Overview Report:

2021 Data Notebook Project

on California Behavioral Health

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For:

The Performance Outcomes Committee of

The California Behavioral Health Planning Council

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The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

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Acknowledgements of Participating Counties and Association

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The California Behavioral Health Planning Council expresses deep gratitude to the local behavioral health boards/commissions and the county staff of their Departments of Behavioral Health for their participation in the Data Notebook Project, as follows.

Counties That Submitted 2021 Data Notebooks

Reports Received: 45 Data Notebooks (representing 46 Counties)[1],[2]

Small Population Counties (N=23)

Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Kings, Lassen, Madera, Mariposa, Mendocino, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra[4], Siskiyou, Sutter-Yuba[3]

Medium-size Population Counties (N=11)

Butte, Marin, Merced, Monterey, Placer[4], Santa Barbara, Santa Cruz, Sonoma, Stanislaus, Tulare, Yolo

Large Population Counties (N=12)

Alameda, Fresno, Kern, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Ventura

[1] Some counties began work on this project but were unable to complete due to pandemic and/or fire-related emergencies, etc. Also, due to a technical problem, L.A. County did not submit numerical data this year for Part 1 but did submit text and narrative/descriptive data for Part 2.

[2] 2021 Summary Notes: The 46 reporting counties represent 78% of the 58 total counties, and together comprise 86% of the population of California in 2021. However, numerical data for Part I was not able to be included for Los Angeles County, which represents 25.3 % of the state population. Other missing data: 11 counties did not submit Data Notebook reports for 2021, including: Contra Costa, Humboldt, Lake, Modoc, Riverside, San Luis Obispo, San Mateo, Solano, Tehama, Trinity, Tuolumne.

[3] Sutter and Yuba counties share one Mental Health Plan, so their Data Notebook represents both counties.

[4] Placer and Sierra Counties share one Mental Health Plan operated by Placer County, and usually one Data Notebook, but each submitted a Data Notebook report from their respective boards this year.

Table of Contents

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

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

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

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

- To help local boards meet their legal mandates[5] to review and comment on their county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council,
- To serve as an educational resource on behavioral health data,
- To obtain opinions and thoughts of local board members on specific topics, and
- To identify unmet needs and make recommendations.

During 2021, the COVID-19 public health emergency continued to pose unprecedented and extensive challenges for all of us, as behavioral health consumers, family members, advocates, health care providers, and our many communities. During this time of increased stress and anxiety, there were greatly increased needs for behavioral health (BH) services.[6] Counties had to adapt to safely meet the needs of both mental health consumers and the staff who serve them. It is for this reason that the prior year's 2020 Data Notebook focused on the telehealth methods that were implemented on a large scale to provide BH services during the COVID-19 public health emergency.

We build on that 2020 project and the experiences of our stakeholders to address questions of health equity, diversity, and inclusion. Public health officers and health care providers frequently commented that existing health disparities were exacerbated by

[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] Kaiser Family Foundation, The Implications of COVID-19 for Mental Health and Substances Use. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Covid-19 and were displayed in ever-sharper contrast.[7] The most vulnerable included front-line essential workers, in food and agriculture, transport, healthcare, and public safety. The most medically vulnerable included the elderly, those with chronic medical conditions, and those in historically underserved populations. Disparities in access to healthcare, including behavioral health services, became more markedly apparent.

Taken together, these and other factors led to the selection of our 2021 focus topic of equity, diversity, and inclusion. Over the years, we endeavored to keep these values foremost in our evaluations of access to behavioral health services, starting with our 2014 Data Notebook. That early Data Notebook focused on access and engagement by different demographic groups, including age, race, ethnicity, and gender identity.

This topic comprises one part of the 2021 Data Notebook, Part II. In contrast, 'Part I' has standard annual questions designed to reveal BH trends affecting certain highly vulnerable populations. Monitoring these trends helps to identify unmet needs or gaps in services that may occur due to changes in population, resources available, or policy.

The Planning Council encourages all members of local behavioral health boards and commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify critical issues in their community. This information contributes to the Planning Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA[8].

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

In recent years, increased online data availability now permits stakeholders to consult Medi-Cal data from the Department of Health Care Services (DHCS), and includes data that can be calculated with a special tool, or 'application.' These data include populations that receive Specialty Mental Health Services (SMHS), Medi-Cal Mental Health (non-specialty), and Substance Use Disorder (SUD) Treatment services. Similar data are used to evaluate county programs. Those annual reports are at www.CalEQRO.com. Also, Mental Health Services Act (MHSA) data can be found with the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.

The Council focuses on data for Medi-Cal funded care that includes the SMHS provided to children with serious emotional disturbances (SEDs) and to adults with serious mental illness (SMI). We keep in mind that during their recovery, individuals may move

[7] California public health data for Covid-19 at: www.COVID19.ca.gov. Also see: U.S. data at www.cdc.gov.
[8] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

between the systems for 'mild-to-moderate' mental health (MH) services and those for more severe disorders, served by specialty mental health (SMHS). However, we do value the statewide goal of "No Wrong Door" for those seeking help.

In summary, for fiscal year (FY) 2019-20,[9] out of our California state population[10] of 39,740,508:

- There were 14,633,010 Medi-Cal beneficiaries in total (36.8% of the population).
- SMHS were received by 592,238 persons (4.05% of those eligible for Medi-Cal).
- In comparison, 1,627,185 individuals were able to access non-specialty mental health services (11.1 % of those eligible for Medi-Cal coverage).
- Compared to adults and older adults on Medi-Cal, children and youth had higher access rates to both specialty (SMHS) and non-specialty mental health services.

The details of the demographic data for those who received either specialty (SMHS) or non-specialty mental health (MH) services are summarized in Table 1 and Table 2. These data are presented separately in Table 1 for 'Children and Youth' (ages 0-20) and in Table 2 for 'Adults and Older Adults' (ages 21 and over). The columns labeled "Certified Eligibles" refer to those who were covered by Medi-Cal at the time they received behavioral health services.

[9] The data for FY 19-20 were the most recent available from DHCS at the time of this report. It represents a slightly different time frame than that in the 2021 Data Notebook questions.
[10] State of California, Department of Finance, E-1 Population Estimates for Cities, Counties, and the State with Annual Percent Change – January 1, 2019, and 2020. www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1.

Table 1. Children: Medi-Cal Mental Health (non-specialty) and Specialty Mental Health Services (SMHS)[11]

Children and Youth:

.	Specialty MH Services (SMHS) FY 19-20 Number of Clients with MH Visits	Specialty MH Services (SMHS) FY 19-20 Certified Eligibles	Specialty MH Services (SMHS) FY 19-20 Rate	Mental Health Services FY 19-20 Number of Clients with MH Visits	Mental Health Services FY 19-20 Certified Eligibles	Mental Health Services FY 19-20 Rate
Children 0-2	7,777	801,586	1.00%	144,743	801,673	18.10%
Children 3-5	19,206	841,770	2.30%	90,098	841,805	10.70%
Children 6-11	79,256	1,706,727	4.60%	173,811	1,706,826	10.20%
Children 12-17	118,686	1,717,523	6.90%	261,601	1,719,590	15.20%
Youth 18-20	31,460	724,208	4.30%	75,822	730,757	10.40%
Alaskan Native or American Indian	1,200	18,572	6.50%	2,563	18,582	13.80%
Asian or Pacific Islander	7,109	373,754	1.90%	45,981	373,805	12.30%
Black	26,745	390,574	6.80%	43,656	390,699	11.20%
Hispanic	153,661	3,369,129	4.60%	423,185	3,370,309	12.60%
Other	10,689	365,314	2.90%	56,047	365,500	15.30%
Unknown	13,657	497,605	2.70%	57,791	504,676	11.50%
White	43,324	776,866	5.60%	116,852	777,080	15.00%
Female	122,205	2,837,274	4.30%	349,670	2,845,599	12.30%
Male	134,180	2,954,540	4.50%	396,405	2,955,052	13.40%
Totals and Average Rates	256,385	5,791,814	4.43%	746,075	5,800,651	12.86%

[11] 'Certified eligible' individuals refer to those deemed eligible for Medi-Cal funded services.

Table 2. Adults: Medi-Cal Mental Health (non-specialty) and Specialty Mental Health Services (SMHS)[12]

Adults and Older Adults:

	Specialty MH Services			MH Services (FFS, MC)		
	FY 19-20			FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	96,242	2,639,420	3.60%	266,198	2,683,740	9.90%
Adults 33-44	84,145	2,052,352	4.10%	204,470	2,068,976	9.90%
Adults 45-56	78,314	1,633,359	4.80%	181,249	1,639,123	11.10%
Adults 57-68	64,195	1,410,393	4.60%	159,904	1,414,097	11.30%
Adults 69+	12,957	1,024,999	1.30%	69,290	1,026,424	6.80%
Alaskan Native or American Indian	2,270	37,482	6.10%	5,723	37,595	15.20%
Asian or Pacific Islander	19,583	1,035,431	1.90%	61,090	1,036,425	5.90%
Black	51,180	676,335	7.60%	76,428	678,557	11.30%
Hispanic	96,024	3,779,762	2.50%	296,583	3,790,474	7.80%
Other	29,540	734,979	4.00%	91,052	737,067	12.40%
Unknown	31,204	611,186	5.10%	65,987	663,125	10.00%
White	106,052	1,885,348	5.60%	284,248	1,889,117	15.00%
Female	172,484	4,916,908	3.50%	568,294	4,975,608	11.40%
Male	163,369	3,843,614	4.30%	312,816	3,856,751	8.10%
Totals and Access Rates	335,853	8,760,522	3.83%	881,110	8,832,359	9.98%

[12] 'Certified eligible' individuals refer to those deemed eligible for Medi-Cal funded services.

Rationale for Monitoring the Standard Annual Data and Questions

Members of the Planning Council believe that it is important to examine certain county-level BH data that are not readily available online and for which there is no other accessible public source. Collecting this information fills one gap in what is known about services that might be needed or provided during a fiscal year and may help advocates and policy makers to identify unmet needs for services.

We asked the local boards to answer questions using information for the most recent fiscal year for which the county has data. Not all counties have readily available data for some of the questions. The topics for the standard annual questions include (a) Adult Residential Facilities (ARFs) that accept clients with serious mental illness, (b) Use of beds in Institutions of Mental Diseases (IMDs), (c) Data about homelessness and programs for those with BH needs, and (d) Foster children with intensive BH needs in a type of congregate care called 'Short-Term Residential Treatment Program' (STRTP).

What does our data set represent as reported in the forty-five 2021 Data Notebook submissions received from 46 counties and their local boards? In summary:

- The 46 reporting counties[13] represent 78% of the 58 total counties, and
- Together they comprised 86% of the population of California in 2021, which we bear in mind when evaluating information in Part 2.
- Numerical data for Part I was not included for Los Angeles County, which represents 25.3 % of the state population.
- As a consequence, Part I data in this report represents 45 reporting counties, and only 60.7 % of the state population.

Our conclusions may be limited by the following missing data:

- Eleven counties did not submit Data Notebook reports for 2021.
- These included 3 large population counties, 2 medium-sized population counties, and six small population counties.
- Numerical data for Part I was not included for Los Angeles County, which represents 25.3 % of the state population.
- Occasionally, a question in either Part I or Par II was left blank by one or two counties, so the total numbers (N) and/or percent of responding counties varies.

For each question in Part I, we will present the statewide totals of numerical data submitted in the 2021 Data Notebooks followed by the totals for the prior year [2020] in square brackets and the percent change from that baseline. *Please note that even*

[13] Sutter and Yuba counties share a mental health plan and are represented by one data notebook, as is often similarly done for Placer and Sierra counties, but this year each of those latter two boards submitted Data Notebook reports. Hence there were 46 counties but 45 Data Notebook reports for 2021.

though that process yields a number for percent change, these must be considered as qualitative indicators. *There is not a meaningful or valid method to pro-rate any of the answers based on totals of county populations (for counties responding to a given question), because the data set for 2020 comprised a slightly different group of 39 counties and one non-county health jurisdiction for a total of 40 Data Notebooks.*

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division at the CA Department of Social Services. This makes it difficult to determine how many of the licensed ARFs operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation[14] was signed that requires the collection of data from licensed operators about how many residents have SMI and whether these facilities have services these clients need to support their recovery or transition to other housing. The first reports of that collected data were expected for release in 2021.

The Planning Council would like to understand what type of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[15] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as a treatment slot (or bed) occupied by one person for one day.

We asked the local boards and their county departments a series of questions beginning with Question 2. Following is the summation of statewide data for the reports received from 46 counties in 2021, and in brackets the comparison to numbers for the 40 reports received in 2020.
These numbers have implications for:

- the costs to counties for those to whom they provide services,
- the total need for these services in the SMI population, and
- the potential amount of unmet need, which is to some extent measured from county waiting lists, or estimated from various sources, or remains unknown.

Question 2. For how many individuals did your county Department of Behavioral Health pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year?

[14] AB 1766, Bloom. Licensed adult residential facilities and residential care facilities for the elderly: data collection: residents with a serious mental disorder. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB1766

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

Total Responses: 43 Counties

Counties reporting that zero persons were served in an ARF: 3 counties.

Total persons served by an ARF in 40 counties**: 9,225.**

[For comparison in 2020: 4,954 individuals. Please note that for 2021 and 2020, these data were collected from slightly different sets of counties].

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

Total responses: 43 Counties

Counties reporting zero persons served and therefore zero ARF bed-days: 3 counties.

Total ARF bed-days paid by the forty counties offering this service: **956,933 bed-days.**
Average number of ARF bed-days per client: 956,933/ 9,225 = **103.8 days per client.**

Note that there is a very wide range of actual days of services received by individual clients, due to the great variability in personal situations and the need for those services It is important to realize the difficulty of continuing to provide ARF services by facility operators due to increasing expenses and lack of adequate sources of funding, The mismatch between funds and the cost of services has led to a decrease in the number of such facilities over the prior two years, according to multiple reports in California newspapers and other sources.

[For comparison, in 2020: 900,531 total ARF bed days. Please note that data were collected from slightly different sets of counties.]

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

Total respondents: 43 counties.

Counties that entered 1 or more persons: 27 counties. These counties' best estimates added up to a total of **4,052 persons** in need of ARF living facilities or similar services.

Respondents that entered 'unknown' or 'not applicable': 8 counties.

Number of respondents that entered zero cases: 8 more counties.

Some respondents based their numbers on waiting lists or referrals received that could not be filled. Most respondents, including those who entered 'unknown', commented that they believed the need was substantially greater than the total number of behavioral health clients currently receiving ARF in their counties.

Thus, the total estimates received in 2021 exceed **4,052 persons** in need of ARFs.

[For comparison, the estimates provided in 2020 exceeded 805 persons, but in both years, several counties stated that this number was unknown].

When comparing counties who reported in 2020 and 2021, even without the numbers from L.A. County for 2021, there has been a marked increase of people said to be living at, or in need of, this level of services, with no significant increase in bed capacity. It may be that more counties are paying attention to the collection of this information.

Question 5: Does your county have any 'Institutions for Mental Disease' (IMD)?

Responses for 2021:

Response:	Number of Counties	Percent of Respondents*
No	22	50 %
Yes	21	48 %
Skipped[16]	1	2 %
Total Responding:	44	100 %

If Yes, how many IMDs? The total was 41 IMDs in 21 counties.

These totals include specialized nursing facilities (SNF) with mental health rehabilitation centers (MHRC), Special Treatment Programs (STP), and general medical hospitals that have psychiatric beds or wards. Some counties also contract with the Department of State Hospitals for psychiatric beds. These are often forensic holds, including 'incompetent to stand trial' (IST), and/or other populations requiring specialized facilities. Those counties without IMDs contract with facilities in other counties as needed.

In summary for 2021, a total of 21 counties reported **41 IMDs**, a result that appears to be a substantial undercount, due to missing 2021 Data Notebooks and therefore missing data. An alternative explanation may include consolidation or closing of IMD beds or facilities.

[For comparison in 2020, of 40 responding counties 24 (60%) stated 'No' and 16 (40%) counties said 'Yes', regarding presence of IMD facilities.
In 2020: 16 California counties reported **64 IMDs**].

Question 6: During the last fiscal year, for how many individual clients did your county pay the costs for an IMD stay, whether in-county or out-of-county)?

This is an important issue because clients may be more likely to succeed in their post-release recovery if there is adequate planning, case management, and identification of

[16] Los Angeles County did not supply numerical data for most questions in Section 1.

local supports, including the ability to set appointments and arrange transportation. Parents and family members often have difficulty being part of the treatment or consultation process when they live far from the facility that is caring for their relative.

For fiscal year 2021: Counties with zero clients who needed IMD beds: 2 counties.[17]

Skipped question: 1 county.

In-County IMD options available?	#Persons placed in-county	#Persons placed out-of- county
Yes	4,258	2,766
No	0	577
Column Totals, All 43 Responding Counties	4,258	3,343

Thus**, data reported for 2021: a total of 7,601 clients** received IMD services that were paid by these 43 counties. Of all IMD patients, 44.0 % received services out-of-county.

However, 39.4 % of those clients from counties with IMDs were not able to be served in their home county due to lack of availability of the specific type of beds needed at the time of service. Some examples include pediatric, adolescent, or elderly psychiatric patients with complex medical needs. Other examples are forensic and IST clients.

[By comparison, reported for 2020: In-county: 10,499 individuals. Out-of-county: 2,947 individuals. Added together, these yield a total of 13,446 IMD patients for these 40 responding counties].

Question 7: What is the total number of IMD bed-days paid for these individuals by your county Behavioral Health Department during the last fiscal year?

Total responding counties: 44 counties.

Counties with zero bed days: 2 counties.

In the total for 41 counties: 718,608 bed-days. Persons treated in an IMD: 7,601.

"Average" Length of stay: 94.5 bed-days per unique individual served.

The average does not reveal the total range or complexity of clinical experiences in this data set. The values for the length of stay ranged from a minimum of 1 day/person to 365 days/person (data were for unique [unduplicated] individuals during this analysis).

[17] Alpine and San Benito.

[For comparison, in 2020, the total number of IMD bed days that were paid by the responding 40 counties was nearly a million: 964,466 bed-days. Average length of stay: 71.7 days per each of the 13,446 unique IMD clients served.]

Note that both 2020 and 2021 calendar years were periods in which the widespread prevalence of COVID-19 may have had varying degrees of effect to increase barriers or to decrease the capacity for number of clients served within inpatient or other residential settings. The pandemic may have skewed our data in unknown ways.

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and increased homelessness. Federal funding was provided to states to be used after March 2020 and throughout 2021 for temporary housing to reduce the spread of Covid-19 among individuals who are homeless. Additional policy changes were made to reduce the rate of evictions for persons who became unemployed during the pandemic.

Some studies[18] indicate that only 20 to 30% of homeless individuals have a serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery is more likely when an individual has a safe, stable place to live. Because this issue is so complex, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD.

Most counties were not able to conduct their count in January 2021 due to the extremely high rates of community transmission of Covid-19 during the scheduled time. Therefore, the prior year data for 2020 are shown below. These data should be viewed with caution as they likely do not fully represent the 2021 homeless population. The next three tables show California data for the January 2020 'Point in Time Count'.[18]

Table 3 describes various categories of especially vulnerable individuals, such as those in families with children (16.0% of the homeless population), unaccompanied youth (7.5% of homeless), and veterans (7.1% of the homeless). Other groups of concern are those with severe mental illness (SMI) and/or substance use disorder (SUD).

[18] The annual HUD "Point-in-Time" counts of homeless persons for all counties are at: https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=2020&filter_Scope=CoC&filter_State=CA&filter_CoC=&program=CoC&group=PopSub.

Table 3: State of California Estimates of Homeless Individuals: PIT Count, 2020

Summary of Homeless individuals	SHELTERED In Emergency Shelter	SHELTERED In Transitional Housing	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Homeless Individuals[19] (not in families)	21,252	7,006	107,525	135,783	5.4%
People in Families with Children	14,711	4,931	6,135	25,777	14.6%
Unaccompanied Homeless Youth[20]	1,374	1,288	9,510	12,172	1.5%
Veterans	1,619	1,786	7,996	11,401	3.8%
Chronically Homeless Individuals	9,493	97	42,195	51,785	24.6%
Severely Mentally Ill	6,125	1,859	2,965	37,599	7.6%
Chronic Substance Abuse	3,599	1,762	30,460	35,821	35.6%
Column Totals, and/or Average (2020) Homeless Persons in CA	35,966	11,922	113,660	161,548	6.8%

Estimates of those with SMI or SUD vary by data source and year. We note data ranges for those individuals who are severely mentally ill (up to 23.3% of homeless), individuals who engage in chronic drug abuse (22.2% - 35.6% of homeless), or individuals who are chronically homeless for extended periods (32.1% of homeless). These three groups may have driven the impetus of political efforts to pass SB 1338:[21] CARE (Community Assistance, Recovery and Empowerment (CARE) ACT.

The data of Table 4 challenge us to think about unsheltered persons in terms of whatever household they may be a part of, whether as parents with children, or those who form bonds as temporary families of choice. These data also reveal that there are young people, including some under 18, who are parents of young children. Getting

[19] Includes unaccompanied youth<18 and adults ≥18. Individuals can be counted in more than one category.
[20] Unaccompanied youth are defined to include those aged 18-24 as well as those under 18.
[21] SB 1338: Community, Assistance, Recovery, and Empowerment 'CARE Court' act: California homeless: How will CARE Courts work? - CalMatters, specifically see: https://calmatters.org/housing/2022/09/california-lawmakers-approved-care-court-what-comes-next/.

families into housing, healthcare, food, and other resources presents an opportunity to mitigate the effects of trauma and severe poverty on the development of young children.

Table 4: State of California Estimates of Homelessness by Household Type

PIT Count, January 2020

Summary of persons in each household type	SHELTERED in Emergency Shelter	SHELTERED in Transitional Housing	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Persons in Households without any Children	21,098	6,953	106,930	134,981	5.6%
Persons in Households with at least one adult ≥18 and at least one child<18	14,711	4,931	6,135	25,777	14.6%
Persons in Households[22] with only Children <18	157	38	595	790	-22% (decrease)
Column Totals and/or Average Changes (2020) Homeless Persons in CA	35,966	11,922	113,660	161,548	6.8%
National Totals and/or Average Changes (2020) in Homeless Persons in U.S.	279,916	74,470	226,080	580,455	2.2%

Next, we consider demographic data of the homeless population in California in Table 5. Reaching individuals for services, especially those who may need behavioral health and other healthcare services, requires our attention to and understanding of the cultural and linguistic needs of a diverse array of individuals from a large variety of backgrounds. Later in this report, we discuss some the strategies employed by county departments of behavioral health in their outreach and engagement efforts to reach those who may otherwise be unserved or underserved. These January 'point-in-time' data show that the numbers of homeless increased for most demographic groups in 2020 compared to 2019, consistent with overall increases in California totals.

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

Table 5: Demographic Estimates for Homeless Persons, State of California[23]

PIT Count, January 2020

DEMOGRAPHIC CATEGORY	EMERGENCY SHELTER	TRANSITIONAL HOUSING	UNSHELTERED	TOTAL (row)	% CHANGE over 2019
Hispanic/ Latino	12,141	4,075	35,750	51,966	+9.4%
Non-Hispanic/ Non-Latino	23,825	7,847	77,910	109,582	+5.6%
Black or African-Amer.	12,697	3,795	33,118	49,610	+12.5%
White	19,356	6,777	61,306	87,439	+6.4%
Asian	719	229	2,292	3,240	+24.3%
Amer. Indian/ Alaska Native	1,049	368	4,969	6,386	-6.05%
Pac. Islander/ Nat. Hawaiian	397	123	1,264	1,784	-18.1%
Multiple Races	1,748	630	10,711	13,089	-2.7%
Female	15,942	5,001	32,562	53,505	+6.02%
Male	19,780	6,722	79,235	105,737	+7.5%
Transgender	191	139	1,271	1,601	-9.2%
Gender Non-conforming	53	60	592	705	+9.6%
Column Totals and/or Average Changes (2020) CA Homeless	35,966	11,922	113,660	161,548	+6.8%

We received a considerable variety of responses from counties to questions related to behavioral health needs and homelessness in the 2021 Data Notebook, as follows.

