Tuolumne | 0 | 0 |
| Ventura | 2 | 31 |
| Yolo | 0 | 0 |
| Yuba | 0 | 0 |

Source: DHCS licensure data.

Table E-8. Availability by County of Short-Term Residential Therapeutic Program (STRTPs) and Community Treatment Facilities (CTFs)

| Counties | STRTP Facilities | STRTP Beds | CTF Facilities | CTF Beds |
|----------------|------------------|------------|----------------|----------|
| Alameda | 11 | 86 | 0 | 0 |
| Alpine | 2 | 12 | 0 | 0 |
| Amador | 0 | 0 | 0 | 0 |
| Butte | 2 | 12 | 0 | 0 |
| Calaveras | 2 | 68 | 0 | 0 |
| Colusa | 0 | 0 | 0 | 0 |
| Contra Costa | 13 | 80 | 0 | 0 |
| Del Norte | 0 | 0 | 0 | 0 |
| El Dorado | 7 | 42 | 0 | 0 |
| Fresno | 37 | 239 | 0 | 0 |
| Glenn | 0 | 0 | 0 | 0 |
| Humboldt | 0 | 0 | 0 | 0 |
| Imperial | 2 | 12 | 0 | 0 |
| Inyo | 0 | 0 | 0 | 0 |
| Kern | 26 | 151 | 0 | 0 |
| Kings | 1 | 6 | 0 | 0 |
| Lake | 0 | 0 | 0 | 0 |
| Lassen | 1 | 10 | 0 | 0 |
| Los Angeles | 77 | 947 | 2 | 68 |
| Madera | 3 | 38 | 0 | 0 |
| Marin | 1 | 67 | 0 | 0 |
| Mariposa | 2 | 12 | 0 | 0 |
| Mendocino | 3 | 12 | 0 | 0 |
| Merced | 7 | 42 | 0 | 0 |
| Modoc | 0 | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 | 0 |
| Monterey | 3 | 18 | 0 | 0 |
| Napa | 0 | 0 | 0 | 0 |
| Nevada | 4 | 30 | 0 | 0 |
| Orange | 21 | 182 | 0 | 0 |
| Placer | 6 | 36 | 0 | 0 |
| Plumas | 0 | 0 | 0 | 0 |
| Riverside | 35 | 396 | 0 | 0 |
| Sacramento | 21 | 198 | 0 | 0 |
| San Benito | 4 | 24 | 0 | 0 |
| San Bernardino | 42 | 471 | 0 | 0 |
| San Diego | 18 | 312 | 0 | 0 |
| San Francisco | 3 | 64 | 0 | 0 |

| Counties | STRTP Facilities | STRTP Beds | CTF Facilities | CTF Beds |
|-----------------|-------------------------|-------------------|-----------------------|-----------------|
| San Joaquin | 5 | 52 | 0 | 0 |
| San Luis Obispo | 2 | 18 | 0 | 0 |
| San Mateo | 2 | 24 | 0 | 0 |
| Santa Barbara | 5 | 50 | 0 | 0 |
| Santa Clara | 5 | 29 | 0 | 0 |
| Santa Cruz | 3 | 18 | 0 | 0 |
| Shasta | 4 | 24 | 0 | 0 |
| Sierra | 0 | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 0 | 0 |
| Solano | 3 | 18 | 0 | 0 |
| Sonoma | 12 | 85 | 0 | 0 |
| Stanislaus | 16 | 135 | 0 | 0 |
| Sutter | 0 | 0 | 0 | 0 |
| Tehama | 0 | 0 | 0 | 0 |
| Trinity | 0 | 0 | 0 | 0 |
| Tulare | 3 | 54 | 0 | 0 |
| Tuolumne | 0 | 0 | 0 | 0 |
| Ventura | 13 | 114 | 0 | 0 |
| Yolo | 3 | 18 | 0 | 0 |
| Yuba | 0 | 0 | 0 | 0 |

Source: Licensure data from Department of Social Services.