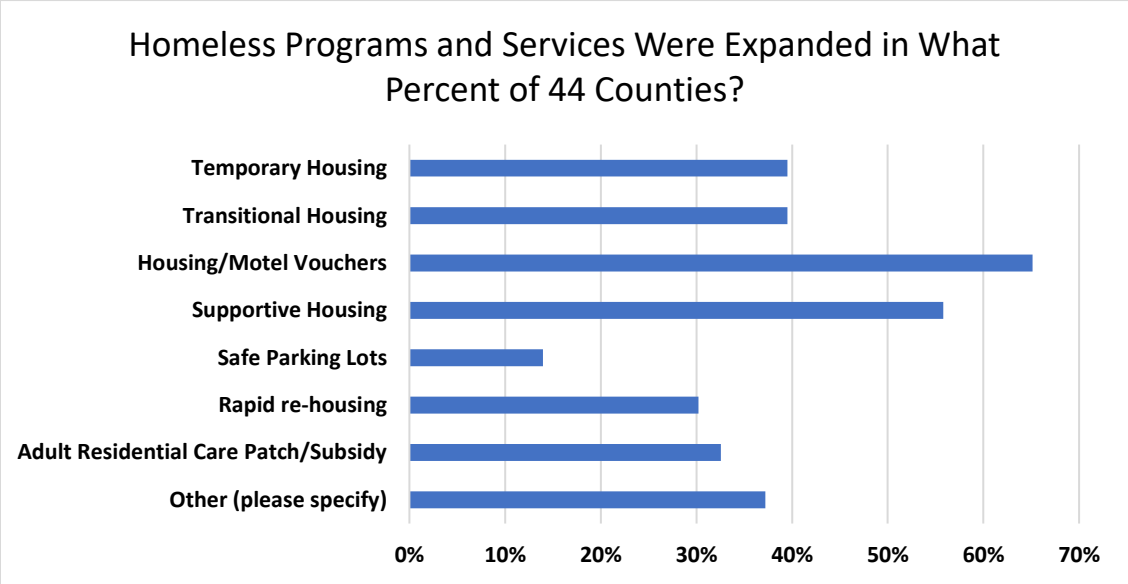
Question 8: During the most recent fiscal year (2020-2021), what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?

The responses to this question are summarized in the graph shown below (Figure 1). These programs and services often used community or multi-agency partnerships to combine funding and expertise to provide services targeted for homeless individuals

[23] https://files.hudexchange.info/reports/published/CoC_PopSub_State_CA_2020.pdf

with mental health and/or substance use disorders (SUDs). Project Room Key[24] played a critical role in helping the counties and the state slow the spread of Covid-19. We cannot underestimate the importance of providing individuals who were exposed and/or infected a place to isolate and quarantine with meals supplied. In many cases, the contracted hotels were able to accommodate persons with physical disabilities with rooms designed for disabled guests. It was particularly important to minimize the spread of Covid-19 in homeless shelters and similar congregate care settings.

Figure 1. New or Expanded County Resources for Homeless Persons with Serious Mental Illness (SMI) in 2020-2021



These data show that the largest increase in programs and program capacity were in vouchers for motels and housing and in supportive housing programs[25]. 'Other' programs and resources implemented by counties for homeless individuals with SMI specified a number of programs (see Appendix I of this report). The programs and services most frequently listed as having undergone initiation, or expansion were:

- Project Room Key
- Emergency Housing Vouchers (EHV's)
- Coordinated Entry System (CES)
- Variations on flexible housing subsidies and similar strategies.

[24] Project Room Key was a federally funded homeless relief initiative in the state of California. The program was launched in April of 2020. The project was expected to end in late 2020. For more information, see: https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey.

[25] We do not have data that define the "effectiveness" of any of these programs. First, we would need to define metrics for effectiveness, the spheres of functioning, and outcomes, and a **non-burdensome** means of collection.

The most exceptional program specified was that of Sacramento County, which 'piloted a homeless encampment clinician to conduct outreach, engagement, screening, assessments, and referrals for individuals living in the encampments' in the region served by their county mental health plan. Such programs are both innovative and labor intensive but have been implemented in a few other places in the U.S. using primary care providers and resulting in improved health outcomes for homeless persons.[26] Since the date of this original 2021 Data Notebook, we have learned of at least 25 'street medicine' teams that include clinicians partnered with community healthcare workers going out to encampments in various parts of the state, notably in the counties of Bakersfield, Los Angeles, and Shasta Counties in addition to Sacramento.

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

Between 2010 and 2012, the California Department of Health Care Services implemented initiatives to study and improve the Continuum of Care for Children's Mental Health with a focus on serious emotional disorders likely to be treated within the county Departments of Mental Health. This initiative expanded its focus to address the emotional and mental health needs of children and youth in foster care, many of whom had experienced severe emotional trauma arising both from the circumstances that resulted in the child being removed from their original families and multiple placements in foster care over their childhood. These included a subgroup of children who needed specialized care and a higher intensity of services. Specialists in children's mental health, medical practitioners, county representatives, and stakeholders were included in committees to evaluate current programs and to develop new approaches.

Some of the strategies developed include a renewed emphasis on Wraparound[27] services for families with children at risk of being placed in foster care, for some foster families and/or their foster youth. Some children were able to participate in Full-Service Partnership Programs offered through Mental Health Services Act funding, similar to Wraparound care programs. However, some older youths were placed in congregate care (group) homes that were considered to be therapeutic and were intended to provide some mental health services. The ideal of a therapeutic foster family was developed but was difficult and expensive to implement. It is unclear to what extent that strategy has been implemented since the time of its proposal. Other strategies developed for foster youth included Short-Term Residential Treatment Program (STRTP) facilities, which were expected to replace traditional congregate care (group) homes, meet higher standards of service and staff training, and have more access to mental health services. However, recent comments from local boards and commissions

[26] Reference describes a program in Boston, MA, which had its roots in a Boston nurses' clinic for homeless people in 1985, and how that program grew and evolved: Rough Sleepers: Dr. Jim O'Connell's Urgent Mission to Bring Healing to Homeless People, by Tracy Kidder (2023). New York: Random House. (Also at Amazon.com: 'Kindel').

[27] The California Department of Social Services (CDSS) describes Wraparound as a "strengths-based planning process that occurs in a team setting to engage with children, youth, and their families

indicate that there is still a substantial need to implement these programs fully to the standards, services, and qualities originally intended.

As of 2020, nearly 56,000 children under the age of 18 were in foster care in California. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a 'resource' family who receives foster children. However, a small number of the children need a higher level of care and are placed in a specialized living situation. California has revised the standards for specialized living situations for children whose needs cannot be met safely within a family setting. Group homes are being transitioned into a new licensed facility type called Short Term Residential Treatment Programs (STRTP) that provide short-term, specialized, and intensive treatment individualized to each child's needs.

All California counties are working to close group homes and establish licensed STRTPs. This process is at various stages of development in each community. Because foster children and youth comprise an extremely vulnerable population, the Planning Council will review foster care system placement and outcomes data as part of a multi-year project. During the four-year transitional period from 2017 to 2020, the total number of children in Group Homes (data not shown) gradually decreased from a high point of 4,669 in 2017 to a much lower number of 934 during the first quarter of 2020.

After this period of transition, the numbers of foster children and youth that require STRTP level of behavioral health care are still relatively small compared to the total in foster care. In the second quarter (Q2) of 2020, there were **52,827** total foster children in California. Of these, about 4%, (or 2,240), received services in an STRTP facility.

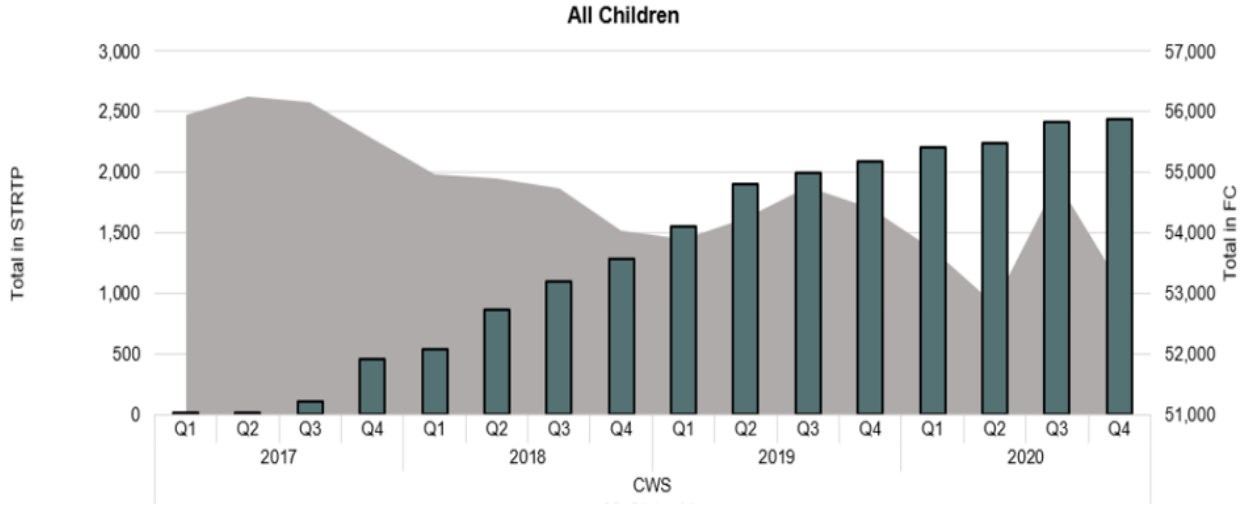
Table 6: Demographics of the STRTP Population for Q2, 2020 in California.

Age Ranges	**Number**
16-17 years	930
11-15 years	1,101
6-10 years	209

Race/Ethnicity	**Number**
Asian/ Pacific Islander	35
Black	640
Latino/Hispanic	958
Native American	33
White	555
Unknown	19
Total	**2,240**

The next figure shows four years of statewide data[28] for children aged 0-17 years who were in foster care, compared to the number of those in an STRTP during each quarter; so foster children in STRTP care were counted in each group as appropriate.

Figure 2. California (2017-2020): Use of Higher Intensity Behavioral Health-Related Congregate Care (STRTP) Compared to Total Children in Foster Care (FC)



Above, the dark blue vertical bars show that the number of children placed in STRTPs increased over this four-year time span as more facilities were licensed and certified to provide this level of care. The right-hand axis shows the total number of foster children in the entire system, but only displays the part of the range from 51,000 to 57,000. The "pale gray cloud" behind the vertical bars shows the total number of California foster children during each quarter. The figure above shows a decrease in the total number of foster children during the last part of Quarter 1 (Q1) and during Quarter 2 (Q2) of 2020, a time period corresponding to the beginning of the COVID-19 pandemic and the widespread mandatory "Stay-at-Home/ Shelter-in-Place" orders from the state and county Departments of Public Health.

Many systems of care were disrupted during 2020, as individuals, providers, and agencies were challenged to provide essential services while following public health guidelines. For the period FY 2022-2023, we do not have any data on how well specialized care settings such as group homes or STRTP facilities were able to cope with the impacts of the pandemic to address anti-infection protocols and isolation/quarantine procedures during illnesses in both clients and staff.

[28] Data source: Child Welfare Services/Case Management System (CWS/CMS). Presented in the California Department of Social Services Child Welfare Data Dashboard. Updated February 2020. *Comparison of numbers of foster children/youth in Group Homes to numbers in Short-Term Residential Treatment Programs (STRTP).* http://www.cdss.ca.gov/inforesources/Data-Portal/Research-and-Data/CCR-Data-Dashboard.

This historic backdrop of major system-wide changes and the beginning of the COVID-19 pandemic in 2020 provide the context for our consideration of behavioral health services that were available to foster children and youth who comprise such a highly vulnerable population. Those children who needed the intensive services of an STRTP may represent the most vulnerable of an already vulnerable population These youth have commensurate needs for specialized care that is both trauma-informed and that helps the child progress through normal developmental stages. These reasons show the importance for local BH boards to understand the types of services and adequacy of ongoing resources that are locally available for children and youth in foster care.

We asked the local boards a series of questions about care of these foster youth.

Question 9: Do you think your county is doing enough to serve the children/youth who are in group care?

2021 Answer Choices:	**Number of Counties**	**Per Cent of Counties:**
YES	20	46 %
NO	24	54 %
Total That Responded	44	100 %

[Prior year's data (2020): Of the 39 boards who responded to this question, 27 (69%) answered 'Yes', and 12 (31%) answered 'No.' Of the recommendations made, most of those in 2020 were similar in type and theme to those received in 2021. Large and small population counties struggled with similar issues, both in 2020 and in 2021 (below)].

If 'No', what is your recommendation? Please list or describe briefly.

Approximately 24 counties and/or their MH boards provided very thoughtful comments and recommendations for improving behavioral health for foster youth in CA counties. These recommendations are listed in detail in Appendix II at the end of this report.

Question 10. During the last year, has your county received any children needing 'group home' or STRTP level of care from another county? If yes, how many?

2021 Answer Options:	**Number of Counties**	**Per Cent of Counties**
No	11	26 %
Yes	31	74 %
Total That Responded	42	100 %

Based on answers provided from the 42 responding counties, the total number of foster children received by transfer from another county in the last fiscal year was**: 1,674**.

Compared to prior year (2020): *Of 40 responding counties, 27 (67.5%) answered 'Yes;' 13 (32.5%) answered 'No.' Answers received in 2020: At least* ***2163***

*children/youth were transferred **into** one of the 27 counties that reported receiving children during the most recent fiscal year (2019-20). This number is likely an undercount due to some entries being estimated, as some boards were unable to access data from their county's child welfare services, and 19 counties did not submit a Data Notebook that year.*

Question 11. During the last fiscal year, has your county placed any children needing 'group home' or STRTP levels of care into another county (or to a facility out of state)? If yes, how many?

2021 Answer Choices:	Number of Counties	Per Cent of Counties
No	4	9%
Yes	39	91%
Total That Responded	43	100 %

During the last fiscal year, the total number of children and youth that were transferred out-of-county due to needing group home or STRTP level of care was**: 2,244.** This number excludes those who may have been transferred for other reasons not related to needing group home or STRTP level of care.

Compared to Prior Year (2020):
*Of 40 responding counties, **35 (87.5%)** answered '**Yes**,' and **5 (12.5%)** answered '**No**.'*

*During the fiscal year 2019-2020, at least **1,569** foster children/youth were transferred **out** of the 35 responding counties. This number is an underestimate, because some counties could not obtain data from their local CWS agency.*

For comparison to more complete data, shown below are quarterly data on STRTP level of services for foster youth supported by county CWS and the California Department of Social Services. Table 7 shows the numbers and any trends over time, spanning all four quarters of each year 2018—2020, inclusive.

Table 7. **Children placed in an Out-of-County[29] or an Out-of-State STRTP Compared to 'All Children' in an STRTP during each Quarter, 2018 - 2020**

Year, Quarter	18Q1	18Q2	18Q3	18Q4	19Q1	19Q2	19Q3	19Q4	20Q1	20Q2	20Q3	20Q4
All	538	868	1,105	1,287	1,556	1,902	2,001	2,089	2,210	2,240	2,413	2,444
Out of County	287	393	513	573	640	796	881	921	964	1,003	1,123	1,174
Out of State	49	49	48	58	81	77	82	79	75	75	61	66

Notes:

- 'All' refers to all foster children in an STRTP during each quarter.

[29] Source at www.cdss.ca.gov for these data: CCR_Dashboard_Public.xlsx (live.com)

- ‘Out-of-County’ and ‘Out-of-State’ are subsets of ‘All foster children in STRTP’.
- If a child was in an out-of-county STRTP during part of one quarter but was in an out-of-state STRTP during another part of that same quarter, the child was counted in each group for that quarter.
- These data serve as a comparison to the data we received from counties and illustrate the degree to which county BH departments may not be able to obtain data from their own county CWS about the MH needs of vulnerable foster youth.

This ends the presentation of the 2021 data and responses to the Questions of Part 1.

Summary of Part I.

The Planning Council chose these three broad areas because there is no other source for these data besides the individual counties. These questions address urgent matters for highly vulnerable populations. We note that most of our data in these sections likely represent undercounts of the ‘true numbers,’ attributable in large part to the number of counties that did not submit Data Notebooks this year. Nonetheless, these are all critical areas of concern affecting separate but potentially overlapping populations:

- Adult residential facilities that serve those with serious or persistent mental illness, specifically those clients who are at a level of recovery sufficient to do well in the community.
- Numbers and rate of use by county BH clients of IMD beds (and beds in specially qualified SNFs) for serious mentally ill persons who require hospitalization
- Homeless persons with serious mental illness and/or substance use disorders. We observe from the data that these two categories do represent significant numbers of the chronically homeless.
- Foster youth with significant mental health needs or who are in crisis and cannot be placed safely within a foster family (or ‘resource family’) or who need the intensive BH treatment environment of an STRTP facility. There is no single or simple measure of any community’s capacity to serve the needs of foster youth.

These data referenced a baseline and trends that we expected would be better understood after at least five years of information had been collected. However, the numbers collected thus far have been impacted by the Covid-19 period that began in mid-March 2020. We also lack sufficient consistency due to missing data that arises from a lack of continuity in year-over-year submission of Data Notebooks.

General conclusions about these data are limited by customary lag times in data reporting at either the state or county levels that could contribute to an undercount for any of the listed categories, and by missing data for the 13 counties that did not submit responses to Part I of the Data Notebook.

A review of the data collected thus far leads to the conclusion that there are very large numbers of individuals that both need and utilize the intensive and very expensive services discussed in Part I.

RECOMMENDATION 1:

AB1766 is a bill that addresses the need for the Department of Social Services to collect timely and accurate data from Adult Residential Facilities (ARF) and Residential Facilities for the Elderly (RFE) in several areas. The bill was signed by Governor Newsom in September 2020. Per language of the bill, the first reports on this data were due in May 2021. When released, these reports should be reviewed and monitored closely to identify needs and trends, such as the loss of beds in residential facilities.

We recommend the following:

- **Request the proposed schedule for release of the data by the Dept. of Social Services.**
- **When released, these reports should be reviewed and monitored closely to identify needs and trends, such as the loss of beds in residential facilities.**
- **Provide updates to community stakeholders on the current data as it is available, including information on the reliability, validity, and usefulness of the data.**
- **Monitor efforts to develop a continuum of support systems to serve the adult mental health population living in the community that include ARFs, RFEs and other options. California needs to convene experts to design a community-based 'continuum of care' to meet the needs of each adult individual diagnosed with severe mental illness. The continuum should include opportunities for 'independent living', 'supported living', and 'congregate' living with an appropriate and effective system of reimbursement for services.**

RECOMMENDATION 2:

The implementation of the specialized care STRTP facilities has been slow and inconsistent across the state. Reports from operators of STRTPs indicate that the funding is inadequate to meet the licensing, certification and accreditation requirements, that qualified workforce is not available, and that youth have very significant issues to manage. A report, *Keeping Youth Close to Home: Building a Comprehensive Continuum of Care for California's Foster Youth* published in October 2021 by the CA Alliance introduces the continuing problems:

> *State efforts to implement both California's Continuum of Care Reform (CCR) (AB-403) of 2015, and Family First Prevention Services Act (FFPSA) of 2018, demonstrate that there are still gaps in the services available to young people in the foster care and juvenile justice system(s). System-involved youth present with unique (and often co-occurring) educational, behavioral, health, housing, prosocial, and familial challenges. Understanding and addressing those needs*

requires examining trend data, mapping services gaps, and identifying opportunities for action.

For detailed information please see the report by the California Alliance at https://www.cacfs.org/news/docs/keeping-youth-close-to-home.pdf.

We recommend the following:

- **Obtain data and reports from Dept. of Health Care Services and the Dept. of Social Services to build an accurate picture of the issues facing the development and continuation of STRTPs.**
- **Assure that the CA Behavioral Health Planning Council monitors changes and developments in the implementation of California's Continuum of Care Reform (CCR).**
- **When data are available, provide information about STRTPs to community stakeholders.**

RECOMMENDATION 3:

The data collected on homeless and unhoused individuals in this section indicates that many homeless persons might be diagnosed with serious mental illness and/or substance use disorders.

This year, the CA legislature passed the CARE Act (SB 1338) to address this issue. The implementation will start in December 2023 with several counties (including Los Angeles and Orange) and continue for the next few years. The Care Act is described:

> *The CARE (Community Assistance Recovery and Empowerment) Act creates a new pathway to deliver mental health and substance use disorder services to the most severely impaired Californians who too often suffer in homelessness or incarceration without treatment. The CARE Act moves care and support upstream, providing the most vulnerable Californians with access to critical behavioral health services, housing and support.*

For detailed information please see Cal HHS website: https://www.chhs.ca.gov/care-act.

We recommend the following:

- **Monitor the implementation of the CARE Act closely to understand changes that are made in the processes currently described in the legislation.**
- **Assure that the civil rights are respected for any individual with a serious mental health and/or substance use disorder involved in the program.**

CBHPC 2021 Data Notebook – Part II:

Racial/Ethnic Inequities in Behavioral Health

Background

The focus of Part II of the 2021 Data Notebook is to examine the role of racial and ethnic inequities in behavioral health. California is one of the most culturally diverse states in the nation regarding race, ethnicity, and language. This diversity is one of the state's greatest assets, but it also comes with a need to provide services in ways that are culturally relevant and respectful of these diverse communities. Health disparities by race and ethnicity are well-documented in medical healthcare services and outcomes. Similarly, there are prominent inequities in behavioral health outcomes and access to services. The state has a responsibility to address these disparities and work towards a mental health system that serves California's cultural and linguistic diversity.

The 2014 Data Notebook touched on some of these issues in a section titled "Access by Unserved and Under-Served Communities." Using data from the External Quality Review Organization (EQRO), the number of individuals eligible for Medi-Cal in each county was compared to the number who received Specialty Mental Health programs as shown in two charts, broken down by race/ethnicity. The counties were then asked three broad questions.

1. Is there a big difference between the race/ethnicity breakdowns on the two charts? Do you feel that the cultural group(s) that need BH services in your county are receiving those services?
2. What outreach efforts are being made to reach underserved groups in your community?
3. Do you have suggestions for improving outreach to, and/or programs for, underserved groups?

Since 2014, there has been growing awareness of inequities in behavioral health. In 2017, Governor Jerry Brown signed AB 470 (Arambula) into law[30], which requires the tracking and evaluation of Medi-Cal specialty mental health services with the goal of reducing mental health disparities. The California Pan Ethnic Health Network (CPHEN) developed an Advisory Workgroup in 2018 to provide recommendations for the implementation of AB 470. The Department of Health Care Services published the first report of the data in 2019, with an update in 2020. The California Health Care Foundation (CHCF) and CPHEN released a report[31] in 2020 with an analysis of that data, highlighting some of the findings supported by the data, while also providing recommendations for additional measures focused on quality of care and outcomes. That report also called for continued stakeholder engagement to ensure that

[30] AB 470 requires tracking and evaluation of specialty mental health services, link to text of bill follows: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB470

[31] https://www.chcf.org/publication/mental-health-california/. Mental Health in California, March 2020. See also: https://www.chcf.org/blog/clinics-respond-anti-asian-hate-many-kinds-support/#related-links-and-downloads.

"performance and disparity reduction measures reflect consumer needs." This was just one example of the efforts being made to address behavioral health inequities; there is much more work to be done. The CBHPC Equity Statement[32] acknowledges the impact of social injustice on the behavioral health system.

The 2021 Data Notebooks contained data customized for each county with the goal of reviewing services, strategies of outreach, and providing demographic data pertaining to the county. We asked each of the county boards "Please review it and reflect on the potential trends regarding race and ethnicity. Refer to these as you answer Part II of the 2021 Data Notebook Survey." Our goal was that presentation of that data would lead to thoughtful discussion about the needs and services in each county. The corresponding statewide data were presented for comparison and reference.

- Here, for the project overview report, the seven statewide summary data figures are shown that correspond to the individual county data presented in the 2021 Data Notebook as a point of reference for the embedded discussion questions.
- We summarize and present the aggregated responses to those questions received in the N= 45 Data Notebook reports from 45 county boards/commissions representing 47 counties[33]. Sometimes a response was left blank by a county, and so the "N" of responses for each question may vary.
- The 47 reporting counties[34] represent 78% of the 58 total counties, and
- Together these counties comprised 86% of the population of California in 2021, which we bear in mind when evaluating information in Part 2.

Statewide Behavioral Health Data Presented in the 2021 Data Notebooks

Some of the services funded by the Mental Health Services Act are shown for the state of California in Figure 3, which is taken from the Highlighting Differences to Understand Disparities[35] dashboard of the MHSOAC transparency suite. These data compared the percentages of total persons served by race/ethnicity in California for these three service populations and overall population categories for fiscal year (FY) 18-19:

1. Full Service Partnerships (FSP): Individuals served in MHSA-funded, highest intensity, wrap-around, "whatever it takes" care programs statewide.
2. CSI: Client Services Information (CSI) system that collects information on all persons served in any publicly funded mental health programs.
3. Total Population (Pop): California Department of Finance population estimates.