Table E-9. Crisis Stabilization Units and Slots by County

| County | CSUs | CSU Slots |
|----------------|-------------|------------------|
| Alameda | 3 | 21 |
| Alpine | 0 | 0 |
| Amador | 0 | 0 |
| Butte | 0 | 0 |
| Calaveras | 0 | 0 |
| Colusa | 0 | 0 |
| Contra Costa | 1 | 8 |
| Del Norte | 1 | 25 |
| El Dorado | 3 | 59 |
| Fresno | 1 | 39 |
| Glenn | 0 | 0 |
| Humboldt | 1 | 39 |
| Imperial | 1 | 7 |
| Inyo | 1 | 4 |
| Kern | 2 | 32 |
| Kings | 0 | 0 |
| Lake | 2 | 32 |
| Lassen | 0 | 0 |
| Los Angeles | 9 | 150 |
| Madera | 0 | 0 |
| Marin | 10 | 122 |
| Mariposa | 0 | 0 |
| Mendocino | 1 | 10 |
| Merced | 0 | 0 |
| Modoc | 0 | 0 |
| Mono | 2 | 12 |
| Monterey | 0 | 0 |
| Napa | 0 | 0 |
| Nevada | 0 | 0 |
| Orange | 4 | 51 |
| Placer | 1 | 4 |
| Plumas | 0 | 0 |
| Riverside | 1 | 12 |
| Sacramento | 5 | 81 |
| San Benito | 2 | 37 |
| San Bernardino | 0 | 0 |
| San Diego | 2 | 40 |
| San Francisco | 3 | 58 |
| San Joaquin | 2 | 17 |

| County | CSUs | CSU Slots |
|------------------------|-------------|------------------|
| San Luis Obispo | 1 | 24 |
| San Mateo | 1 | 4 |
| Santa Barbara | 1 | 14 |
| Santa Clara | 2 | 13 |
| Santa Cruz | 2 | 20 |
| Shasta | 1 | 10 |
| Sierra | 0 | 0 |
| Siskiyou | 0 | 0 |
| Solano | 1 | 16 |
| Sonoma | 1 | 16 |
| Stanislaus | 1 | 12 |
| Sutter | 0 | 0 |
| Tehama | 0 | 0 |
| Trinity | 1 | 5 |
| Tulare | 0 | 0 |
| Tuolumne | 0 | 0 |
| Ventura | 0 | 0 |
| Yolo | 0 | 0 |
| Yuba | 2 | 12 |

Sources: DHCS licensure data and surveys with county behavioral health directors.

Table E-10. Jail-Based Competency Treatment Program Capacity, Psychiatric Inpatient Units, and Crisis Intervention Teams

| County | Jail-Based Competency Treatment Program Capacity | Psychiatric Inpatient Units | Crisis Intervention Teams |
|--------------|--|-----------------------------|---------------------------|
| Alameda | 0 | 0 | 0 |
| Alpine | 0 | 0 | 0 |
| Amador | 0 | 0 | 0 |
| Butte | 5 | 0 | 1 |
| Calaveras | 10 | 0 | 0 |
| Colusa | 0 | 0 | 0 |
| Contra Costa | 0 | 0 | 1 |
| Del Norte | 0 | 0 | 0 |
| El Dorado | 0 | 0 | 1 |
| Fresno | 0 | 0 | 0 |
| Glenn | 0 | 0 | 0 |
| Humboldt | 6 | 0 | 1 |
| Imperial | 0 | 0 | 0 |
| Inyo | 0 | 0 | 0 |
| Kern | 60 | 0 | 1 |
| Kings | 5 | 0 | 0 |
| Lake | 0 | 0 | 0 |
| Lassen | 0 | 0 | 0 |
| Los Angeles | 0 | 0 | 1 |
| Madera | 0 | 0 | 0 |
| Marin | 0 | 0 | 1 |
| Mariposa | 6 | 0 | 0 |
| Mendocino | 6 | 0 | 0 |
| Merced | 0 | 0 | 1 |
| Modoc | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 |
| Monterey | 10 | 1 | 1 |
| Napa | 0 | 0 | 0 |
| Nevada | 0 | 0 | 0 |
| Orange | 0 | 0 | 1 |
| Placer | 15 | 0 | 1 |
| Plumas | 0 | 0 | 0 |
| Riverside | 25 | 1 (Women) | 1 |
| Sacramento | 44 | 0 | 0 |
| San Benito | 0 | 0 | 0 |