[32] http://www.dhcs.ca.gov/services/mh/pages/CBHPC-Equity-Statement.aspx

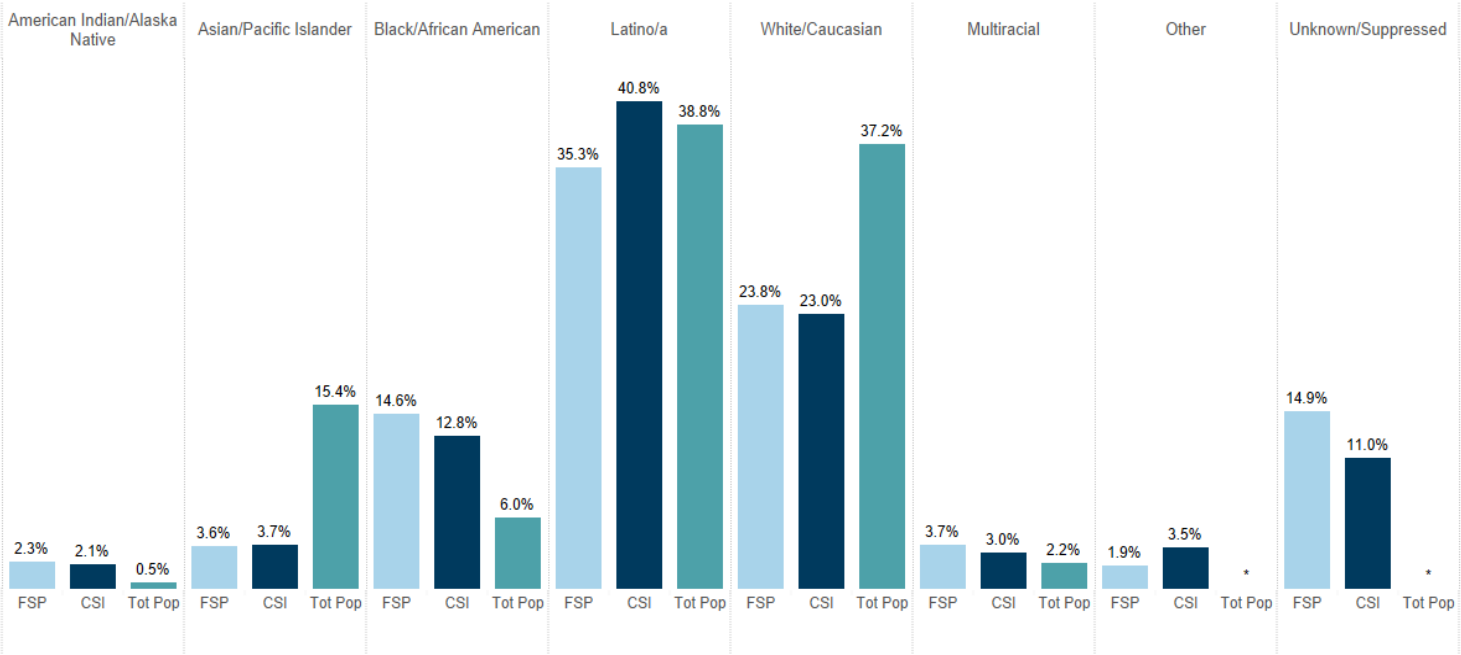
[33] Sierra and Placer counties are served by one Mental Health Plan (and therefore one Data Notebook), as are Sutter and Yuba counties.

[34] Sutter and Yuba counties share a mental health plan and are represented by one data notebook, as done similarly for Placer and Sierra counties; hence 46 counties but 45 Data Notebook reports received for 2021.

[35] https://www.mhsoac.ca.gov. "Highlighting Differences to Understand Disparities."

The data are also presented in table format below the chart. Some values may be unavailable or suppressed to protect patient privacy. Comparing these percentages may yield some insight into potential disparities in access based on race/ethnicity.

Figure 3. Mental Health Access by Race/Ethnicity in California, FY 18-19, Totals



**Data not available or suppressed (any count <11)*

Table 8. Mental Health Access by Race/Ethnicity in California, FY 18-19, Total

	American Indian/ Alaska Native	Asian/ Pacific Islander	Black/ African American	Latino/a	White/ Caucasian	Multiracial	Other	Unknown/ suppressed
FSP	2.3%	3.5%	14.6%	35.3%	23.8%	3.7%	1.9%	14.9%
CSI	2.1%	3.7%	12.8%	40.8%	23.0%	3.0%	3.5%	11.0%
Total Population	0.5%	15.4%	6.0%	38.8%	37.2%	2.2%	*	*

**Data not available or suppressed (any count <11 clients).*

Next, we examine Medi-Cal funded mental health services data separately for adults and for children.

Further data is provided below from the Performance Dashboard AB 470 Report Application, published by DHCS. The first two charts (Figures 2 & 3) show the percentages of adult beneficiaries in California receiving **Specialty Mental Health**

Services or **Mental Health Services** compared to the overall Medi-Cal eligible count, by race/ethnicity. **Mental Health Services** refers to non-specialty mental health services; mostly mild-to-moderate mental health services found in fee-for-service claims and managed care encounters. The **access** rate includes beneficiaries receiving **at least one** mental health services visit in a single fiscal year while the **engagement** rate includes beneficiaries with **five or more** visits in a fiscal year.

It is important that we show data for both non-specialty mental health and specialty mental health, because we obtain a broader picture of how people are served in these systems. We will be able to see that the numbers of those receiving mental health services are not limited to the much smaller numbers served in the specialty mental health system. Individuals may be referred between systems as their clinical needs change, whether due to need for a greater intensity or specialized service type, or alternately, due to client recovery and readiness to transition (or 'step down') to less intensive services.

Differences in the percentages by race/ethnicity may suggest potential disparities in access to services or in specific cultural or system-wide barriers to access. For example, Asian or Pacific Islander and Hispanic beneficiaries have notably lower access and engagement rates than other race/ethnicity groups according to these data. These specific data do not provide information about disparities in clinical outcomes of adult or youth clients. However, these data can alert us to risks of the possibility for less successful outcomes in vulnerable populations due to insufficient, or inappropriately delivered, behavioral healthcare.

The next set of data figures provided below were derived from the Performance Dashboard AB 470 Report Application,[36] published by DHCS. The first two charts (Figures 4 and 5) show the percentages of adult beneficiaries in California receiving **Specialty Mental Health Services** or **Mental Health Services** compared to the overall Medi-Cal eligible count, by race/ethnicity.

[36] MHS Dashboard Adult Demographic Datasets and Report Tool - Performance Dashboard AB 470 Report Application - California Health and Human Services Open Data Portal. Also see: https://www.dhcs.ca.gov

Figure 4. Medi-Cal Mental Health Access Rates, California Adults, by Race/Ethnicity, FY 19-20

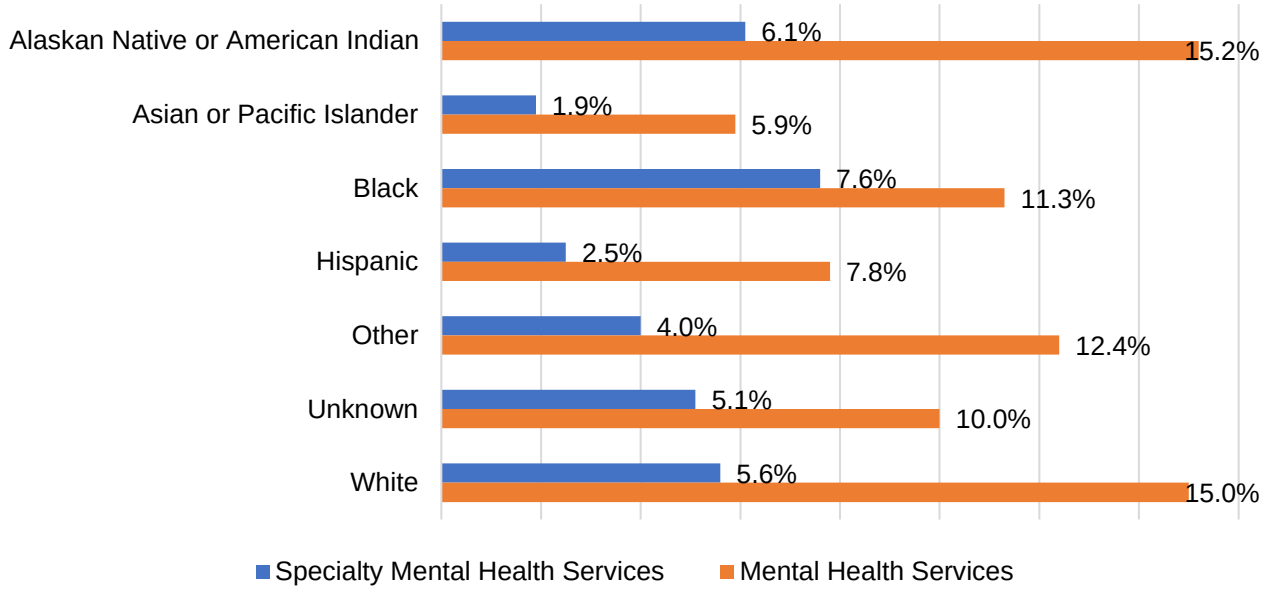
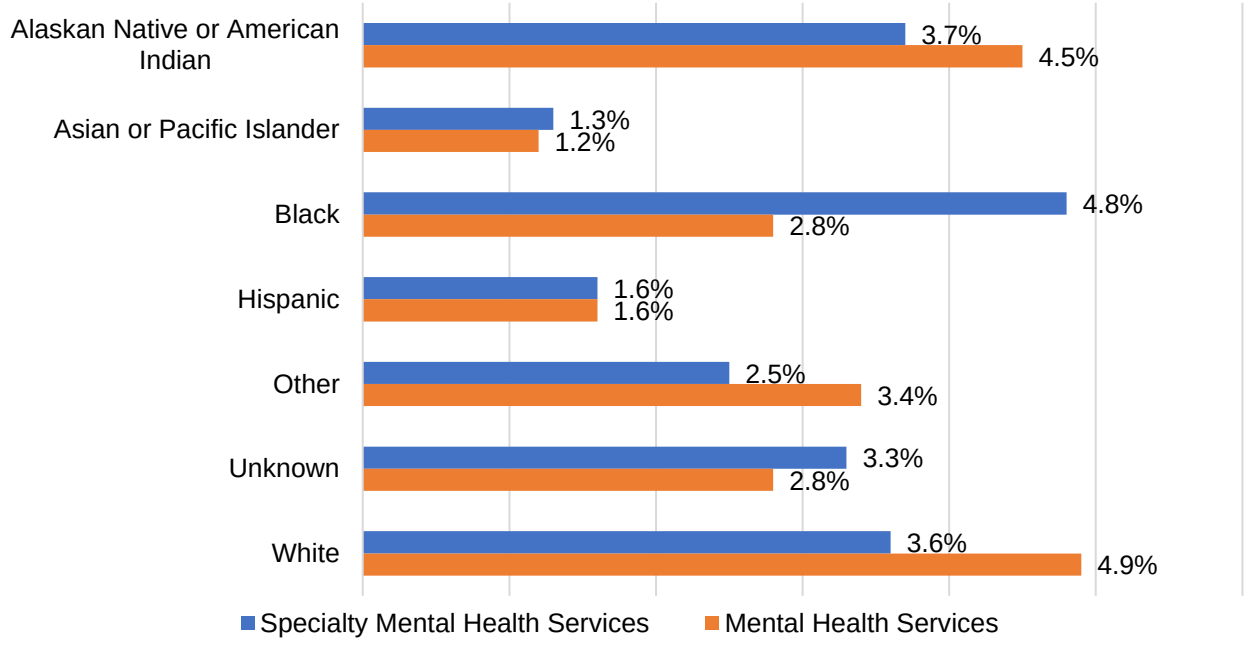


Figure 5. Medi-Cal Mental Health Engagement Rates, California Adults, by Race/Ethnicity, FY 19-20



The next two charts (Figures 6 and 7) show the same measures for children and youth in our state. Again, differences in the rates between groups may indicate inequities in access to care, and trends may be different from the data for children in your county.

Figure 6. Medi-Cal Mental Health Access Rates, California Children & Youth by Race/Ethnicity, FY 19-20

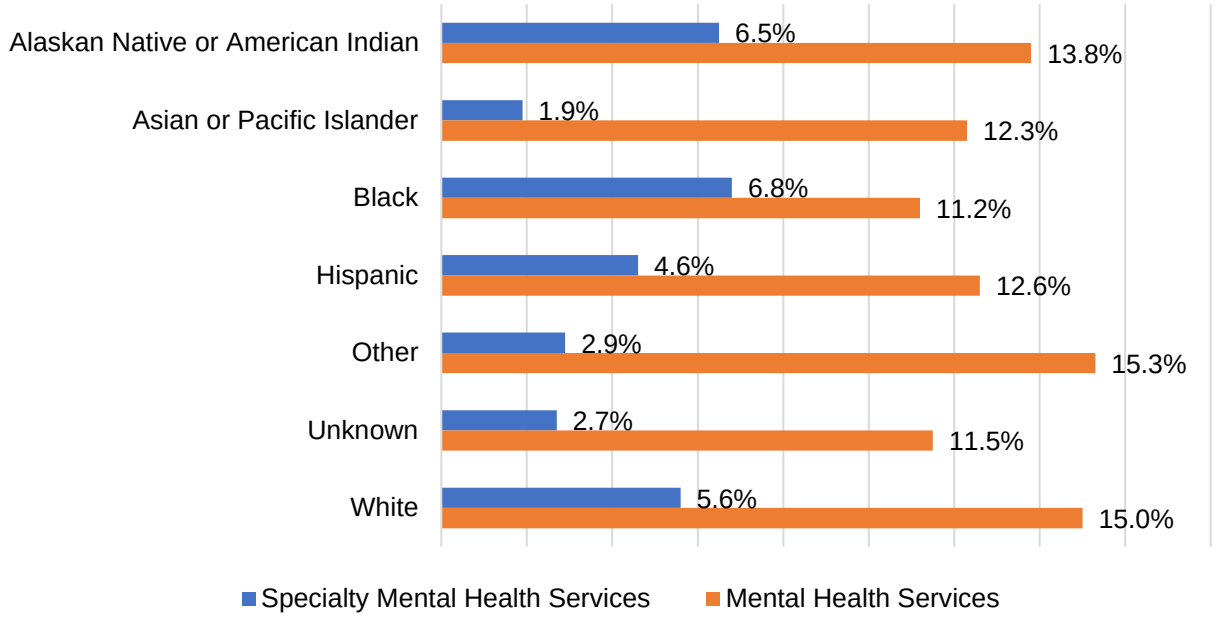
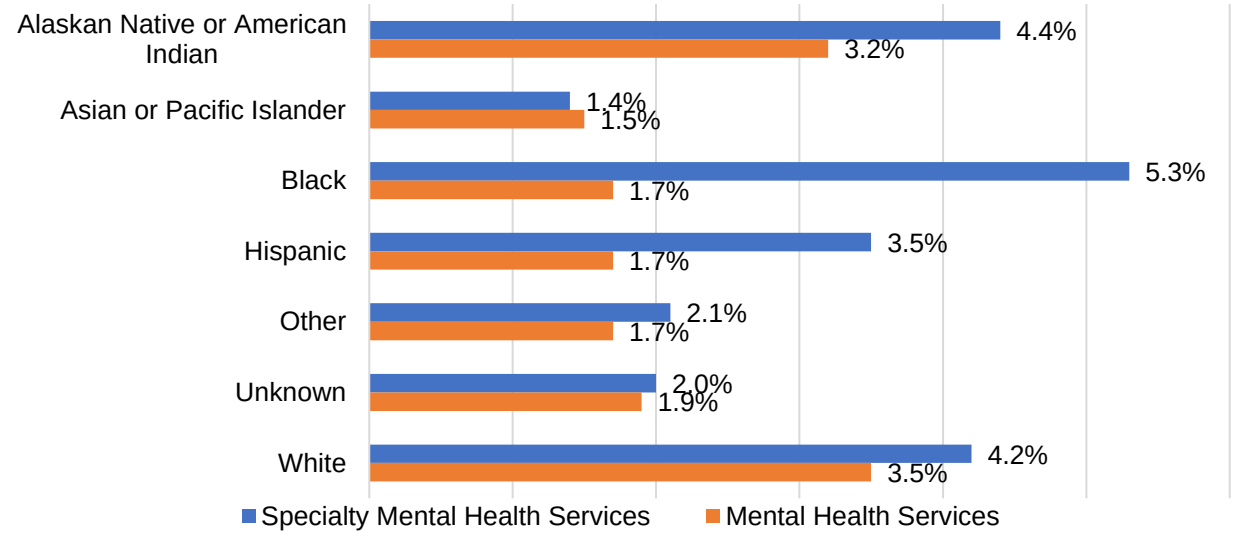


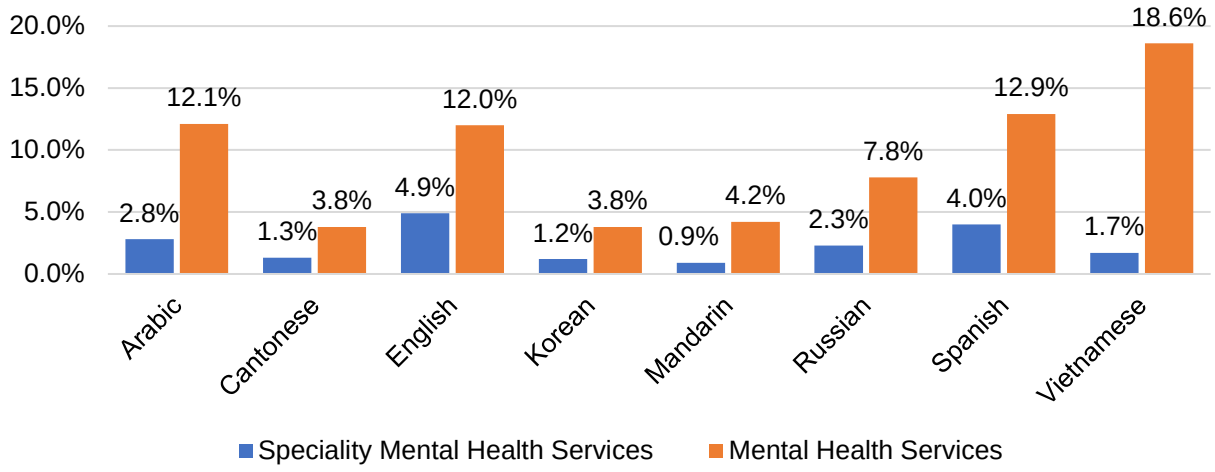
Figure 7. Medi-Cal Mental Health Engagement Rates, California Children & Youth by Race/Ethnicity, FY 19-20



The next two charts (Figures 8 and 9) show the percentage of Medi-Cal beneficiaries receiving at least one Specialty Mental Health Service or Mental Health Service (per FY), when compared for the eight most common preferred written languages for Medi-Cal enrollees overall. Listed in alphabetical order these eight languages included: Arabic, Cantonese, English, Korean, Mandarin, Russian, Spanish, and Vietnamese.

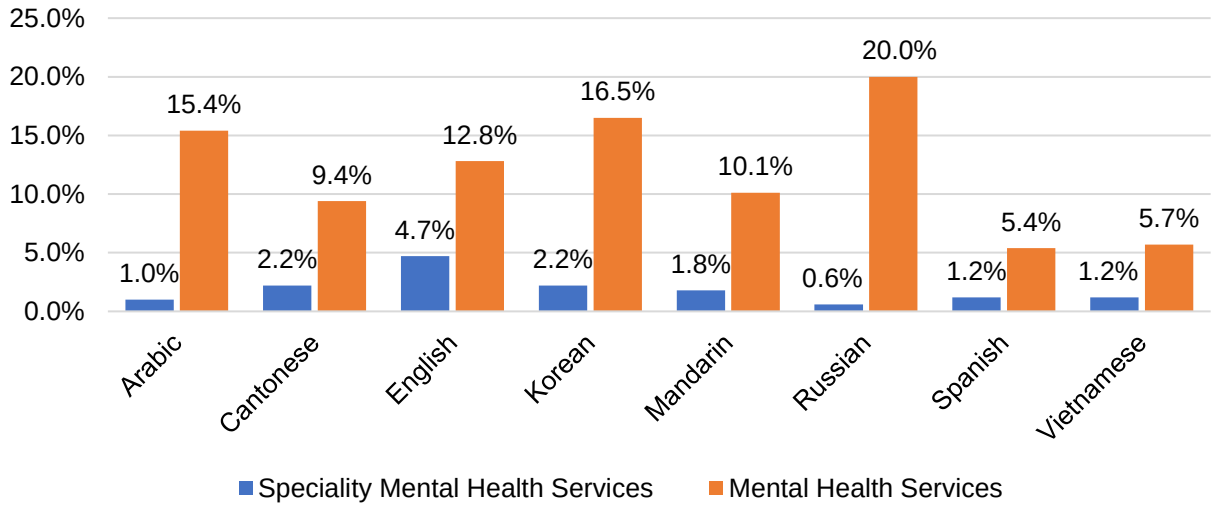
These data do not indicate what language was used to provide the services, just the written language preference of the individuals. Based on these data, access rates for Specialty Mental Health Services among non-English speaking adults were lower than for English speaking beneficiaries, with Cantonese, Mandarin and Korean having the lowest rates of access relative to their prevalence in the Medi-Cal population.

Figure 8. Medi-Cal Mental Health Access Rates by Language, California Adults, FY 19-20



Similarly, for the data for children and youth shown below, observe which enrollees were less likely to receive mental health services through either Specialty Mental Health Services or Mental Health Services based on their preferred language. Again, where the data show marked differences, we can explore possible reasons and strategies that might reduce the differences in access by these diverse communities.

Figure 9. Mental Health Access Rates by Language, California Children & Youth, FY 19-20



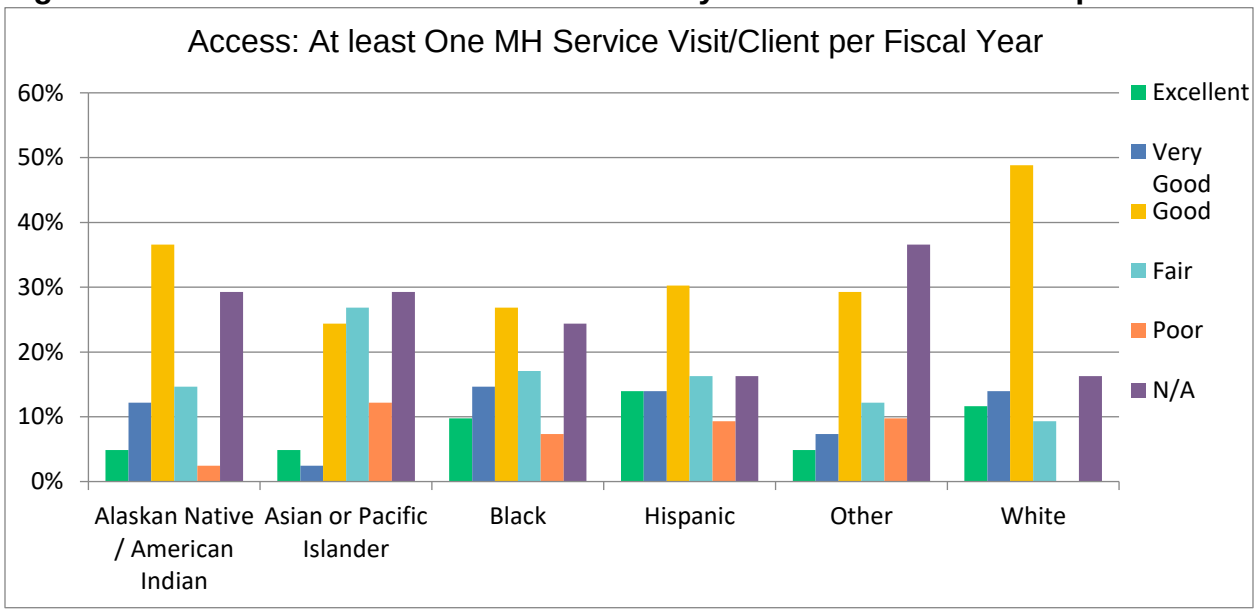
Discussion of the Data Notebook responses received from all of the 2021 Data Notebooks resumes with Question 12, below.

Question 12: Based on the data provided for your county, please rate the access and engagement to stepdown[37] services for each of the following racial/ethnic groups. (Dropdown menus for access rate and engagement rate with the ratings of "Excellent", "Very Good", "Good", "Fair", and "Poor" for each group.)

- **Alaskan Native / American Indian**
- **Asian or Pacific Islander**
- **Black**
- **Hispanic**
- **Other**
- **White**

The values below indicate the percent of responding counties that ranked quality of 'Access to Behavioral Health Services' for each listed demographic group as Excellent, Very Good, Good, Fair, Poor, or Not Applicable.