| County | Jail-Based Competency Treatment Program Capacity | Psychiatric Inpatient Units | Crisis Intervention Teams |
|------------------------|---|------------------------------------|----------------------------------|
| San Bernardino | 146 | 0 | 1 |
| San Diego | 30 | 0 | 1 |
| San Francisco | 0 | 0 | 1 |
| San Joaquin | 12 | 1 (Men) and 1 (Women) | 0 |
| San Luis Obispo | 5 | 0 | 1 |
| San Mateo | 0 | 0 | 1 |
| Santa Barbara | 10 | 0 | 1 |
| Santa Clara | 0 | 0 | 1 |
| Santa Cruz | 0 | 0 | 0 |
| Shasta | 6 | 0 | 1 |
| Sierra | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 0 |
| Solano | 12 | 1 | 0 |
| Sonoma | 12 | 0 | 1 |
| Stanislaus | 18 | 0 | 1 |
| Sutter | 0 | 0 | 0 |
| Tehama | 0 | 0 | 0 |
| Trinity | 0 | 0 | 0 |
| Tulare | 0 | 0 | 0 |
| Tuolumne | 0 | 0 | 0 |
| Ventura | 8 | 0 | 1 |
| Yolo | 0 | 0 | 1 |
| Yuba | 0 | 0 | 0 |

Sources: Data on jail-based competency treatment program capacity provided by the California Department of State Hospitals and data on psychiatric inpatient units were provided by CDCR. Data on crisis intervention teams were obtained from the University of Memphis Crisis Intervention Team Resource Center website.

Table E-11. Pre-Trial Diversion Programs Petitions, Prison Community Reentry Programs and Community Based Restoration Program Capacity by County

| County | Pre-Trial Diversion Program Petitions Received in Q1 2020 | Prison Community Reentry Total Programs | Prison Community Reentry Program Total Capacity | Community Based Restoration Program Capacity |
|---------------|--|--|--|---|
| Alameda | 8 | 12 | 207 | 0 |
| Alpine | 1 | 0 | 0 | 0 |
| Amador | 0 | 0 | 0 | 0 |
| Butte | 51 | 13 | 198 | 0 |
| Calaveras | 0 | 0 | 0 | 0 |
| Colusa | 0 | 0 | 0 | 0 |
| Contra Costa | 0 | 7 | 91 | 0 |
| Del Norte | 0 | 0 | 0 | 0 |
| El Dorado | 2 | 4 | 0 | 0 |
| Fresno | 14 | 23 | 896 | 0 |
| Glenn | 0 | 0 | 0 | 0 |
| Humboldt | 0 | 3 | 28 | 0 |
| Imperial | 0 | 8 | 31 | 0 |
| Inyo | 1 | 0 | 0 | 0 |
| Kern | 0 | 26 | 479 | 0 |
| Kings | 1 | 4 | 69 | 0 |
| Lake | 0 | 3 | 46 | 0 |
| Lassen | 0 | 0 | 0 | 0 |
| Los Angeles | 0 | 161 | 3,398 | 350 |
| Madera | 0 | 0 | 0 | 0 |
| Marin | 0 | 0 | 0 | 0 |
| Mariposa | 0 | 0 | 0 | 0 |
| Mendocino | 1 | 1 | 0 | 0 |
| Merced | 0 | 5 | 55 | 0 |
| Modoc | 0 | 0 | 0 | 0 |
| Mono | 4 | 0 | 0 | 0 |
| Monterey | 1 | 13 | 85 | 0 |
| Napa | 0 | 6 | 0 | 0 |
| Nevada | 6 | 0 | 0 | 0 |
| Orange | 35 | 26 | 388 | 0 |
| Placer | 2 | 9 | 69 | 0 |
| Plumas | 0 | 0 | 0 | 0 |
| Riverside | 1 | 106 | 1,028 | 0 |

| County | Pre-Trial Diversion Program Petitions Received in Q1 2020 | Prison Community Reentry Total Programs | Prison Community Reentry Program Total Capacity | Community Based Restoration Program Capacity |
|-----------------|--|--|--|---|
| Sacramento | 69 | 35 | 675 | 0 |
| San Benito | 7 | 32 | 651 | 0 |
| San Bernardino | 36 | 100 | 1,043 | 0 |
| San Diego | 0 | 43 | 978 | 0 |
| San Francisco | 35 | 9 | 220 | 0 |
| San Joaquin | 49 | 18 | 192 | 0 |
| San Luis Obispo | 0 | 6 | 42 | 0 |
| San Mateo | 6 | 5 | 130 | 0 |
| Santa Barbara | 8 | 29 | 604 | 0 |
| Santa Clara | 66 | 14 | 201 | 0 |
| Santa Cruz | 39 | 8 | 106 | 0 |
| Shasta | 3 | 26 | 148 | 0 |
| Sierra | 0 | 0 | 0 | 0 |
| Siskiyou | 8 | 0 | 0 | 0 |
| Solano | 0 | 19 | 182 | 0 |
| Sonoma | 4 | 1 | 6 | 0 |
| Stanislaus | 10 | 8 | 93 | 0 |
| Sutter | 0 | 0 | 0 | 0 |
| Tehama | 0 | 3 | 38 | 0 |
| Trinity | 0 | 0 | 0 | 0 |
| Tulare | 15 | 14 | 118 | 0 |
| Tuolumne | 0 | 0 | 0 | 0 |
| Ventura | 10 | 87 | 1 | 0 |
| Yolo | 23 | 225 | 1 | 0 |
| Yuba | 3 | 46 | 0 | 0 |

Sources: Data on pre-trial diversion program petitions in Q1 2020 were provided by the Judicial Council of California. Data on prison community reentry programs were provided by CDCR. Data on community-based restoration program capacity were provided by the California Department of State Hospitals

Table E-12. Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Inpatient Treatment Beds

| County | Number of Acute Psychiatric Inpatient Beds Available | Number of Acute Psychiatric Inpatient Beds Needed According to Crisis Resource Calculator | Gap Between Beds Available and Beds Needed |
|--------------|--|---|--|
| Alameda | 339 | 179 | 160 |
| Alpine | 0 | 0 | 0 |
| Amador | 0 | 2 | -2 |
| Butte | 16 | 22 | -6 |
| Calaveras | 0 | 2 | -2 |
| Colusa | 0 | 1 | -1 |
| Contra Costa | 116 | 113 | 3 |
| Del Norte | 0 | 1 | -1 |
| El Dorado | 10 | 22 | -12 |
| Fresno | 93 | 92 | 1 |
| Glenn | 0 | 3 | -3 |
| Humboldt | 16 | 14 | 2 |
| Imperial | 0 | 10 | -10 |
| Inyo | 0 | 1 | -1 |
| Kern | 37 | 94 | -57 |
| Kings | 0 | 7 | -7 |
| Lake | 0 | 3 | -3 |
| Lassen | 0 | 1 | -1 |
| Los Angeles | 2143 | 1289 | 854 |
| Madera | 0 | 6 | -6 |
| Marin | 17 | 28 | -11 |
| Mariposa | 0 | 1 | -1 |
| Mendocino | 0 | 5 | -5 |
| Merced | 16 | 22 | -6 |
| Modoc | 0 | 1 | -1 |
| Mono | 0 | 1 | -1 |
| Monterey | 40 | 35 | 5 |
| Napa | 66 | 20 | 46 |
| Nevada | 0 | 6 | -6 |
| Orange | 442 | 439 | 3 |
| Placer | 16 | 50 | -34 |
| Plumas | 0 | 1 | -1 |
| Riverside | 192 | 288 | -96 |