Figure 10. Access to BH Services Received by Members of Each Group

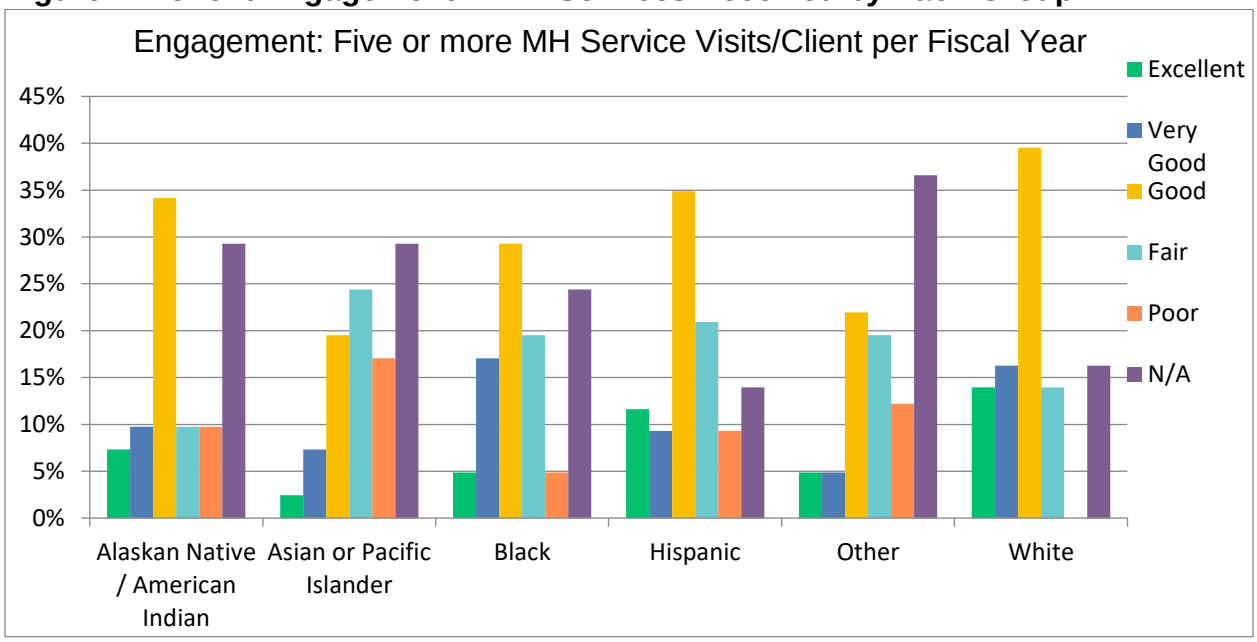


At least two counties criticized these 'quality' rankings. They believed that their Access data could not support making those judgments, because this measure of Access relies on achieving only a minimum of one visit per client in that fiscal year. Similar arguments

[37] We received several requests to clarify this term, defined as "outpatient" services, in the context of prior discussions of data for hospitalized psychiatric patients in IMDs or intensive BH services of STRTPs for foster youth.

can apply to quality rankings of the metric for client Engagement (below), defined as a minimum of five or more BH service visits per unique client per fiscal year.

Figure 11. Client Engagement in BH Services Received by Each Group

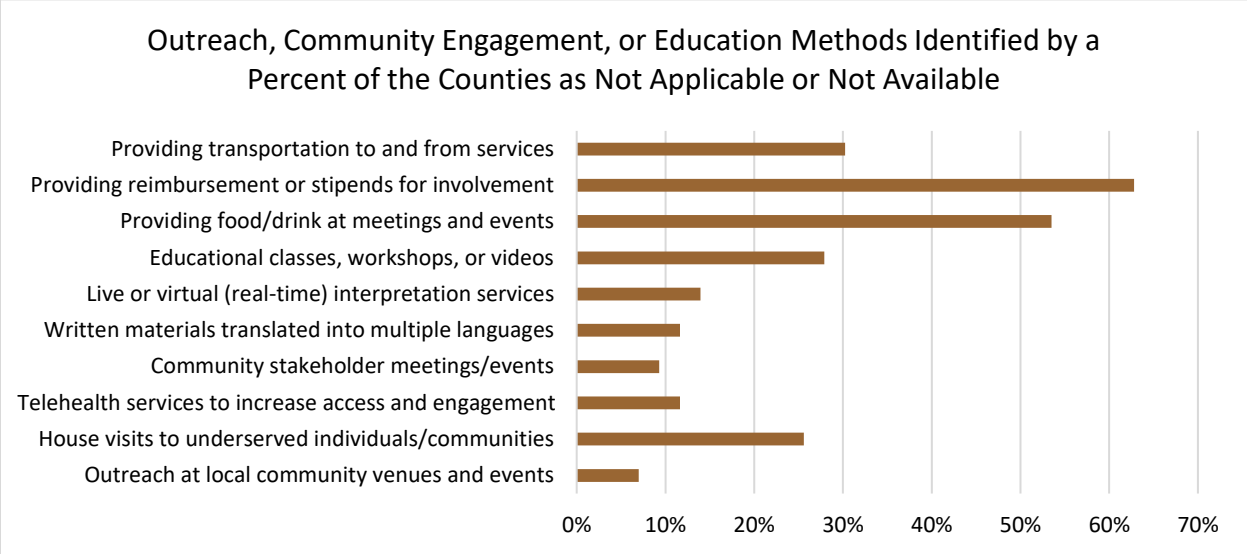


Question 13. What outreach, community engagement, and/or education methods are being used to reach and serve the following racial/ethnic groups in your community? Please select all that apply. (Matrix of checkboxes for each item below and each racial/ethnicity group.)

- **Outreach at local community venues and events**
- **House visits to underserved individuals/communities**
- **Telehealth services to increase access and engagement8**
- **Community stakeholder meetings/events**
- **Written materials translated into multiple languages**
- **Live/virtual interpretation services**
- **Educational classes, workshops, or videos**
- **Providing food/drink at meetings and events**
- **Providing reimbursement or stipends for involvement**
- **Providing transportation to and from services**
- **Other (please describe)**

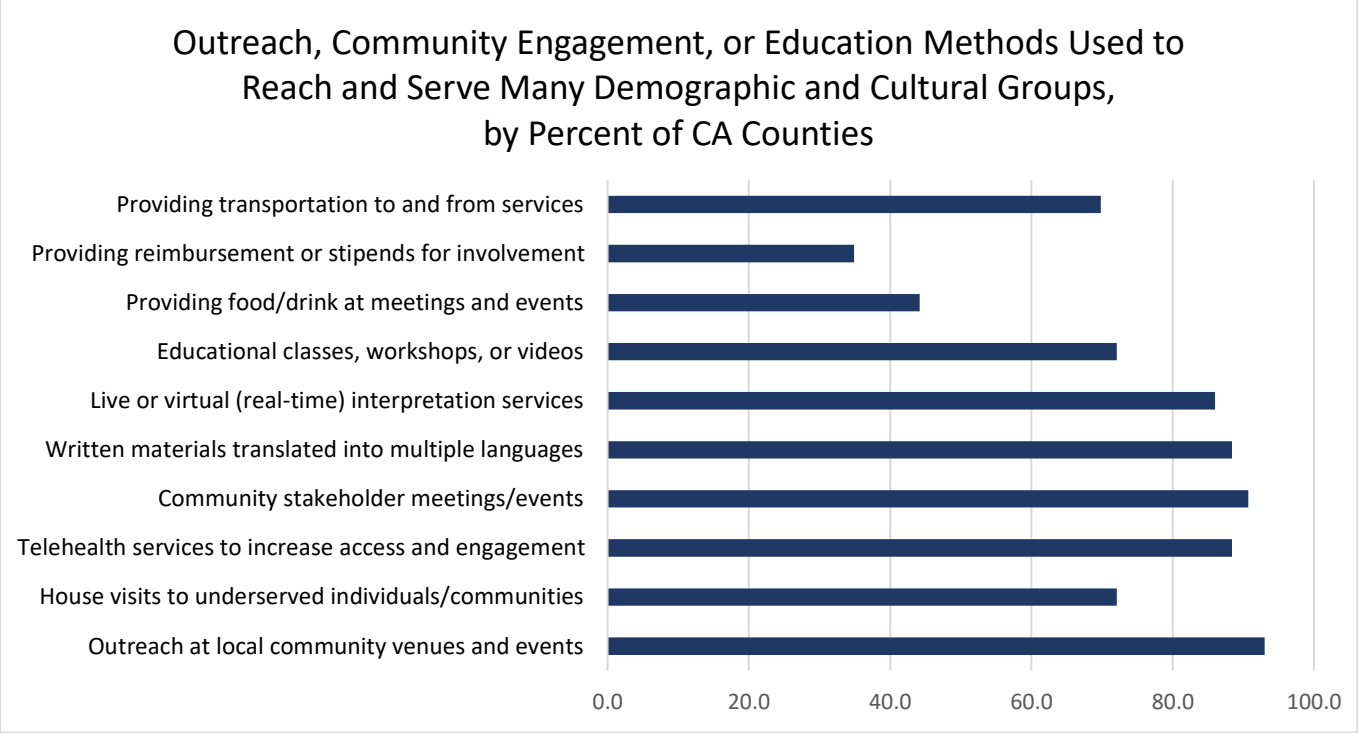
The initial figure (below) indicates that a number of services or strategies were not available or not applicable in some of the counties. Most common was the lack of any availability of stipends or reimbursement for involvement. For some counties, there was no provision (or funds available) for either transportation or food and drink at meetings or other events. The data of Figure 12-A serve as a baseline point of reference.

Figure 12-A. County Identified these Services as Not Available or Not Applicable



Next, Figure 12-B shows the percent of counties that were able to use a variety of strategies for outreach and engagement of the cultural and demographic groups in their communities. The goal was to reduce barriers and improve access to behavioral health services of all types. Some of these strategies could promote engagement with other programs such as: behavioral health board meetings, community planning processes, public health outreach, or stakeholder educational events.

Figure 12-B. Outreach, Engagement, and Education Methods Used by Counties



Additional detailed data and graphs are presented in Appendix III, so that the reader can examine, compare, and evaluate the data for the strategies most commonly used to target each cultural group, and draw one's own conclusions. These represent the responses to a survey of the counties and should not be taken as representative of populations at large, nor of how many individuals partook of these programs or services. Careful inspection of the data figures in Appendix III shows that many strategies were utilized across multiple demographic and cultural groups. The outreach and engagement strategies used by many counties, and which helped get people involved in BH services, bore both similarities and some differences among groups. The most frequently used were:

- Outreach at local community venues and events
- Availability of telehealth services
- Community stakeholder meetings/events
- Live or virtual (real-time) translation during events or while receiving BH services
- Providing transportation to events or BH services (or for some, home visits).

Some other strategies were more useful for specific cultural groups, for example, written materials translated into languages other than English and the availability of food/beverage at events to create a welcoming environment consistent with cultural traditions. However, local regulations may restrict use of county funds for food/beverages at outreach events and meetings, unless private donations are used. Home visits were helpful to those with physical frailty or disabilities but also in communities with limited options (or lack of funds) for transportation.

'Other' Outreach Strategies Employed by the Responding Counties:

- Engaged faith-based organizations and local cultural groups
- Several counties mentioned the use of gift cards for participants in focus groups and various stakeholder meetings, targeted outreach events
- Collaborated with local government agencies, i.e. Parks and Recreation, School Districts, Law Enforcement, Public Defender's Office
- Use local Spanish language radio stations for information and outreach
- Communication via mass message texting
- Social media posts in English and Spanish
- Outreach to foster youth in the Community
- Outreach to LGBTQ+ individuals
- Recommend ASL (American Sign Language) and other translators or translated written materials (Punjabi, Hindi, Tagalog, and Russian were suggested).
- Due to Covid-19 this year, most counties held few, if any, in-person events. Once it is safe to do so again, it is expected that a variety of activities will resume.
- Certain MHSA programs were designed for outreach to Hispanic and Native American populations, and these likely will resume post-Covid.

Question 14. Which of the following groups are represented on your mental health board/commission or related work groups/task forces? (Please select all that apply.)

- **Alaskan Native / American Indian**
- **Asian or Pacific Islander**
- **Black**
- **Hispanic**
- **White**
- **Other race/ethnicity**
- **Older adults (65+ years)**
- **Transition-age youth (16-24 years)**

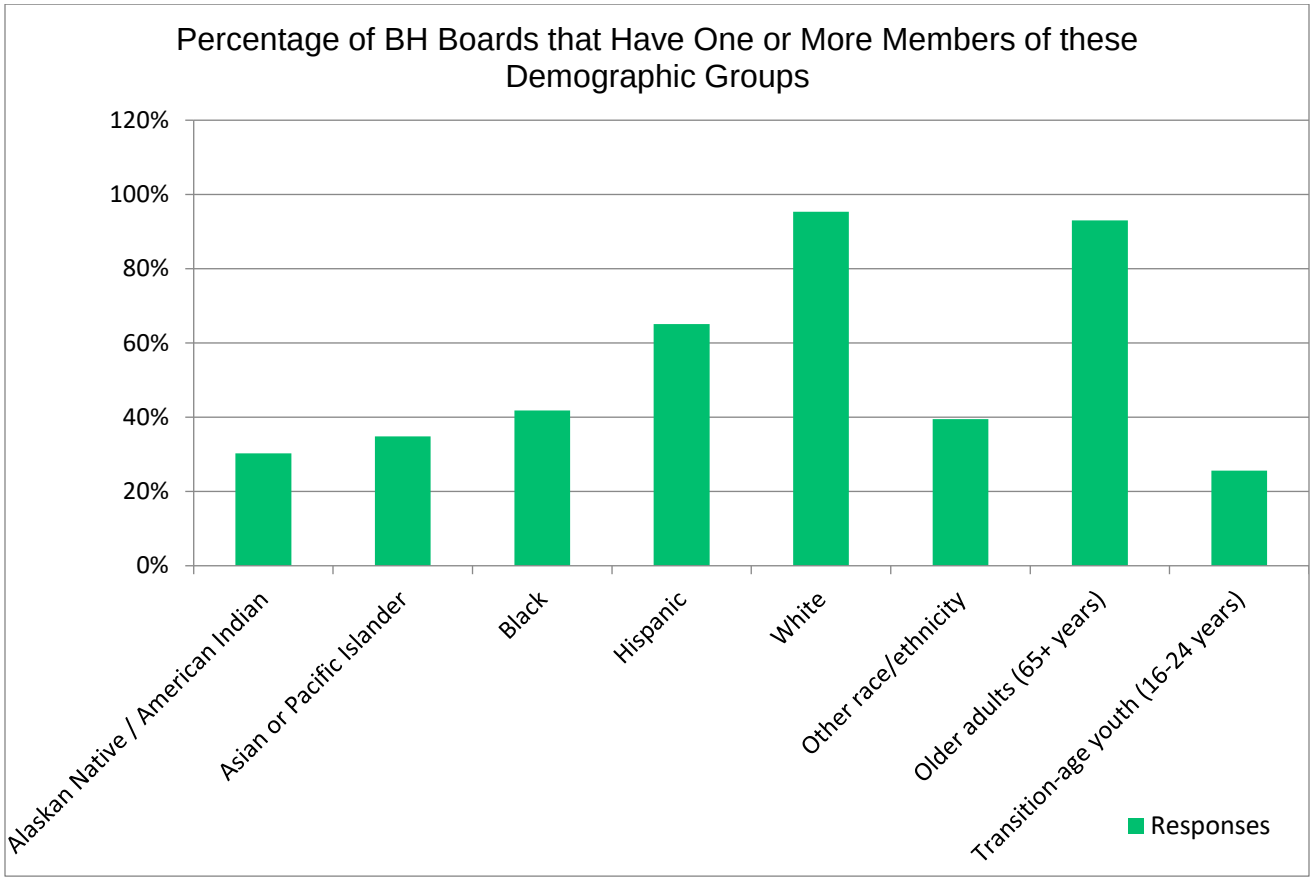
Table 9. Representation on County Behavioral Health Boards/Commissions

Demographic Groups	**%Boards with ≥1 Persons**	**#Boards with ≥ 1 Persons**
Alaska Native/Am. Indian	30	13
Asian or Pacific Islander	35	15
Black	42	18
Hispanic	65	29
White	95	42
Other Race/Ethnicity	40	17
Older Adults (65+ years)	93	41
Transition-age Youth(16-24)	26	11
# Boards Responded	100%	44

Total responses tabulated: 186 selections were chosen by 44 county MH boards.

These data represent information from boards and commissions that have one or more representatives who are members of the listed demographic groups. A single member may represent both an age group and a race/ethnicity. “Other” includes those who identify as being of two or more ethnicities, or a group not listed, or ‘declined to state.’ We followed standard designations used by the California Department of Health Care Services. For privacy reasons, we did **not** attempt a detailed ‘census’ to tabulate every member’s data. Many boards have only a few members, and all boards include clients and/or family members served by the local Department of Behavioral Health. Both HIPAA laws and good data practices do not permit detail for categories of fewer than eleven persons. Other ‘safe harbor’ practices may also limit the type of detail permitted. The figure below is included for those who prefer a broad visual overview of the data**.**

Figure 13. County Behavioral Health (BH) Board/Commission with at least One Member from these Demographic Groups (n = 186 responses).



Question 15. Which of the following steps have been taken to develop a culturally diverse behavioral health work force in your county? Please check all that apply.

- **Tailoring recruitment efforts (re: professional outreach and job ads) to all applicants representative of the racial/ethnic populations in your county**
- **Utilizing behavioral health workforce pipeline programs that value cultural/linguistic diversity among applicants**
- **Actively cultivating a culturally inclusive workplace environment in which racial/ethnic minority staff are engaged**
- **Conducting listening sessions or other methods for staff to provide feedback on workplace environment and hiring/promoting practices**
- **Providing professional development opportunities such as mentorship or continued education and training for behavioral health staff and providers**
- **Other (please describe)**
- **None of the above.**

The following responses were received in Data Notebooks from 43 counties.

Table 10. Recruiting Strategies for a Culturally Diverse BH Work Force in CA

Strategies:	**% Counties**	**# Counties**
None of these	**2 %**	**1**
Tailoring recruitment efforts (re: professional outreach and job ads) to applicants who are representative of the racial/ethnic populations in your county	**53%**	**23**
Utilizing behavioral health workforce pipeline programs that value cultural/linguistic diversity among applicants	**63%**	**27**
Actively cultivating a culturally inclusive workplace environment in which racial/ethnic minority staff are engaged.	**86%**	**37**
Conducting listening sessions or other methods for staff to provide feedback on workplace environment and hiring/promoting practices.	**63%**	**27**
Providing professional development opportunities such as mentorship or continued education and training for behavioral health staff and providers	**91%**	**39**
Other (please specify)	**42%**	**19**
Number and Percent of Responding Counties:	**98%**	**43**

Additional Detail for responses under "Other" can be found in **Appendix IV** at the end of this Report.

Question 16. Does your county provide cultural proficiency training[38] for behavioral health staff and providers? Most counties are required to provide (or contract for) such training on a yearly basis, especially if their Behavioral Health Department functions as a managed care plan (also called a Mental Health Plan).[39]

- **Yes (please describe):**
- **No**

The result is that 41 of 44 (93%) responding counties answered in the affirmative. A comprehensive and detailed list of each responding county's required CLAS trainings are provided in Appendix V. Counties may take slightly different approaches to training, depending on their unique cultural groups, populations, and specific local needs.

The goals of this question were to familiarize board members with their county's training in cultural competency and to increase the members' own understanding of the diverse cultural groups within their community and the needs of each group for BH services.

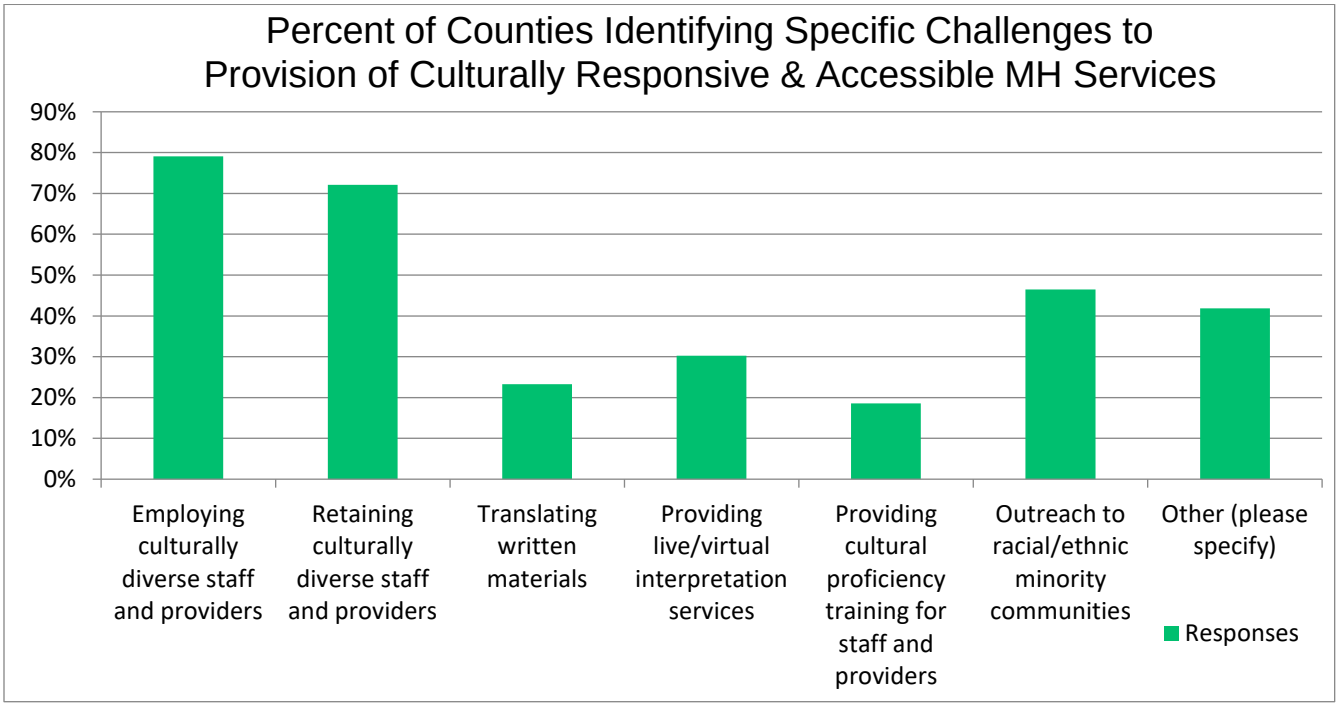
[38] Cultural Competency Plan, to meet the requirements of (CCPR) standards and criteria (per CCR9, 1810.410).

Question 17. With which of the following does your county have difficulty in regard to providing culturally responsive and accessible mental health services? (Please select all that apply.)

- **Employing culturally diverse staff and providers**
- **Retaining culturally diverse staff and providers**
- **Translating written materials**
- **Providing live/virtual interpretation services**
- **Providing cultural proficiency training for staff and providers**
- **Outreach to racial/ethnic minority communities**
- **Other (please specify).**

A total of 43 counties and their Boards responded to this question. The comments received were thoughtful, showed insight, and provided specific recommendations. Challenges were experienced in common by many counties, as shown below. Some of these county self-ratings were developed partially in discussion with their local boards.

Figure 14. Challenges Faced by Your County in Providing Culturally Responsive and Linguistically Accessible Mental Health Services



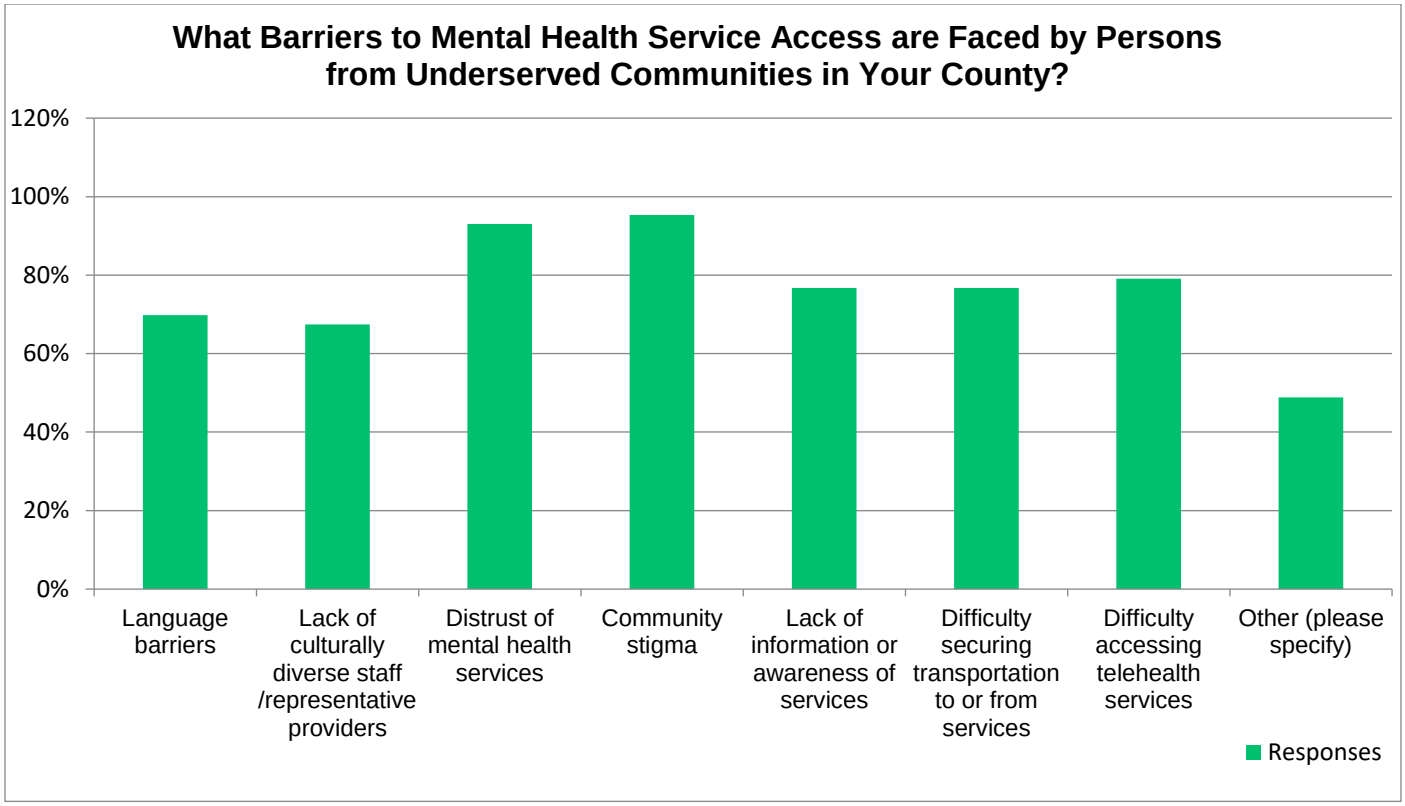
Examples of 'Other' Challenges Identified by Counties as Goals and Areas for Improvement in Their Ability to Reach and Serve Diverse Communities are listed in **Appendix VI** at the end of this report**.**

Question 18. What barriers to accessing mental health services do individuals from underserved communities face in your county? (Please select all that apply.)

- **Language barriers**
- **Lack of culturally diverse/representative staff providers**
- **Distrust of mental health services**
- **Community stigma**
- **Lack of information or awareness of services**
- **Difficulty securing transportation to or from services**
- **Difficulty accessing telehealth services**
- **Other; please specify.** (See responses below).

Our Council members and other stakeholders remind us that community stigma and distrust of mental health services remain significant barriers in serving individuals from diverse communities. And once people engage with mental health services, there can be fear of this fact becoming known to others at work or in the community. For example, it's still common to hear from clients that they are reluctant to disclose their present or prior mental health status to their physicians, for fear that their physical symptoms might be discounted as 'psychosomatic' because of prejudice. Additional detail described in response to "Other, please specify" can be found in **Appendix VII** at the end of this report. The summary in Figure 15 (below) supports our continued efforts to reduce stigma and promote understanding.

Figure 15. Barriers to BH Services, as Reported by Percentages of 43 Counties

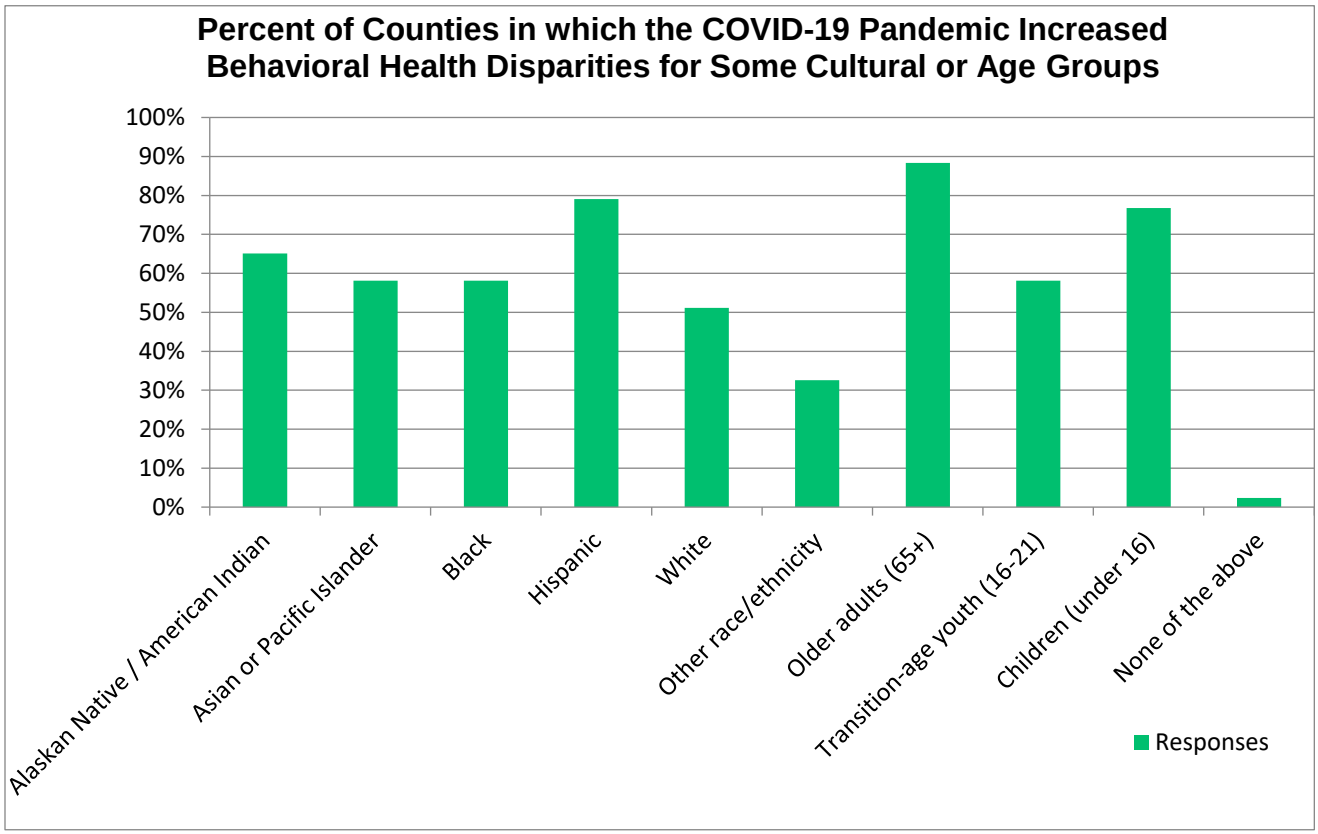


Question 19. Do you feel that the COVID-19 pandemic has increased <u>behavioral health</u> disparities for any of the following groups? (Please select all that apply.)

- **Alaskan Native / American Indian**
- **Asian or Pacific Islander**
- **Black**
- **Hispanic**
- **White**
- **Other race/ethnicity**
- **Older adults (65+ years)**
- **Transition-age youth (16-24 years)**
- **Children (under 16)**

The responses received in Data Notebooks from 44 counties are summarized in the following figure. The three groups that are perceived as having experienced the most impact of worsened BH disparities as a result of the pandemic are: (a) the elderly, (b) Hispanics, and (c) children under the age of 16, as illustrated by the following data.

Figure 16. Perceived Increases in BH Disparities during Covid-19, as Identified by the Percentage of 44 Responding Counties

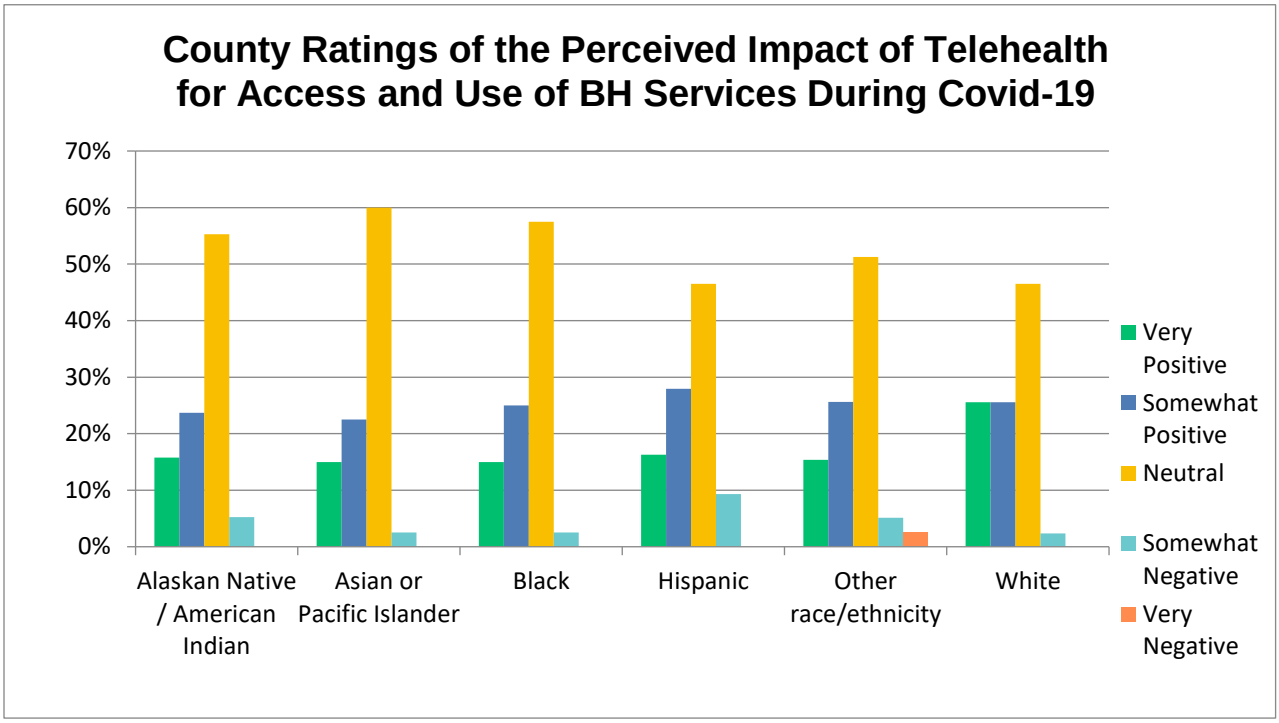


Question 20. Please rate the impact of the use of telehealth services during Covid-19 for the following groups regarding access and utilization of behavioral health services. (Rating options for each group are "very positive", "somewhat positive", "neutral", "somewhat negative", and "very negative".

- **Alaskan Native / American Indian**
- **Asian or Pacific Islander**
- **Black**
- **Hispanic**
- **Other race/ethnicity**
- **White**

These ratings are the perceptions and experiences of those who participated in discussions to provide answers for their county's Data Notebook. They may have also drawn on the experiences of their family members. Participants may include board members, staff and service providers who also gave input to the board members, and possibly participants in any online or public meetings of the board.

Figure 17. Perceived Impact of the Use of Telehealth for BH Services by Demographic Groups as Reported by 44 Counties during the Pandemic



Responses show that telehealth for access during COVID-19 worked better for some populations than for others. In our goal to reduce inequities, we recommend a focused analysis at local levels to target where adjustments or additional supports are needed in the expansion of telehealth services as we transition to post-pandemic delivery systems for Behavioral Health. Lack of proficiency or support for learning to deal with the technology can be significant barriers. Other challenges may include lack of bandwidth that is both affordable and available in a local or rural region. Those who are hearing-impaired, or have impaired vision, or who speak English as a second language, may face additional difficulties in accessing teletherapy or telemedicine services, or attending online ('virtual') stakeholder or public health outreach meetings. These have indeed been the experiences of some of our Council members or their own family members.

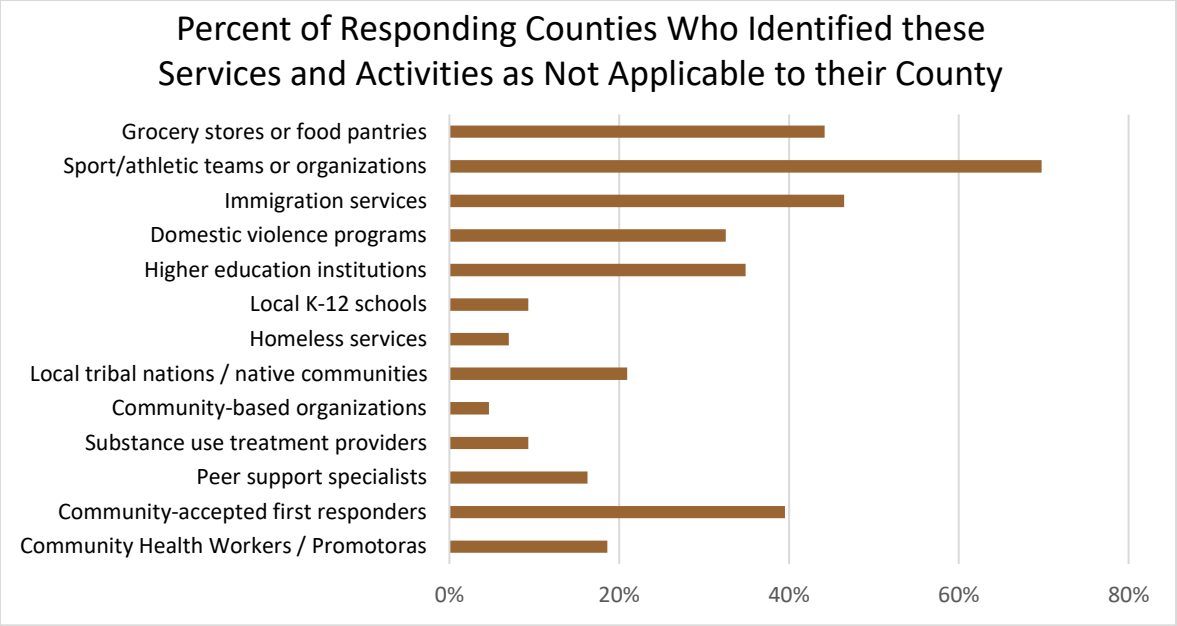
Question 21. Which providers or services have been employed, utilized, or collaborated with, to serve the following racial/ethnic populations in your county? Select all that apply. (Matrix of checkboxes for each item and racial/ethnic group.)

- **Community Health Workers / *promotoras***
- **Community-accepted first responders**
- **Peer Support Specialists**
- **SUD treatment providers**
- **Community-based organizations**
- **Faith-based leaders/organizations**

- **Local tribal nations / native communities**
- **Homeless services**
- **Local K-12 schools**
- **Higher education**
- **Domestic violence programs**
- **Immigration services**
- **Sport/athletic teams or organizations**
- **Grocery stores or food pantries**
- **Other (Please specify).**

As a baseline point of reference, we considered the percentage of counties that were not able to provide these services or programs (or the ability to do so only minimally) as part of their outreach to engage those in need of BH services.

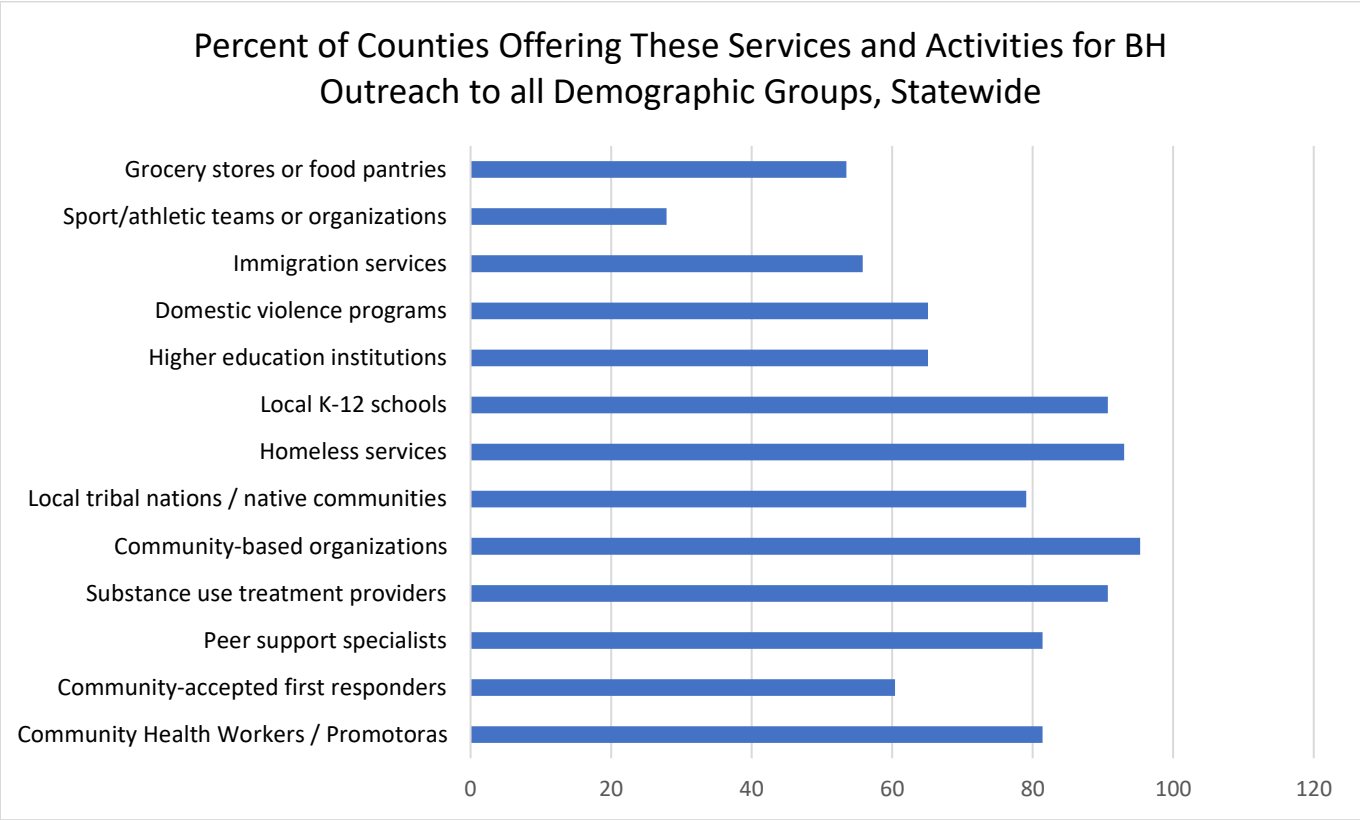
Figure 18. "These Services Were Not Available or Not Applicable to their County"



The selections above that were least likely to be available as a means of outreach in the counties were, in order: (a) sport/athletic teams, (b) immigration services, (c) grocery stores or food pantries, and (d) community-accepted first responders.

Next, we consider the items which were most likely to be used or available in the counties as a positive means of outreach and engagement to help reach those in need of BH services. Figure 19 shows a statewide summary of services and programs most frequently used as a means of outreach across several demographic groups. There is additional informative detail in Appendix III about those services most frequently used to engage various groups of different race/ethnicities.

Figure 19. Statewide Summary of Services and Activities Most Frequently Used by Counties to Provide Services and Outreach to All Eligible Residents of Various Demographic Groups in their Communities.



Based on the data in Figure 19 (above), the most frequently-offered services for outreach and engagement were co-located or implemented at the following service providers and agencies:

(a) Community-based Organizations

(b) Homeless Services

(c) Local K-12 Schools

(d) Substance Use Treatment Providers

Examples of 'Other' Services, Agencies, or Organizations with Whom County Behavioral Health Interacts to Serve their Diverse Populations. Examples of these programs are shown in detail for several counties, as described in **Appendix VIII**, at the end of this report.

Question 22. Do you have suggestions for improving outreach to and/or programs for underserved groups?

For this question, 39 counties answered 'Yes', and 5 counties answered 'No'. Counties and their board members provided thoughtful suggestions to improve outreach and access to underserved demographic groups in their communities. These suggestions and goals expressed by many counties that could help to 'Improve Outreach to Underserved Communities' are listed in **Appendix IX**, at the end of this report.

Summary and Conclusions

The Planning Council received responses for the 2021 Data Notebooks in 45 Reports representing 46 counties out of 58 total counties. Data collection and reporting began in the last half of 2021 and continued into early 2022, due to a variety of extenuating local circumstances. Those circumstances included large fires, floods and landslides, a series of regional power company shutdowns for fire mitigation, and winter surges in COVID-19 cases with impacts on staffing and board member participation rates.

Responses from the 45 Local Mental and Behavioral Health Boards and Commissions provide a very complex picture of barriers and sources of disparities in access to BH services. Some of the challenges and limitations of this report arise from attempting to address substantial complexity within individual questions. The analytical issues involved in addressing these complex qualitative data parallel the complexities of statistical analyses of numerical data with multiple comparison groups.[40]

However, this Planning Council project works to extract meaningful conclusions from descriptive and qualitative data, a process that is more difficult than for analyses of quantitative metrics. Our motivations are driven by an intense awareness of the critical needs of vulnerable populations for behavioral health and social services for these individuals' recovery and continued well-being.

In the 2021 Data Notebook project, the Planning Council sought to obtain a complete picture of the various barriers and difficulties by asking questions from the different perspectives of the users of services and of the providers (and administrators) of services. We collected data on different types of outreach and engagement efforts; many of those in-person efforts had to be suspended due to the highly infectious nature of COVID-19. Several counties stated that they are carefully re-starting some of those in-person programs and activities again.

In this Overview Report, the Planning Council has begun to evaluate the additional complications of trying to either provide or to access any kind of healthcare services during a pandemic that has exceeded two years in duration. There have been necessary changes in the way services and programs were provided, including the implementation of BH therapy by telehealth services. Therapy by telehealth has worked

[40] These concepts are addressed in basic statistical courses regarding analyses of variance, ranging from the simplest to the most complex. One major way to avoid or minimize the necessity to implement measures for corrections for multiple comparisons is design study questions in the most simple and logical manner possible. Many software programs have built-in options to address some of the issues presented by multiple comparisons problems, providing that the user understands the limitations.

well for some populations with good internet access, but less well for those lacking adequate bandwidth or reliable access to the underlying technologies. Those who do not speak English as a first language, or who have impaired hearing or vision, and some of the elderly, appear to have had substantially more difficulties with accessing telehealth services. These challenges were highlighted in our conversations with family members, BH stakeholders with lived experience, and in various public forums.

The COVID-19 public health emergency disrupted behavioral health service systems across California and had a unique impact on communities representing diverse populations. Outreach and engagement activities were shut down in many cases and telehealth emerged as a tool for broader engagement. This report timeframe covers fiscal year 2020-2021, which overlaps a large part of this public health emergency period. We learn from the observations of public mental health boards and counties on how they used their experience to adjust their strategies in working with people of diverse communities providing a valuable lens to on-the-ground efforts.

We received some important feedback to our questions on racial and ethnic inequities. Again, the observations are more qualitative and the lessons learned do not lend themselves to pure statistical analysis. Further, because we evaluated only 47 of 58 counties, that limitation affects what we can conclude about the state as a whole. Like the rest of the country, we are still seeking to comprehend and analyze what happened during the last three years. Children and youth have faced a number of challenges due to difficulties in accessing or relating to telehealth and in attempting to maintain school attendance by virtual or on-line technologies. We have collected only a small amount of data pertaining to children and youth in the 2021 Data Notebook and this accompanying Overview Report.

There are now extensive investigative news articles reporting on these issues, including early data from www.kidsdata.org, and the Kaiser Healthcare Foundation (www.khcf.org), among others. Most of these reports catalog the data describing the challenges presented for youth mental health and unmet needs for services, and the gaps in educational progress thus far. Few have identified meaningful solutions, although such efforts are beginning.

Some new information and recent analysis places our current experience in the context of, and attempts to draw lessons from, other recent historical events in which large social upheavals due to wars or natural disasters have interrupted the schooling and continuity of children's education as well as their natural social and family supports. We note the analyses contained in a new book[41] from the NY Times bestseller list: '*The Stolen Year: How COVID Changed Children's Lives, and Where We Go Now.'*

[41] The Stolen Year: How COVID Changed Children's Lives, and Where We Go Now (2022) by Anya Kamenetz [New York: Public Affairs, Hachette Book Group].

In spite of the foregoing caveats and limitations, some key findings emerged from our observations and require continued work and improvement:

- Stigma and distrust are still areas in need of significant work, both in the community at large, and even within some of the healthcare professions.
- There are major impacts on older adults with prolonged isolation and difficulties with access and ability with technology. Prolonged social isolation and fragility of social connection are known health risks for increased disease and mortality, as well as increased risks for clinical depression and anxiety.
- There is significant variability in minority communities with basic Wi-Fi access and ability to use the technology underlying telehealth and teletherapy applications. Lack of financial resources often compounds these limitations.
- Basic Wi-Fi access technology issues also impacts the ability of children and youth to maintain social connection, continue their studies, and access any ongoing therapy including speech therapy and reading assistance.

Planning Council Recommendations Based on Part 2 of the Overview Report on the 2021 Data Notebook

Recommendation #1: All counties should develop a plan for training in diversity, equity and inclusion for their staff, specific to their county needs. The training should provide, at a minimum, quarterly opportunities for staff to build knowledge and understanding of how to best serve their unique and diverse populations.

- Counties should encourage all county contracted providers to develop a plan for training in diversity, equity and inclusion for their staff, specific to their service population.
- Counties may develop a stakeholder group to help develop their plan for training in diversity, equity and inclusion that includes organizations within the community with specific expertise and knowledge**.**

Recommendation #2. The Department of Health Care Access and Information (HCAI) should develop a plan to recruit culturally competent individuals who understand the needs of serving each county's population/communities. This plan might include attending the community colleges recruitment fairs and promoting Behavioral Health industry jobs, especially in communities of color. Many ideas suggested by California's counties have been included in this document.

Recommendation #3. All counties should review their stakeholder engagement plans to assure that the issues of diversity, equity and inclusion are specific to the needs of their population and county. That plan should be approved by their local mental health board/commission.

Recommendation #4. All counties should review the composition of their local mental health board to assure that the board represents the demographics of the county as a

whole, as defined in the Welfare and Institutions Code Section 5604.5. The demographics of the local mental health board may be further defined in their bylaws.

Recommendation #5. The CA Behavioral Health Planning Council should continue and expand advocacy and support efforts regarding diversity, equity and inclusion for statewide anti-stigma programs, public outreach and engagement, stakeholder engagement, and other activities.

Recommendation #6: The CA Behavioral Health Planning Council should continue to advocate for valid and reliable data on a timely basis. This might include provisional or early data that is not yet fully verified, or sources besides the paid-claims data which are often three years old by the time data are published.