| County | Number of Acute Psychiatric Inpatient Beds Available | Number of Acute Psychiatric Inpatient Beds Needed According to Crisis Resource Calculator | Gap Between Beds Available and Beds Needed |
|-----------------|---|--|---|
| Sacramento | 396 | 220 | 176 |
| San Benito | 0 | 3 | -3 |
| San Bernardino | 340 | 181 | 159 |
| San Diego | 661 | 495 | 166 |
| San Francisco | 175 | 260 | -85 |
| San Joaquin | 65 | 70 | -5 |
| San Luis Obispo | 16 | 22 | -6 |
| San Mateo | 62 | 113 | -51 |
| Santa Barbara | 16 | 43 | -27 |
| Santa Clara | 246 | 240 | 6 |
| Santa Cruz | 16 | 30 | -14 |
| Shasta | 36 | 33 | 3 |
| Sierra | 0 | 0 | 0 |
| Siskiyou | 0 | 3 | -3 |
| Solano | 77 | 57 | 20 |
| Sonoma | 75 | 56 | 19 |
| Stanislaus | 83 | 47 | 36 |
| Sutter | 32 | 20 | 12 |
| Tehama | 16 | 7 | 9 |
| Trinity | 0 | 1 | -1 |
| Tulare | 63 | 52 | 11 |
| Tuolumne | 0 | 3 | -3 |
| Ventura | 130 | 83 | 47 |
| Yolo | 18 | 21 | -3 |
| Yuba | 0 | 7 | -7 |

Source: Data on number of acute inpatient beds from DHCS licensure data. Data on the number of beds needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator

Table E-13. Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Crisis Stabilization Unit Slots

| County | Number of CSU Slots Available | Number of CSU Slots Needed According to Crisis Resource Calculator | Gap Between CSU Slots Available and CSU Slots Needed |
|--------------|-------------------------------|--|--|
| Alameda | 21 | 79 | -58 |
| Alpine | 0 | 0 | 0 |
| Amador | 0 | 2 | -2 |
| Butte | 0 | 11 | -11 |
| Calaveras | 0 | 2 | -2 |
| Colusa | 0 | 1 | -1 |
| Contra Costa | 8 | 55 | -47 |
| Del Norte | 25 | 1 | 24 |
| El Dorado | 59 | 9 | 50 |
| Fresno | 39 | 47 | -8 |
| Glenn | 0 | 1 | -1 |
| Humboldt | 39 | 6 | 33 |
| Imperial | 7 | 9 | -2 |
| Inyo | 4 | 1 | 3 |
| Kern | 32 | 42 | -10 |
| Kings | 0 | 7 | -7 |
| Lake | 32 | 3 | 29 |
| Lassen | 0 | 1 | -1 |
| Los Angeles | 150 | 482 | -332 |
| Madera | 0 | 7 | -7 |
| Marin | 122 | 12 | 110 |
| Mariposa | 0 | 1 | -1 |
| Mendocino | 10 | 4 | 6 |
| Merced | 0 | 13 | -13 |
| Modoc | 0 | 0 | 0 |
| Mono | 12 | 1 | 11 |
| Monterey | 0 | 21 | -21 |
| Napa | 0 | 7 | -7 |
| Nevada | 0 | 5 | -5 |
| Orange | 51 | 151 | -100 |
| Placer | 4 | 18 | -14 |
| Plumas | 0 | 1 | -1 |
| Riverside | 12 | 115 | -103 |
| Sacramento | 81 | 73 | 8 |
| San Benito | 37 | 3 | 34 |

| County | Number of CSU Slots Available | Number of CSU Slots Needed According to Crisis Resource Calculator | Gap Between CSU Slots Available and CSU Slots Needed |
|------------------------|--------------------------------------|---|---|
| San Bernardino | 0 | 103 | -103 |
| San Diego | 40 | 158 | -118 |
| San Francisco | 58 | 42 | 16 |
| San Joaquin | 17 | 35 | -18 |
| San Luis Obispo | 24 | 13 | 11 |
| San Mateo | 4 | 37 | -33 |
| Santa Barbara | 14 | 21 | -7 |
| Santa Clara | 13 | 92 | -79 |
| Santa Cruz | 20 | 13 | 7 |
| Shasta | 10 | 9 | 1 |
| Sierra | 0 | 0 | 0 |
| Siskiyou | 0 | 2 | -2 |
| Solano | 16 | 21 | -5 |
| Sonoma | 16 | 24 | -8 |
| Stanislaus | 12 | 26 | -14 |
| Sutter | 0 | 5 | -5 |
| Tehama | 0 | 3 | -3 |
| Trinity | 5 | 1 | 4 |
| Tulare | 0 | 22 | -22 |
| Tuolumne | 0 | 3 | -3 |
| Ventura | 0 | 40 | -40 |
| Yolo | 0 | 10 | -10 |
| Yuba | 12 | 4 | 8 |