Recommendation #7: County behavioral health departments and local mental health boards should partner in conducting a focused analysis on the use of telehealth services within their county to identify the needs of their consumers. The analysis should include a focus on the demographics of their population, the geography of the county, the availability of Wi-Fi services, and the ability of the consumers of service to afford and use those services.

DATA APPENDICES

Appendix I. Question 8: Additional Programs for Homeless Persons with SMI or SUD.

Appendix II. Question 9: Recommendations for Improving Behavioral Health Services for Foster Youth in CA who need STRTP or Group Home Care.

Appendix III. Question 13: Services and Programs Most Commonly Used by Various Demographic Groups, in Detail.

Appendix IV. Question 15: Other' Strategies for Development of a Diverse Workforce

Appendix V**.** Question 16: Strategies that California Counties Use to Meet their Requirements for Cultural Proficiency Training (CLAS).

Appendix VI. Question 17, in partial response. With which of the following does your county have difficulty in regard to providing culturally responsive and accessible mental health services? Under "Other", please specify.

Appendix VII. Question 21, partial response. Detailed Data and Graphs for Services and Programs Most Commonly Used by Various Demographic Groups.

Appendix VIII. Question 21, in partial response under "Other" Services, Agencies or Organizations with Whom County BH Interacts to Serve their Diverse Population.

Appendix IX. Question 22, in partial response. Counties' Suggestions and Goals to Improve Outreach to Underserved Communities.

APPENDIX I: Responses to Question 8, in part.

'Additional Programs' and Services for Homeless Persons with SMI and/or SUD

Imperial County

- In FY 20-21, our county faced the COVID-19 Pandemic with unique challenges for individuals experiencing homelessness and those at risk of homelessness.
- To address these challenges, ICBHS along with community agencies, prioritized individuals who are experiencing homelessness with the following programs:
- CESH/HEAP served 184 persons
- PATH served 168 persons
- Woman Haven Center for Family Solutions 'Spread the Love Charity'
- Crisis Co-Response Team (FY 20-21) received 99 calls for immediate MH services to persons experiencing an emotional crisis.

Mariposa County

- Continuation of uncompleted county projects that were started pre-COVID-19.
- These projects will allow housing (22 to 24 units) for this population.

Marin County

- Supportive Housing (Added Project Home Key, Housing Voucher)

Mendocino County

- Development of a Crisis Residential Treatment program for temporary emergency shelter for those in a mental health crisis.
- Partnered with health and human services in connecting BHRS clients to emergency shelter options, transitional housing Options, motel vouchers, and Rapid Rehousing resources that were expanded through COVID-19 funding.
- BHRS contractors made adjustments among available MHSA housing programs to expand supported housing models.

Merced County

- Navigation Center, opened on March 29, 2021, and
- Project Room Key, by the Human Services Agency.

Mono and Placer Counties

- Flexible housing subsidy,
- Various agencies offered Rental Assistance related to COVID-19, and
- Mono County operated both Project Room Key and Project Home Key.

Sacramento County

- Outreach and engagement activities were expanded, including:

- Youth Help Network program entered individuals into the online homeless queue.
- Piloted a homeless encampment clinician to conduct outreach, engagement, screening, assessments, and referrals for individuals living in the encampments in our mental health plan; and
- Provided screening and assessment services to persons in project Room Key.

San Francisco County: SIP Hotels and Sobering Centers

Santa Barbara County: 'Tiny Home' shelters in Lompoc, Santa Barbara and inner valley.

Santa Cruz County: Project Room Key

Sonoma County

- The programs (choices as listed in the question above) were expanded in-county, but not by Behavioral Health; services were not exclusive to BH clients

Tulare County

- Project Room Key
- Emergency Housing Vouchers (EHV's)
- Coordinated Entry System (CES)

Ventura County

- Project Room Key, administered by County CEO's office.

APPENDIX II: In partial response to Question #9.

Recommendations for Improving Behavioral Health for Foster Youth in CA Counties who need STRTP Level of Care with MH Services

Alameda County

- Covid-19 related staffing shortages and placement challenges have impacted our ability to provide several modalities of services and has also impacted the availability of residential settings due to occupancy limits early in the first 12 months of the pandemic.
- Additionally, many staff in these programs because of the in-person nature of the services have left these positions or been unable to work at full capacity because of their own health needs and caregiver needs due to school closures.
- We hope that as the pandemic subsides, we can replenish the workforce and expand services.
- Many counties do not yet have STRTPs and may place children/youth in another county.
- Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Amador County

- There are no group homes or STRTPs in our County. Currently there is only one youth placed out of county in an STRTP.
- If there is a need for this level of service, ACBH will contract with the facility outside of the county to ensure treatment for the youth.

Butte County

- In spite of repeated attempts to expand the provider network, there are no foster family agencies that will -or are able to - provide therapeutic foster care.

Del Norte County

- Currently, Del Norte County does not have enough qualified foster homes to care for children who would need higher levels of care.
- We do not have a local STRTP; when we determine that a child needs more intensive services, they are placed out of the county, often hundreds of miles away. This presents a problem for family reunification as many of the families served are not able to travel due to lack of transportation.
- Our recommendation would be to encourage more foster care homes that can house higher levels of care and/ or create a local STRTP so that our local children can remain close to family during treatment.

El Dorado County

- More comprehensive services for youth related to SUDS embedded into the STRTPs are needed. For some, this needs to be a stronger focus of services and treatment, not just a secondary focus.
- We need to look at how we step youth out of group care and into the home environment. We suggest engaging the aftercare services while the youth is still in care, so they are clearly in place and active upon discharge.
- Additionally, while there has been some improvement, youth in STRTPs could be better served by offering high fidelity wrap-around services to help transition children/youth to a lower level of care, which entails intensive behavioral health services and case facilitation.
- There is also an ongoing need for families to receive respite care.

Fresno County

- Children in Group Homes need more access and awareness of mental health services and support. This would require a stronger relationship with the Department of Social Services.

Imperial County

- Our County worked to implement required mandates for youth in foster care, which include intensive care coordination, intensive home-based services, and the Family Urgent Response System (FURS).
- ICBHS has been working in collaboration with partner agencies, Department of Social Services and the Probation Department, to implement services according to the Integrated Core Practice Model and the Continuum of Care Reform.
- A multi-agency MOU as required by AB 2083 was approved by the Board of Supervisors on May 25, 2021. The MOU outlines roles and responsibilities of agencies to provide coordinated care to children and youth in foster care who have experienced trauma.
- The system is still not able to meet the needs of all foster youth of our County as there continues to be a shortage of Resource Family Homes (RFM) and Short-Term Residential Treatment Programs (STRTP) due to increased requirements, making it difficult to meet qualifications, resulting in a shortage of local resources.

Kern County

- Our BHRS is working closely with Kern County placement agencies to provide well-coordinated services to youth in STRTPs.
- There has been a pattern of youth being placed from other counties that typically are very high acuity which takes time and much clinical intervention for youth to be stabilized upon arrival, and it's often more difficult to coordinate with placement agencies from other counties.

Kings County

- There is a lack of awareness of group care homes since most youth needing higher levels of care are placed out of county. We only have one STRTP in Kings County for up to 6 females, all other placements in STRTP are out of county.
- Kings County does not have therapeutic foster care (TFC) homes.
- Also, all youth psychiatric hospitalizations are out-of-county.

Lassen County

- We need more therapeutic foster care homes in the Lassen County area. Many family style group homes closed when the STRTP requirements were initiated.
- Many of the smaller group homes could not meet all the requirements so closed.

Madera County

- Our BHS is interested in expanding our crisis continuum for children and youth.
- We were recently awarded a grant that is focused on children's services.
- MCBHS is interested in applying for funding for a children's crisis residential treatment program, a subacute setting uniquely designed to keep young people in a minimally restrictive environment while providing comprehensive services.
- In addition, MCBHS is interested in enhancing the kind and extent of our community service activities to assure youth can meaningfully contribute to their community. This would include traditional community service as well as public speaking opportunities and individualized recognition.

Marin County

- There are too few STRTP beds available in California, which means that some youth in need of this are unable to be placed.
- We lack a reliable emergency foster home in Marin when needed. There are too few hospital beds for youth in crisis.
- We don't yet have a crisis residential program or hospital diversion program for youth to prevent higher levels of placement.

San Diego County

- There are many obstacles to developing sufficient numbers of Short-Term Residential Therapeutic Programs (STRTP): appropriate housing and workforce.
- We suspect funding is an issue. Also, services to children and youth in group care can always be enhanced and improved for this disadvantaged group.

San Francisco County

- A timelier access system needs to be employed, and
- A safety net for 18–24 year-old youth, along with substance abuse treatment.

Santa Barbara County

- The alarming rate of youth suicide is a warning that we're not doing enough.
- Although we believe the quality of mental health care provided by our county is adequate, it's still not enough.
- STRTPs struggle to hire adequate numbers of staff and adequately trained staff.
- Staff struggle to manage the acuity of the clients being referred, such that clients can be suddenly exited out of placements.

Santa Cruz County

- Youth in congregate care require the highest level of support within our system. Therefore, additional support is always needed. Santa Cruz County Children's Behavioral Health (CBH), in partnership with Juvenile Probation and the Human Services Department Family and Children's Services (FCS/Child Welfare) are working to implement components of the Families First Prevention Services Act (FFPSA) to support these youth and their families/caregivers.
- These supports include the provision of:
  a. Qualified Individual (QI) Assessments for all youth being considered for initial placement and/or transitions between Short-Term Residential Therapeutic Programs (STRTPs), and
  b. Comprehensive aftercare services for youth stepping down from STRTP level of care to home-based placement.
- FCS is exploring use of the Family Urgent Response Services (FURS) program to better support high needs Child Welfare- and Probation-involved children/youth who have been at, or are at risk of going to, congregate care.
- All three departments (CBH, FCS, and Juvenile Probation) are working to align staff training efforts to best serve youth with complex needs, with special focus on Permanency Planning, Child and Family Team Meeting Facilitation, and Implementation of the Integrated Core Practice Model (ICPM).
- With one of our two Santa Cruz County-based STRTP closing this Fall (i.e. Encompass Community Services' Tyler House closed in the Fall due to staffing and other challenges; the only remaining in-county STRTP is Haven of Hope which serves only female-identified youth), our partners are focusing on provision of support to Haven of Hope to ensure access to quality care at their two houses for our Santa Cruz County youth.
- At the beginning of 2021, our County had seventeen (17) STRTP beds available across three houses, with twelve beds available for cis-gender and transgender female youth across two houses.

Shasta County: We could always use more resources, due to our ongoing needs.

Sonoma County

- We are just starting conversations with Child Welfare to look at implementing Therapeutic Foster Care (TFC), which would help in providing more alternatives to residential placement. So we are looking into integrative options.

Sutter-Yuba Counties: Yes, as a county.

Ventura County

- Better paid and better trained staff.
- There is frequent staff turnover that inhibits continuity of services and treatment.

Yolo County

- We have grown increasingly concerned with the lack of consistency across STRTP providers to effectively deliver high quality behavioral health services to children and youth in their care. We have had multiple experiences with STRTP providers that refuse to allow placement of our children/youth and/or who give notice because their behavior is deemed to be "too severe," "too disruptive," or is interfering with the treatment milieu of the facility.
- Unfortunately, there appears to be no actual mechanism to hold STRTP providers accountable when they refuse to serve children/youth, which frequently results in disrupted placements that exacerbate the very behaviors that the STRTPs are supposed to be addressing.
- We had success when providing Wraparound and/or Wrap-like services to youth so that they could remain connected to consistent BH providers while in STRTP placements, thus ensuring a smoother transition when youth left STRTP care.
- However, there is no formal funding mechanism that allows for these services while the youth are in STRTPs, so we need a way to fund this approach.
- Our local efforts around this issue include ensuring that youth who discharge to a placement in or near the county receive Wraparound services that begin at least 30 days before the youth discharges from placement, and prioritizing assignment of court appointed special advocates for youth in STRTP placements.

APPENDIX III: Outreach and Community Engagement Strategies Employed by Counties to Engage Specific Demographic Groups. For detailed responses to Question 13: 'Outreach Strategies to Demographic Groups', listed under "Other.

Figure A. Alaskan Natives and American Indians

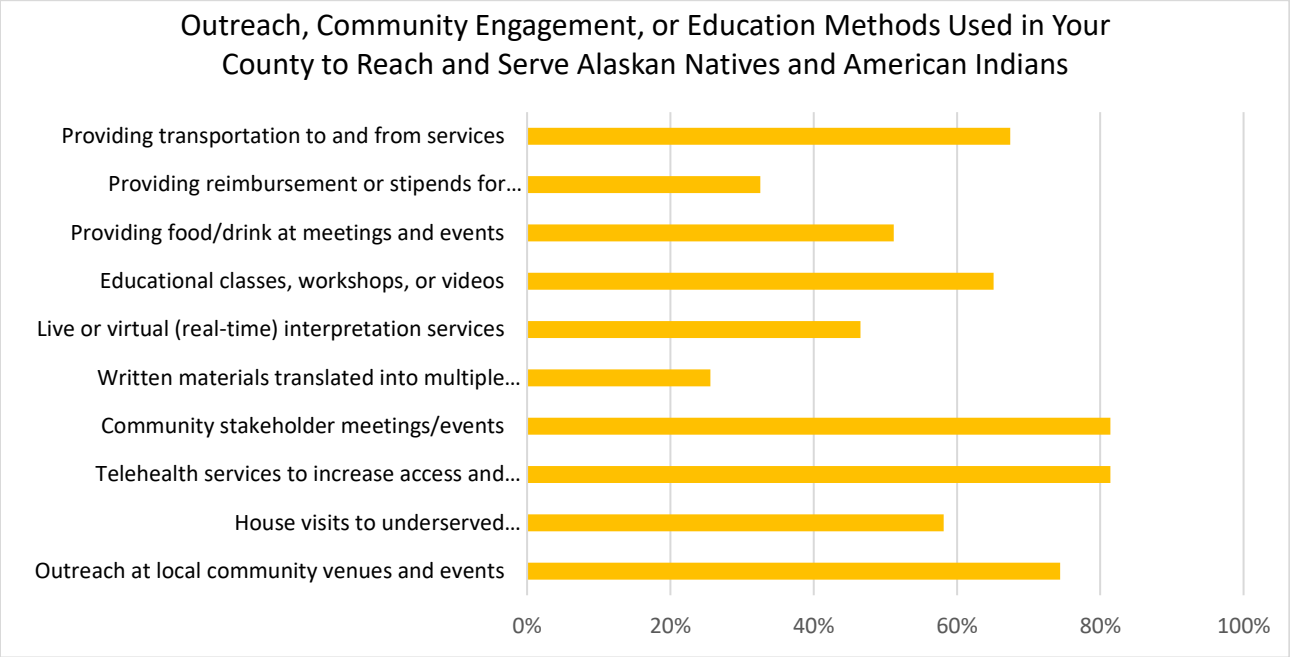


Figure B. Asians and Pacific Islanders

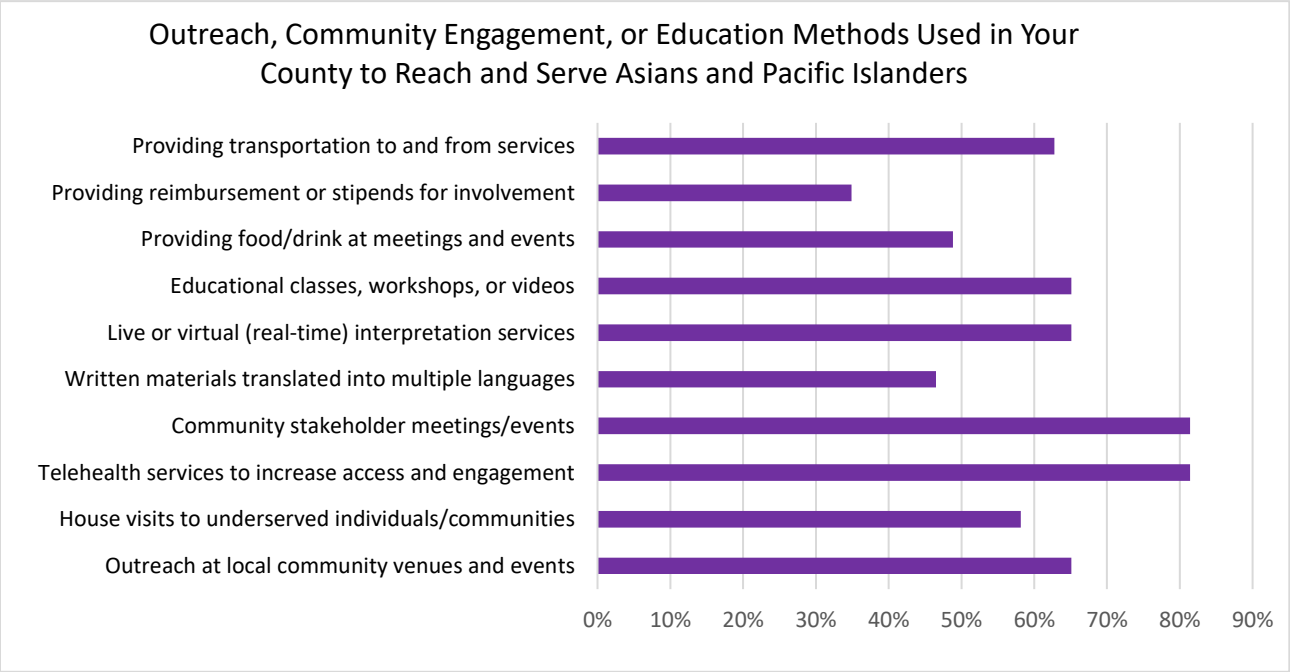


Figure C. Blacks / African Americans

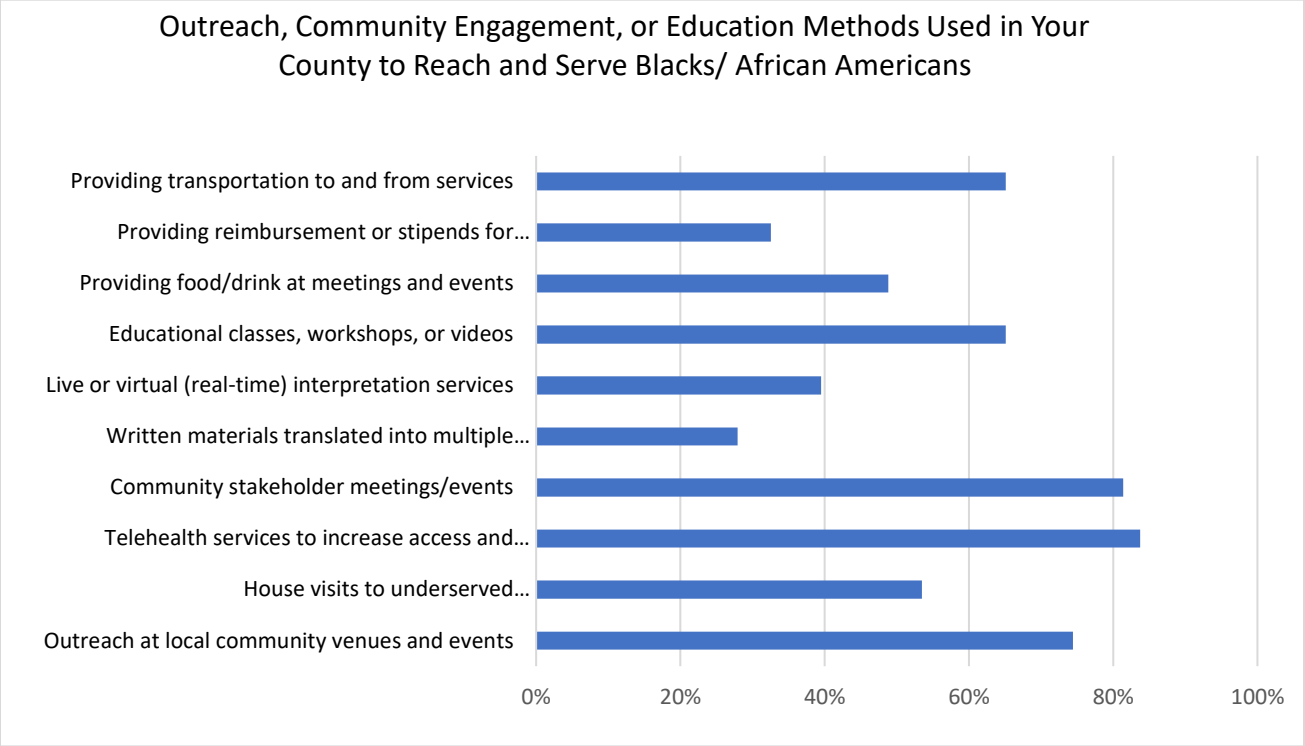


Figure D. Hispanics/Latinos

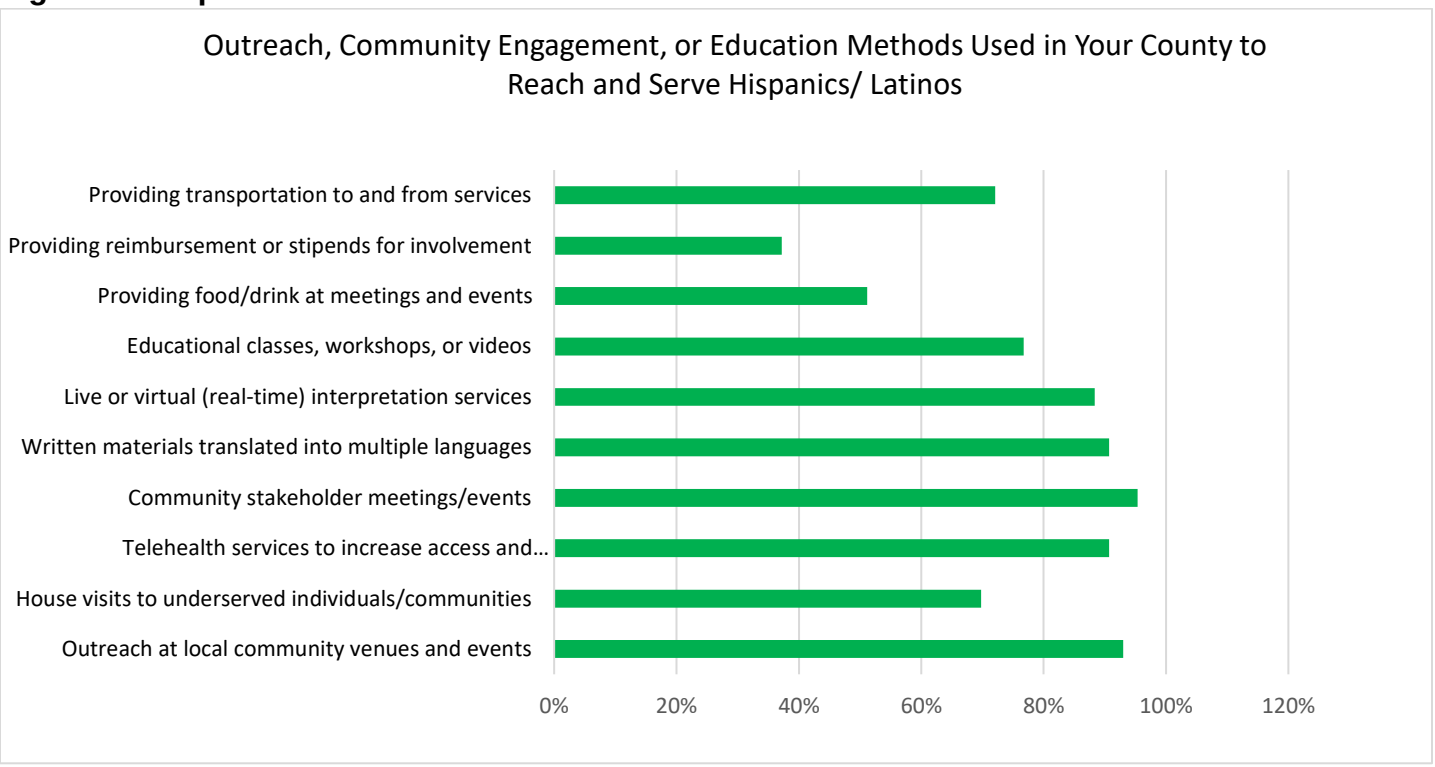


Figure E. Persons of More than One Race/Ethnicity (or of a Group not Listed)

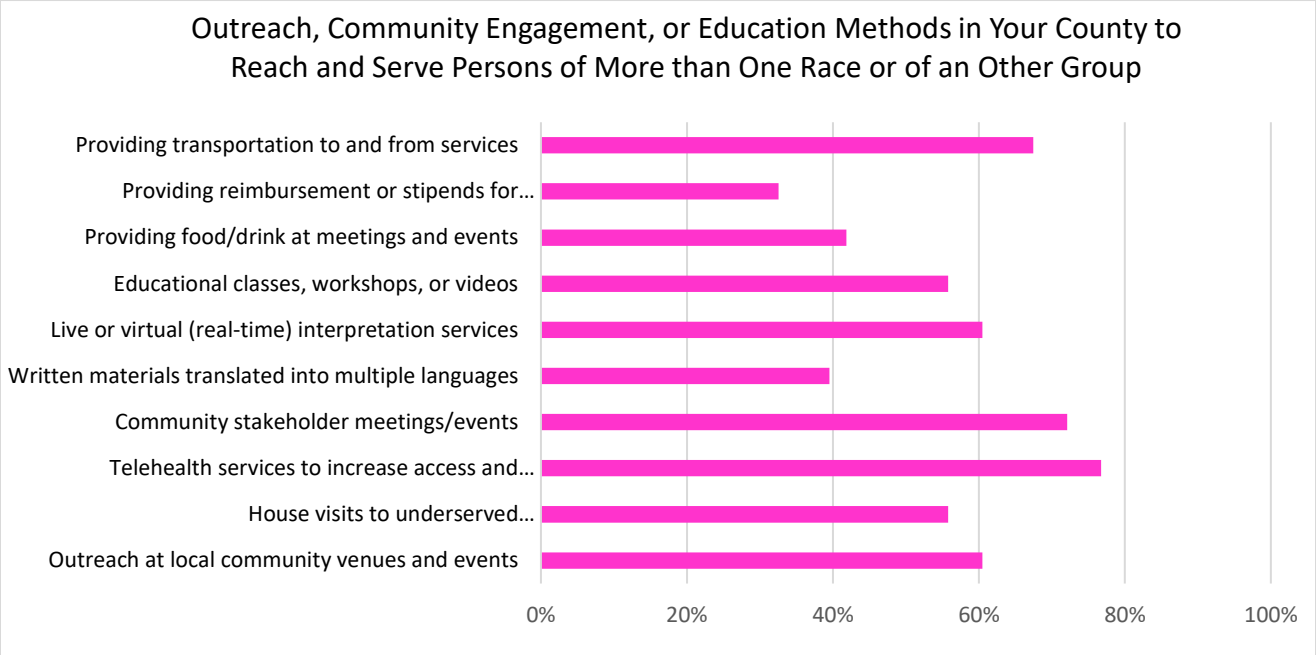
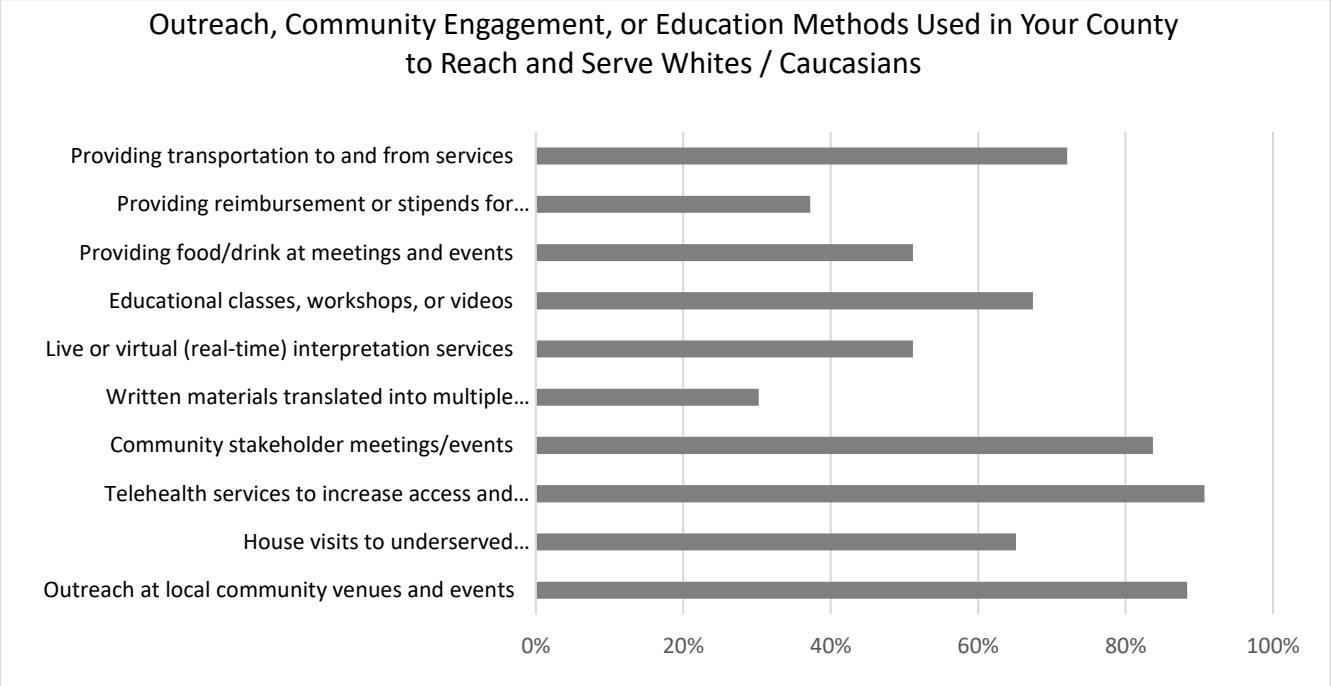


Figure F. Whites/ Caucasians



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Appendix IV, for Detailed County Responses to Question 15

'Other' Strategies Used for Development of a Diverse Workforce

Butte and Glenn Counties:

- Chico State University BSW and MSW Internship program, and
- Other on-line colleges with related programs.

El Dorado County: Formed a Cultural Competency Workgroup to identify options.

Kern:

- Cultural Discussions in Supervision, Recruitment: Partnering with community agencies on recruitment events, behavioral health programs in universities to recruit for hard to fill positions such as recovery specialists, therapists, nurses, psychologist, etc.
- Internship placement opportunities, e.g., at The Center for Sexuality & Gender Diversity.
- Other forums that cultivate inclusive workplace and listening sessions include: town halls, Behavioral Health Board Meetings, Cultural Competence Resource Committee, Good Governance Workshops, System Quality Improvement Committee, community event recruitments

Lassen and Napa Counties: Providing a stipend for staff who speak/write Spanish.

Mono County:

- We adopted Core Values: Justice, Equity, Diversity and Inclusion (JEDI).

Sacramento County: Webinar on how to apply for BH jobs with the County.

San Benito County:

- New BH building promotes culturally diverse and inclusive services and allows input from staff to identify needs of diverse clients and staff.

San Bernardino County**:**

- Targeted outreach, for example, a job fair that highlighted males in the nursing field, as they are an underrepresented population in nursing.

San Francisco County: Culturally specific trainings

San Joaquin County:

- Stakeholder engagement through monthly MHSA Consortium meetings, and

- Monthly BHS Cultural Competency committee meetings.

Santa Barbara County: Internship opportunities for clinical and non-clinical positions.

Santa Clara County:

- The Division of Consumer Affairs, Family Affairs, Cultural Communities Wellness Program includes peer leads in management meetings, provides coaching, support, guidance and practice in management/leadership roles for peer leads.

Sonoma County**:**

- The goal of the WET (Workforce, Education and Training) component is to develop a diverse workforce. Individuals with lived mental health experience and DHS BHD staff and contractors are given training to promote wellness and other positive mental health outcomes.
- WET funds are also used to promote and expand the cultural responsiveness of DHS BHD system of care.
- In order to improve cultural responsiveness and continue to develop the Division's workforce the Division has created a new position: Diversity, Equity, and Inclusion (DEI) Development Manager. Historically, this position has been referred to as the Ethnic Services Manager (ESM).
- Each county Mental Health Plan (MHP) in California (CA) has an ESM and this position reports directly to the Behavioral Health Director.
- The Ethnic Services Manager (ESM) is responsible for ensuring that counties meet cultural and linguistic competence standards in the delivery of community based mental health services.
- ESMs function as the liaison between the county and cultural groups in their communities and are tasked with the development and submission of CA county's cultural competence plans consistent with Cultural Competency Plan.

Tulare County: Leadership Academy

Ventura County:

- Volunteer/shadow opportunities
- Engaging vocational schools, community colleges, colleges and universities.

Yolo and Nevada Counties:

- Peer Workforce Development Workgroup
- Loan repayment incentives through WET (Workforce, Education, Training) funds.

Appendix V. for Detailed Responses to Question 16.

Examples of a Variety of Strategies that California Counties Use to Meet their Requirements for Cultural Proficiency Training (CLAS)

Alameda County: Culturally and linguistically appropriate services (CLAS) trainings.

Amador County

- ACBH provides various cultural proficiency training to staff. All ACBH contract providers have in their contracts that they will provide ongoing cultural competency training.

Butte County

- Per BCDBH Policy 068, all BCDBH staff and contracted providers are required to attend one cultural competency training per fiscal year.
- The Department offers multiple trainings on a variety of cultural competency related topics through electronic learning management system, 'Relias' in-person and virtual trainings, webinars, and Grand Rounds to accommodate staff needs and schedules.

Calaveras County

- Numerous trainings were conducted, including (but not limited to) training on awareness and needs for transitional age youth, older adults, LGBTQ+ community and veterans.
- Subjects also include substance abuse issues for youth, adults and veterans and PTSD, 5015 crisis/suicide ideation, understanding "recovery", cultural and mental health issues for paraprofessionals, overweight and obesity, and human trafficking: sexual exploitation and intimate partner violence.

Colusa County: CCP goal is to provide quarterly cultural humility training to all staff.

Del Norte County:

- Our Behavioral Health Branch provides annual cultural proficiency training along with multiple other small trainings every fiscal year.
- The County also holds monthly Cultural Competency meetings open to our community, including all county staff and all are welcome to attend.

El Dorado County:

- All Specialty MH Services providers are required to take cultural proficiency training.
- Hours of cultural proficiency training per 12 month period are recorded on the Provider Directory and in the Network Adequacy Tool submitted annually to the state of CA.

Fresno County:

- All contracted providers are required to complete annual training and to provide documentation of such training.

- DBH staff receive foundational training annually. The 'Relias' platform used allows DBH staff and contracted providers to access an array of training in the area of culturally responsive care.
- Trainings provided for the system of care include HEMCDY, REIA, CLAS and interpreter. Information on training efforts is also outlined in the annual Cultural Competency Plan 'Delivered with Humility.'

Glenn County:

- One of the goals in the Glenn County Cultural and Linguistic Competency Plan (CLCP) is to create a work climate where dignity and respect are encouraged and modeled, so that everyone enjoys equitable opportunities for professional and personal growth.
- The county supports staff by providing cultural and linguistic competency trainings for GCBH staff a minimum of 8 times per fiscal year.
- Glenn County Behavioral Health also provides interpreter and language line training to all new hires and existing staff at least once each fiscal year, and
- Periodic trainings for bilingual staff to ensure consistency and common language across all bilingual staff.

Imperial County

- Annual training for cultural competence is required for all staff.
- For FY 21-22, a consultant was hired for training all staff on LGBTQ; tracks were separated for clinical and clerical staff.
- Training was conducted during September and October 2021.

Kern County

- We offer Cultural Competence trainings throughout the year.
- Minimum required training for staff is 6 hours; however the average cultural competence trainings completed for staff is 30 hours, exceeding the required hours.
- Trainings are offered in multiple platforms such as on-site, on-line and virtually through 'Relias' Learning System, Zoom, and/or Webex trainings, cultural competence events, town halls and community symposiums, etc.
- These trainings cover a range of topics including the national CLAS standards, the California Cultural Competence Plan Requirements,
- Providing services for diverse population categories including ethno-racial, sexuality and gender, veterans, age groups, socioeconomic groups.
- Additional topics covered include best telehealth practices for diverse communities and BIPOC (Black, Indigenous, People of Color), implicit bias, intergenerational and racial trauma, and of course
- Our Multicultural Clinical Supervision year-long training series that delves deep into how culture informs various aspects of clinical supervision.

Kings County:

- We have cultural competency trainings including CEUs and workshops as required for the MHP.
- Some providers also have LGBTQIA specific training.

Lassen County

- Each year BH staff are required to take training in cultural humility training which incorporates the CLAS Standards.

Madera County:

- Madera County BHS leverages 'Relias" Learning Management to offer continuous training on discrimination, cultural competence, and interacting with diverse staff.

Marin County:

- BHRS requires that its staff and providers complete cultural humility trainings each year.
- Recently, BHRS has added a requirement for staff to attend not just cultural humility trainings, but also LGBTQ+ trainings and working with interpreters.
- BHRS provides both internal and externally referred training opportunities for staff and providers to meet this requirement.

Mariposa County:

- Minimum of annual training based on the Cultural and Linguistic Committees Plan.

Mendocino County: All staff and providers receive training regularly.

Merced County:

- Trainings: Implicit bias, multi-cultural, inclusion and diversity,
- Culture specific trainings: Latinx, African American Spirit,

Mono County:

- MCBH contracts with Dr. Jei Africa for regular training sessions in cultural competency.
- So far there have been 10 trainings between October 2020 to August 2021.
- MCBH hosts bi-weekly "In-Service" staff trainings in which cultural competency is a frequent topic.
- Each year MCBH hosts an LGBQT+ training, typically during Pride month (June).
- Historically, MCBH has received Gathering of Native Americans (GONA) facilitator trainings; however, this has recently been on hold due to COVID-19.
- MCBH is currently seeking additional training for Spanish speaking providers through the Spanish for Professionals Institute.
- On the County level, Mono County has created a Justice, Equity, Diversity and Inclusion (JEDI) committee in which the Board of Supervisors provides county-level cultural proficiency trainings.

Monterey County: has a mandate for staff to participate in 6 hours of cultural proficiency yearly.

Napa County:

- Multi-session LGBTQ+ sensitivity training;
- "Connect to Inclusion" (3 hour program)
- "Embrace Equity" (2-3 hour program

Nevada County:

- We provide an annual training on some topic related to building cultural proficiency.
- Last year, for example, we brought in a half day training on implicit bias.

Orange County:

- All trainings must be reviewed by the Ethnic Services Manager (ESM) before they are finalized and advertised to ensure cultural considerations have been incorporated throughout the training.
- Most trainings developed by Behavioral Health Training Services (BHTS) qualify as a cultural development training.
- In FY 19/20, 82 trainings qualified as a cultural development or cultural competency training.
- Furthermore, a specific 1-hour cultural competency training is required for all BHS staff and contract providers to complete annually.
- For FY 20/21, the training was called "Cultural Competence 3.0 Unconscious Bias in the Workplace."

Placer County:

- System of Care network providers, service delivery, supervisory and management staff are required to participate in at least one training annually inclusive of cultural linguistic competency components.
- Systems of Care has a goal of offering trainings at least annually, specifically targeted to increase understanding and responsiveness to diverse cultures.

Plumas County:

- Ongoing cultural competency training for diverse populations within our county (Native Americans, veterans, senior citizens, LGBTQ, Latinx).

Sacramento County:

- We provide annual required cultural proficiency training for behavioral health staff and providers. This year the focus is on eliminating inequities

San Benito County:

Senta Burton, Cultural Proficiency Trainings and Mathew Mock, Psy.D. presented trainings on:

- The Imperatives of Effective Behavioral Health Services: Engaging Cultural & Ethnic Populations.

- Cultural Competence and Human Diversity: Effectively Working as Support Service Staff and Teams.
- Bilingual Staff and Interpreters in the Therapeutic Relationship

San Bernardino County:

- Department has a Cultural Competency Training Policy (CUL1014) in place.
- Staff are required to take Annual Cultural Competency Training.
- Supervisors monitor staff training annually as part of their workforce performance evaluations.
- In FY 20/21 the county provided 15 live virtual trainings to staff and providers.

San Diego County:

- BHS provides Cultural Competence Academy annual training and education for BHS providers. Providers have a minimum of 4-hour Cultural Competence requirement.
- The Cultural Competency Academy is also available for BHS staff, as well as Diversity and Inclusion training.

San Francisco County:

- Primarily trauma informed care, racial equity, transgender trainings, unconscious bias, diversity in hiring.

San Joaquin County

- All BHS staff and contractors are required to take a cultural competency training entitled, “Improving Cultural Competency for Behavioral Health Professionals”

Santa Barbara County:

- Annual Cultural Competency Trainings are mandated by DHCS that include, but are not limited to Cultural Formulation, Multicultural knowledge, Cultural Sensitivity, Cultural Awareness and Social/Cultural Diversity,
- Interpreter(s) in the Behavioral Health Setting and training staff in the use of behavioral health interpreters.
- Per policy, all staff and contracted providers must attend Cultural Competency trainings.
- These trainings are provided by subject matter experts in the field (live or via Zoom) via our training platform ‘Relias’, as well as through learning opportunities provided by various behavioral health organizations.

Santa Clara County: County offers these trainings throughout the year:

- Advancing Suicide Prevention and Clinical Management for Diverse Clientele
- Asian Americans: Complexities for Effectively Serving Diverse Communities including Language, Bi-Lingual Staff and Interpreters in the Therapeutic Relationship
- Building the Beloved Community Through Cultural Humility, Client Culture
- Cultural Humility: Looking inward to create systemic change,

- Eating Disorders In Trans Communities
- Family Acceptance Project: Helping Families to Reduce Health Risks & Promote Well-Being for LGBTQ Children & Youth
- Furthering the Foundations of Culturally Responsive Services: Optimizing the Practice of Cultural Humility Through CLAS for Direct Service Staff
- Furthering the Foundations of Culturally Responsive Services: Optimizing the Practice of Cultural Humility Through CLAS for Non-Direct Service Staff
- Gender Wheel Training : Changing How We Think and Talk about Gender – (Part I Reorientation, Part II Hands-On Practice, Part III Implementation)
- QIPS: Intentional Peer Support through an LGBTQ+ Lens (10 days)
- RISE: Sexual Orientation, Gender, Identity and Expression Core Training,
- LGBTQ+ Clinical Academy: Foundations, Theory and Intersectional Identities (Part I, II and Part III)
- Trans Youth Care: Comprehensive Approach to the Care of Gender Non- Conforming Children
- Transgender Youth & Young Adults, Understanding and Addressing Racial Trauma, and Writing the Support Letter: Assessing and Planning for Gender Affirming Procedures.

Santa Cruz County:

- CLAS Plan - Culturally and Linguistically Appropriate Services Plan submitted to DHCS.

Shasta County:

- On an annual basis, Mental Health Program staff receive cultural competency training, ensuring that a variety of topics and cultures are discussed.
- Additionally, staff receive interpreter training for awareness on use of interpretation services.
- The Cultural Competency Committee also brings cultural enrichment through "cultural sharing," where staff on a bi-monthly basis attend an hour-long presentation on culture and history.

Siskiyou County:

- Yes, all county staff and contracted providers are required to complete courses in cultural proficiency on an annual basis.
- The county provides training both via ‘Relias’ and in person.
- Training on CLAS standards is required of all staff.

Stanislaus County:

- All BHRS Employees are required to complete a minimum of (2) hours of training related to the topic of Cultural Competency per year.
- BHRS Training continues to promote access to free trainings and educational webinars from various nationally-recognized behavioral health organizations that focused on providing sensitive, responsive, and effective services to clients related to cultural competency.

- Organization include but are not limited to: California Institute for Behavioral Health Solutions (CIBHS), National Council for Behavioral Health, National Association for Alcoholism and Drug Abuse Counselors (NAADAC, the Association for Addiction Professionals), HealthNet, PESI and more.
- Some of the these trainings included:
  • Adolescent Substance Use Current Trends and the Impact of COVID-19
  • Historical and Ending Contemporary Racial Inequities
  • SAMHSAs Veterans Best Practices and Systems of Support for Justice-Involved Veterans
  • LGBTQ+ Health Equity Pronoun PSA Effects of COVID-19 on Mental Health
  • Adverse Impacts of COVID-19 on Children with Serious Mental Emotional Disorders
  • Stanislaus State Black Trans discussion
  • Youth AFFIRM Program Black LGBTQ Pioneers Trans Healthcare
  • The Line Between Authenticity and Bias
  • Reimagining Engagement to Foster Diversity and Equity
  • Critical Clinical Conversations About Race Racial Identity and Racism Virtual Training
  • How Culture and Race Can Impact Identifying and Treating Mental Health Conditions
  • Engaging Older Youth to Help Them Navigate the New Normal
  • Transgender Awareness: Moving Beyond The Basics
  • Ask the Experts – Trauma-informed Care, Cultural Humility and the Impact of Supporting Individuals with IDD
  • Responses to Q&A - Eliminating Inequities in Behavioral Health
  • Virtual Conference on First-Episode Psychosis with Culturally Informed Care
  • Virtual Homelessness Summit Registration
  • Talking About Race and Racism With Clients_ Challenges_ Benefits & Strategies for Fostering Meaningful Dialogue
  • Minority mental health_ racial trauma_ and cultural competency
  • Online 2020 Suicide Prevention Summit
  • Therapeutic Support When Working with Young Children (0-5) and Caregivers in a Virtual Setting
  • Evidence-Based Practices 2020 Symposium
  • Complex Trauma Workshop: The Connection Between Mental Health, COVID-19 and Social Unrest

<u>Sutter-Yuba Counties:</u>

- Each staff member attends at least one hour of cultural competence training either in person or virtually.
- We have made cultural competency courses available through online learning management system, Relias.

<u>Tulare County:</u>

- There is an annual Cultural Competency Training as part of everyone's training plan in ‘Relias.’

- We will have a Mental Health Interpreter Training scheduled for early 2022. We have sent staff to multiple conferences with topics related to cultural competency.
- 'The Source' is contracted to put together LGBTQ+ training for our staff through the 'Connectedness to Community' program. Those trainings are currently being developed.
- We are also completing a contract with a Consultant to help us organize our Cultural Competency Committee so that we can better determine training needs throughout the MHP.

Ventura County

- Cultural Competency: Juvenile Justice with Hispanic and Latino Youth;
- LGBTQ RISE training;
- Cultural Competency: Start Again, Not Over;
- Cultural Competency, Health, Mental Health & Spirituality;
- Cultural Competency-Reflections: What Do We Know About Us?;
- Cultural Competency - Building a Culturally Informed Framework for the Delivery of Behavioral Health Services with CLAS (4 trainings);
- LGBTQ Rise training with Dr. Stroud;
- Cultural Sensitivity and Diversity

Yolo County: 'Relias' online portal; Cultural Competency Monthly Training opportunities.

Appendix VI. Responses for Question 17. With which of the following does your county have difficulty in regard to providing culturally responsive and accessible mental health services? Under "Other", please list or describe.

Amador County:

- Getting certification for translators and interpreters

El Dorado County**:**

- Engagement (not just outreach) of racial/ethnic minority communities in mental health services
- Staff feeling as if they can't take time for training when caseloads are so high.

Imperial County:

- Retaining nurses and clinicians in is difficult due to very competitive salaries elsewhere.

Kern County:

- Similar to most counties, there are challenges in recruitment and retention for bilingual and/or diverse staff, especially licensed professionals.
- County procedures sometimes make it a challenge to recruit due to county policies, including limitations on obtaining demographic data.

Kings County:

- Outreach staffing is limited as well as bilingual staff to perform outreach.

Mendocino County:

- Employing and retaining staff is difficult for our rural community.

Orange County:

- Employing and retaining culturally diverse staff and providers, and outreach to racial/ethnic minority communities.
- Continuous recruitment for bi-lingual and bi-cultural behavioral health providers is necessary, and is accomplished by HR advertisements and targeted recruitments.
- Efforts to increase pipeline recruiting at local high schools, community colleges, and colleges/universities is ramping up with the OSHPD WET Grant which provides a stipend for internships.
- Existing employees are now eligible for loan repayment programs, especially those employees that speak another language.
- Outreach to racially and ethnically diverse communities is done through the Behavioral Health Equity Committee (BHEC) and other community activities, i.e. MHSA Community engagement meetings.

Sacramento County:

- Outreach challenges due to barriers regarding mental health stigma within several diverse communities.

San Benito County:

- Provide additional services and outreach to older adults in the county.

San Bernardino County:

- Employing culturally diverse staff, specifically for remote Mountain and Desert areas of the County.
- Need for bi-lingual, bicultural persons in addition to existing workforce shortage is exacerbated due to COVID-19.

San Diego County**:**

- The County of San Diego strives to provide outreach to unserved/ underserved communities - including racial/ethnic minority communities - through community engagement and outreach efforts.
- Limited workforce availability affects the entire system and impacts workforce diversity (including a shortage of clinicians).

San Francisco County:

- The current BHS/DPH system is unable to adjust quickly to the rapidly changing landscape, i.e., fentanyl treatment, direct care, language issues.

Santa Barbara County:

- Connecting with trusted sources is key, but is labor-intensive and takes time.

Santa Clara County:

- Providing services to the hearing and/or visually impaired.

Shasta County:

- The MH Program has difficulty in staff and provider employment and retention, regardless of cultural diversity.
- Our county does not have a threshold language, so live translation services are limited to the top two languages spoken.
- Other interpretation services available by telephone.