Source: Data on number of CSU slots from DHCS licensure data and county survey results. Data on the number of CSU slots needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator

Table E-14. Results of Crisis Resource Calculator Analysis Assessing Gaps in Number of Mobile Crisis Teams Available

| County | Number of Mobile Crisis Teams Available | Number of Mobile Crisis Teams Needed According to Crisis Resource Calculator | Gap Between Number of Mobile Crisis Teams Available and Number Needed |
|--------------|---|--|---|
| Alameda | 5 | 13 | -8 |
| Alpine | 0 | 0 | 0 |
| Amador | 1 | 0 | 1 |
| Butte | 2 | 2 | 0 |
| Calaveras | 2 | 0 | 2 |
| Colusa | 1 | 0 | 1 |
| Contra Costa | 5 | 9 | -5 |
| Del Norte | 0 | 0 | 0 |
| El Dorado | 2 | 2 | 0 |
| Fresno | 1 | 8 | -7 |
| Glenn | 1 | 0 | 1 |
| Humboldt | 2 | 1 | 1 |
| Imperial | 1 | 1 | 0 |
| Inyo | 1 | 0 | 1 |
| Kern | 13 | 7 | 6 |
| Kings | 1 | 1 | 0 |
| Lake | 7 | 1 | 6 |
| Lassen | 0 | 0 | 0 |
| Los Angeles | 171 | 81 | 90 |
| Madera | 1 | 1 | 0 |
| Marin | 1 | 2 | -1 |
| Mariposa | 1 | 0 | 1 |
| Mendocino | 1 | 1 | 0 |
| Merced | 2 | 2 | 0 |
| Modoc | 0 | 0 | 0 |
| Mono | 0 | 0 | 0 |
| Monterey | 2 | 3 | -1 |
| Napa | 0 | 1 | -1 |
| Nevada | 2 | 1 | 1 |
| Orange | 25 | 25 | 0 |
| Placer | 3 | 3 | 0 |
| Plumas | 0 | 0 | 0 |
| Riverside | 12 | 19 | -7 |

| County | Number of Mobile Crisis Teams Available | Number of Mobile Crisis Teams Needed According to Crisis Resource Calculator | Gap Between Number of Mobile Crisis Teams Available and Number Needed |
|-----------------|--|---|--|
| Sacramento | 8 | 12 | -4 |
| San Benito | 1 | 0 | 1 |
| San Bernardino | 18 | 17 | 1 |
| San Diego | 2 | 27 | -25 |
| San Francisco | 3 | 7 | -4 |
| San Joaquin | 4 | 6 | -2 |
| San Luis Obispo | 2 | 2 | 0 |
| San Mateo | 1 | 6 | -5 |
| Santa Barbara | 3 | 4 | -1 |
| Santa Clara | 10 | 15 | -5 |
| Santa Cruz | 7 | 2 | 5 |
| Shasta | 2 | 1 | 1 |
| Sierra | 0 | 0 | 0 |
| Siskiyou | 0 | 0 | 0 |
| Solano | 4 | 4 | 0 |
| Sonoma | 3 | 4 | -1 |
| Stanislaus | 0 | 4 | -4 |
| Sutter | 0 | 1 | -1 |
| Tehama | 0 | 1 | -1 |
| Trinity | 0 | 0 | 0 |
| Tulare | 2 | 4 | -2 |
| Tuolumne | 3 | 0 | 3 |
| Ventura | 1 | 7 | -6 |
| Yolo | 4 | 2 | 2 |
| Yuba | 0 | 1 | -1 |

Source: Data on number of mobile crisis teams available from county survey results. Data on the number of mobile crisis teams needed and gaps between the number needed and number available based off analysis of Crisis Resource Calculator