Ventura County:

- Increased efforts for culturally responsive and accessible MH services

Appendix VII. Detailed Data and Graphs for Services and Programs Most Commonly Used by Various Demographic Groups, in response to: Question 21. Which providers or services have been employed, utilized, or collaborated with, to serve the following racial/ethnic populations in your county? Select all that apply

Figure A: Services and Activities Used by Alaska Natives and American Indians

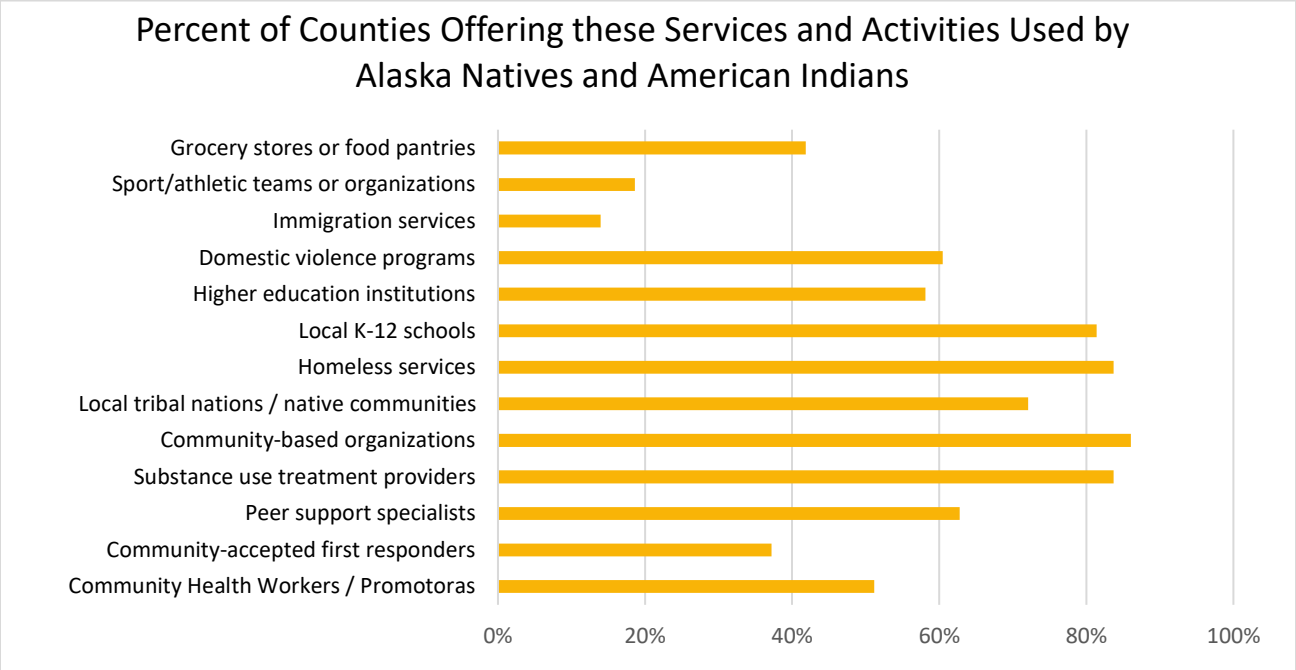


Figure B: Services and Activities Commonly Used by Asians and Pacific Islanders

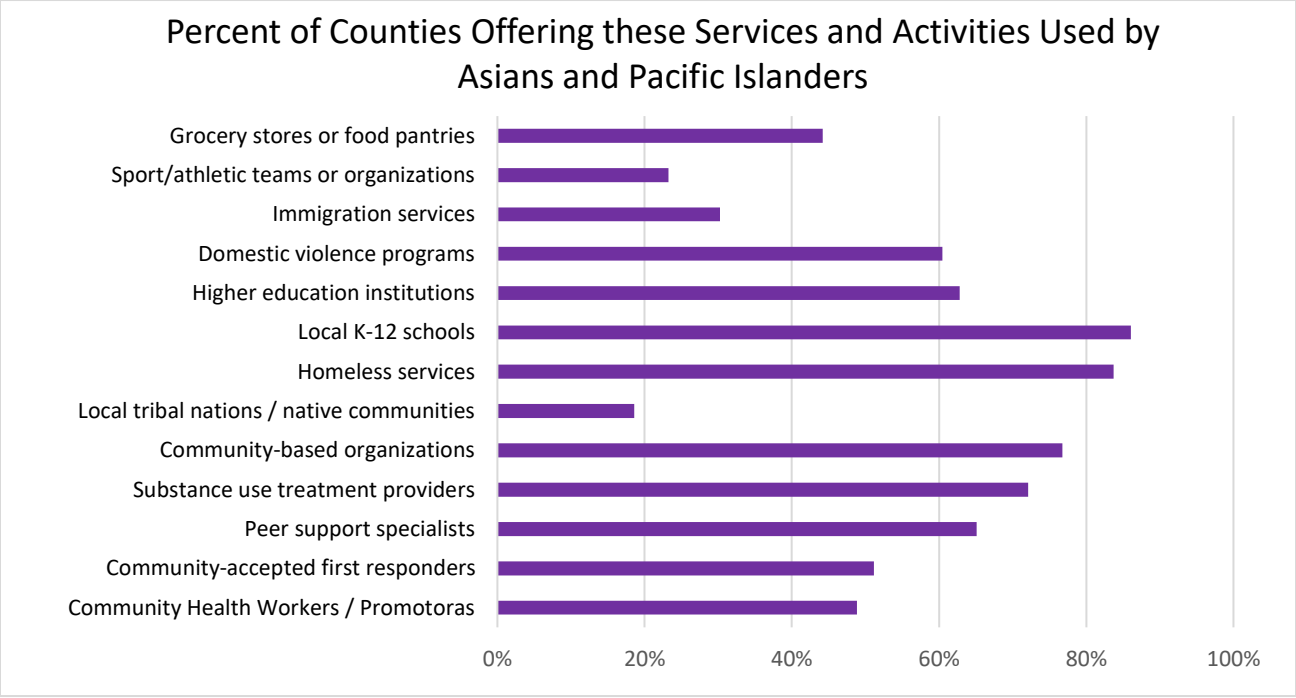


Figure C. Services and Activities Frequently Used by Blacks /African Americans

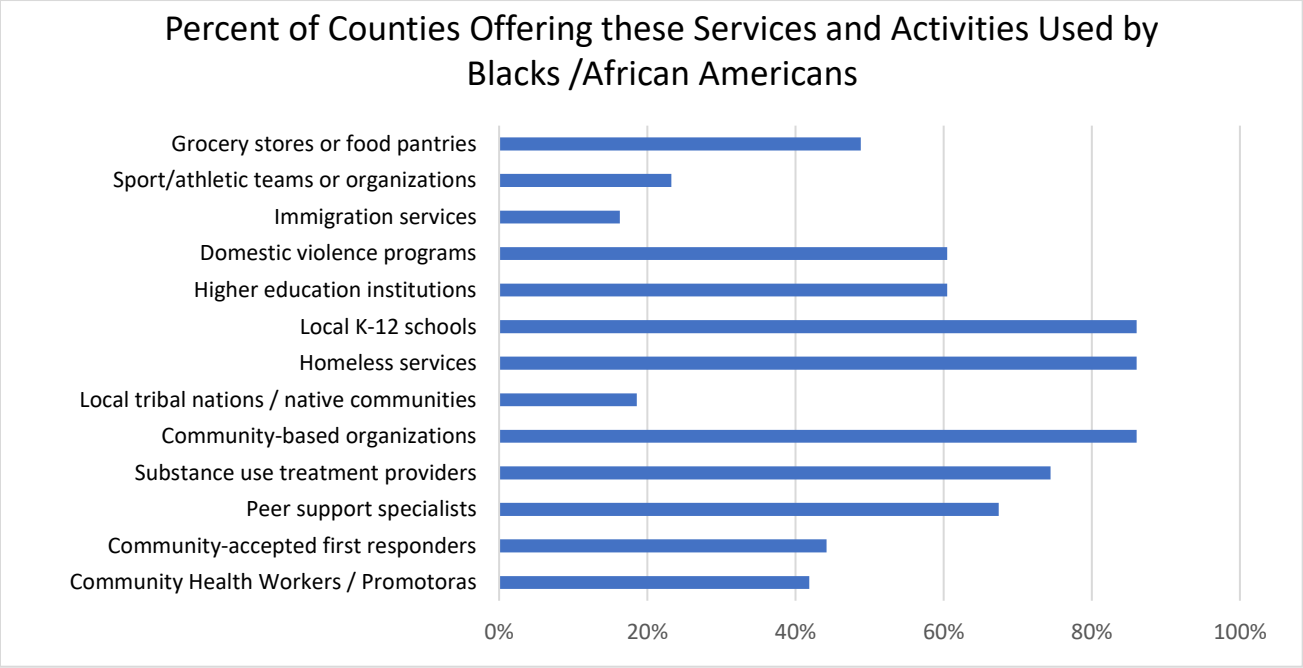


Figure D: Services and Activities Frequently Used by Hispanics / Latinos

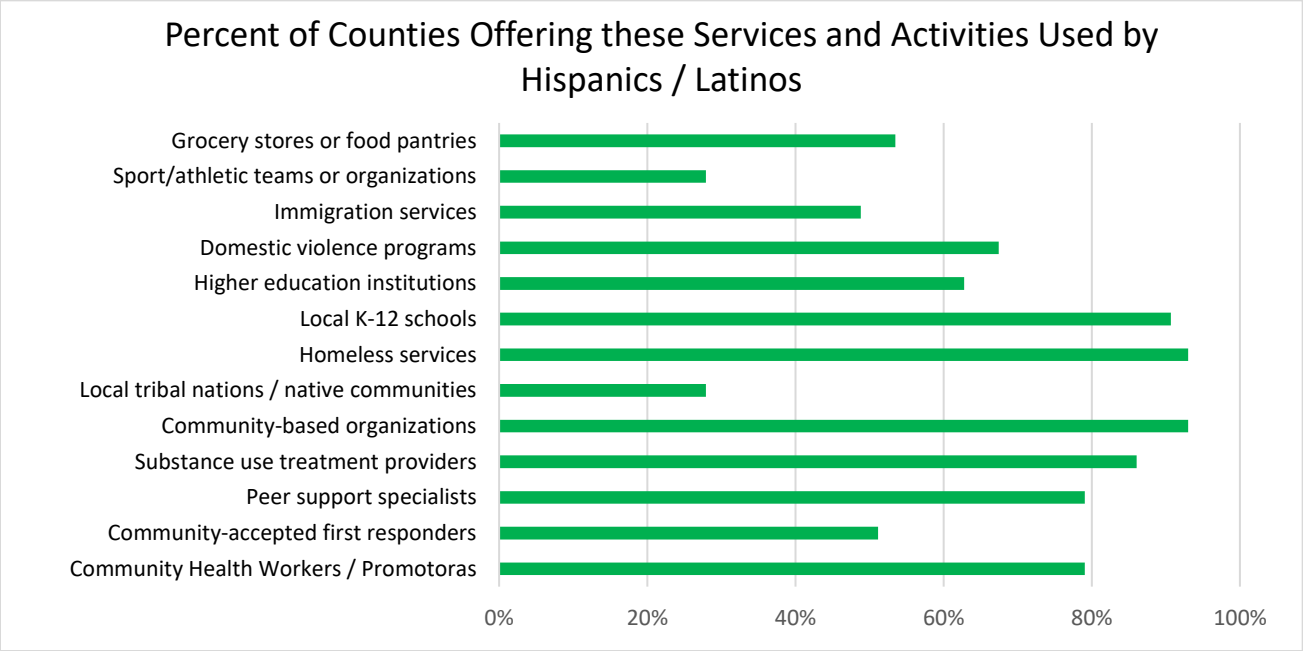


Figure E: Services Commonly Used by Those of More than One Race-Ethnicity, or of a Group Not Listed

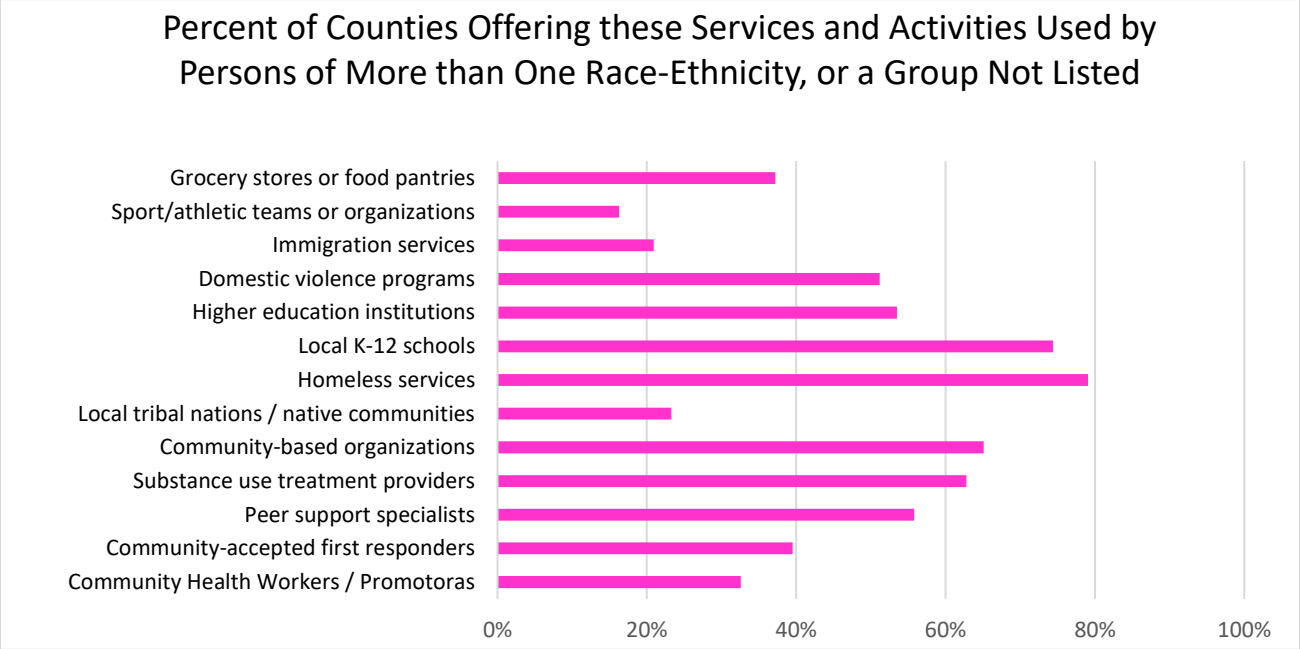
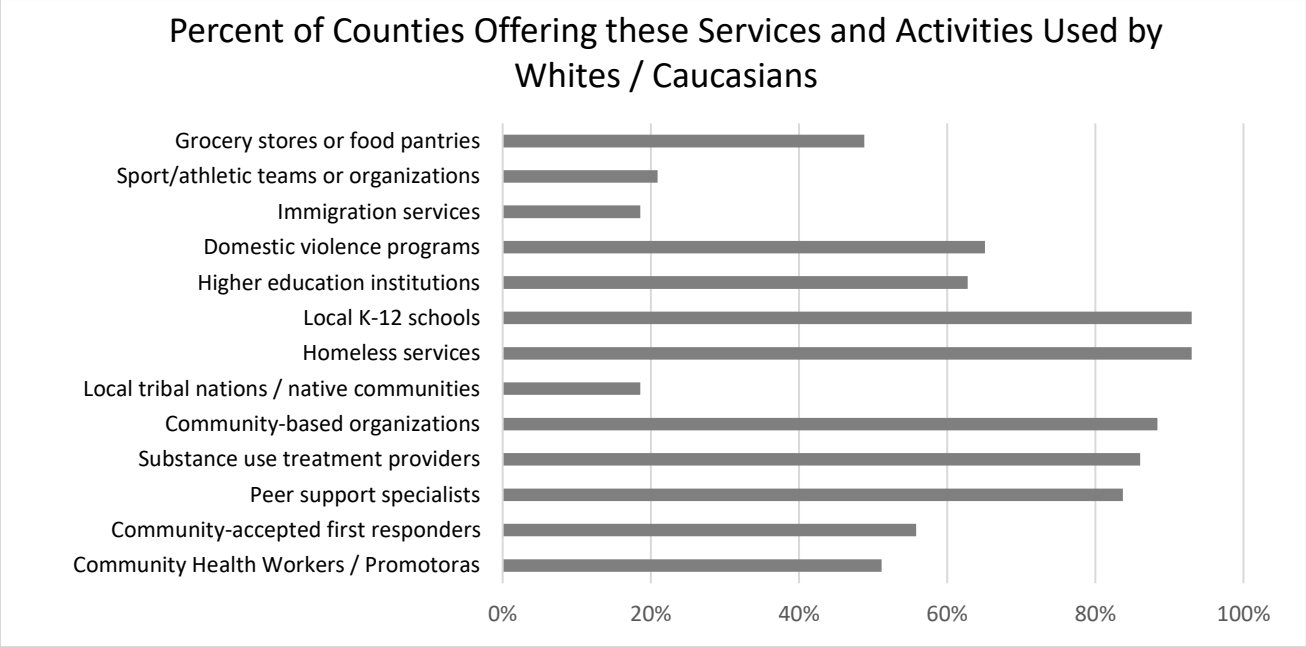


Figure F: Services or Activities Frequently Used by Whites / Caucasians



Appendix VIII. In partial response to Question #21, under "Other" Services, Agencies or Organizations with Whom County BH Interacts to Serve their Diverse Population.

Fresno County

- Services marked "N/A" were attributed to restrictions due to the COVID-19 pandemic.
- This limitation applies to a variety of services/activities in active use prior to March, 2020.

Kern County Partnerships and collaboration with:

- Bakersfield Sikh Population & Indian Community, Adventist Health, Black Infant Health with Public Health
- School Districts, LGBTQ+, BAIHP, Owens Valley Career Development Center (OVCDC)
- Other Faith-Based groups, RSA-CFLC, Sports-CSOC, TAY & Friday Night Prevention Team
- Refugee populations such as Central American.

Mendocino County

- Many members of our community do not identify in the categories provided. The use of these targeted labels does not represent the complex ways that individuals choose to identify.
- Note that for impact related to telehealth, there is no data to support conclusions of impact, so it is marked 'neutral' for all groups.

Monterey County: County BH has a contact with Centro Binacional.

Sacramento County: Religious organizations and community elders.

San Bernardino County:

- County Agencies: Transitional Assistance Department (TAD), Department of Aging and Adult Services (DAAS), Sherriff, Law Enforcement, Police Department, Department of Public Health (DPH), Children and Family Services (CFS)
- County Hospital (Arrowhead Regional Medical Center) and Preschool Services Department (PSD)
- Homeless Court for all races/ethnicities.
- Federal Emergency Management Agency (FEMA) aid during pandemic and disasters.
- Sport/athletic teams or organizations (not during FY 20/21 but prior to COVID), partnered on Mental Health Awareness with Los Angeles Chargers, Ontario Reign and Ontario Fury.

Santa Barbara County: Needs in our Mixteco community

Sutter-Yuba Counties: We have a very active Casa Esperanza group that focuses on domestic violence and victim services and shelter.

Ventura County: Laundromats and churches may have sources of information.

Appendix IX. Counties' Suggestions and Goals to Improve Outreach to Underserved Communities. In partial response to Question 22.

Alameda County**:**

- Identify culturally specific ways to increase Asian American penetration rates; listen to our Asian American communities, which include staff on effective ways improve access
- Disaggregate API data to closely examine the trends and specific needs for Pacific Islander populations
- More intentional focus on the LGBTQ+ community, more funding, services and programs.
- A more coordinated approach on African American needs, which includes more funding for culturally affirming programs and the identification of a central and accessible location for the African American Wellness HUB in Oakland.
- Development of a Latino/Latinx Community Advisory Board.
- Re-commissioning of the African American Utilization Report
- Development of an Asian American Steering Committee
- Conduct a comprehensive needs assessment for the Afghan/Afghan American community

Amador County:

- As a result of COVID-19, our outreach efforts stopped and then had to be transitioned to virtual formats. As the pandemic improves, we hope to re-engage with the community by incorporating in person outreach activities safely.
- Our hope is to utilize peer support to re-engage our community in our various outreach efforts.

Calaveras County:

- The department and MHB are attentive to identifying underserved groups/clients, but are forced to triage improved outreach and programs for underserved groups, given limited resources, both financial and professional availability.
- This really is a matter where more resources and more staffing would make a difference.

Colusa County:

- More staff
- More time allowed to attend events.

Del Norte County: Board members plan to continue to monitor outreach efforts.

El Dorado County:

- Utilize community hubs and service organizations that focus on underserved groups, e.g. Family Resource Enter in South Lake Tahoe.

- Reach out through employers whose workforce contains a number of the underserved as a means of getting information to them. Similar to the program EDC instituted to vaccinate AG workers in rural areas.
- Expand the 2-1-1 information network as a way to provide outreach and to connect consumers with services.

Fresno County:

- Collaborating with faith-based groups, community centers, and other places of non-behavioral health-based organizations and groups would allow for more thorough understanding and integration of services for the targeted populations.
- Create marketing literature using non-technical simple language.
- Behavioral Health Board can assist in expanding outreach by hosting additional community forums accessible by the identified target populations.

Glenn County:

- Behavioral Health staff coordinates services with Ampla Health, the local Federally Qualified Health Center (FQHC) to improve outreach to persons who are underserved.
- The Behavioral Health Department also utilizes the Outreach Case Manager to provide access, linkage, and outreach to promote suicide prevention and stigma reduction activities, as well as to coordinate the efforts of all Outreach staff in the county to distribute information and resources to diverse underserved groups.

Imperial County:

- Increase professional public relations, presence of community service workers at local events, public service announcements to break the stigma about seeking behavioral health services.

Kern County:

- When having community events or focus groups, having someone that speaks the preferred language may improve attendance and engagement.
- Enhance community engagement, partnership and collaborations, increase listening sessions for specific diverse groups.
- Enhance internship placement opportunities in diverse programs with community partners such as The Center for Sexuality & Gender Diversity.
- Enhanced additional support for children and family services from age 9 through High School-Prepare U Program.
- Increase sub-committee participation and space for focused discussion of improvement strategies for enhanced outreach to specific populations such as individuals experiencing homelessness utilizing programs such as ‘ROEM’ and ‘Navigators’.

Kings County:

- Yes, recommendations from Kings County include more funding for this purpose and for increasing the capacity of outreach staff and the number of available bilingual staff.
- It would be beneficial to hire staff that speak languages other than English and Spanish.

Lassen and Mariposa Counties:

- Additional funding is needed specifically for outreach.

Madera County:

- Madera County BHS is interested in enhancing our community engagement with multiple underserved groups.
- MCBHS is interested in building our partnerships with the local education agencies to assure accessible behavioral health services are available to youth. These services can consult with parents, teachers, and other school-based stakeholders. These programs could be enhanced by specialized service and funding opportunities specifically for immigrant youth and children of immigrants who may distrust the public service system.
- In addition, MCBHS suggests building partnerships with local superior court systems, district attorneys, public defenders, and other justice partners to assure individuals that can benefit from behavioral health services, receive them. Funding sources incentivizing these partnerships similar to AB 2083 could enhance the delegation and collaboration between justice partners and behavioral health.
- Lastly, those that are homeless and at risk of homelessness can benefit from improved outreach. MCBHS suggests funding for non-Medi-Cal covered services to assertively engage chronically homeless individuals.
- Madera County BHS is also invested in developing opportunities to outreach and engage with peer support staff for underserved groups, including: parent partners, youth partners, and youth mentors. These individuals could support service delivery distinct from other professionals by sharing lived experience, common interests, strength development, and natural/community supports outside of the traditional setting.
- Madera County BHS views *promatoras* as pivotal to engaging cultural/ethnic groups that have undergone significant stigma or apprehension towards behavioral health services. These culturally specific services can be embedded in community access points and communicate in practical, naturalistic ways with community members.

Marin County: The Outreach and Engagement Coordinator will**:**

- Provide a minimum of 3 MHFA trainings to a 90% Latinx/Hispanic audience.
- Coordinate meetings with PEI providers to discuss engagement and outreach in underserved in inappropriately served populations of Marin.
- Attend West Marin Collaborative monthly meetings to coordinate and engage with other organizations about BHRS – mental health and substance use services and resources.
- Organize collaborative meetings with other organizations that are currently providing services Marin county communities, such as Multicultural Center of Marin and North Marin Community Services to coordinate partnerships and create groups to offer trainings, presentations and provide resources and support.
- Create new partnerships with at least three faith-based organizations to increase knowledge of BHRS resources
- Create a community outreach calendar tied to community events to engage in outreach (I.e., farmer's markets, Marin Community Clinic, food pantries, *Día de los Muertos*).

- Create quarterly *Promotores*/Community Health Advocates meetings to improve collaboration between all *Promotores* programs and provide standardized trainings
- Strengthen understanding of Outreach and Engagement strategies that are currently happening in Marin, where to support, and where to build.
- Communicate with community partners to avoid overlap of services and to avoid working in siloes.

Mendocino County:

- There is a high level of distrust for governmental institutions making it difficult to create programs to reach underserved populations.
- There need to be more ways to build natural leadership within the communities.

Merced County:

- Merced County continues to develop and implement upstream strategies to improve outreach and programs for our underserved communities.
- BHRS programs provide outreach, engagement, community activities, events, suicide prevention, stigma and discrimination, and builds upon cultural wisdom and continuous support and linkage to resources.
- BHRS has established collaborations with the schools and other community providers to build buffering resources for families to ensure health, wellness, equity and access.
- Identify culturally appropriate stakeholder and data analysis tools that recognize and utilize communities' cultural assets and knowledge.
- Continue to build strong and sustainable relationships and partnerships.
- Create effective community input processes and forums with opportunities for communities to fully participate.
- Strengthen connections with communities through knowledge gathering.
- Enhance Relationships & Engagement.
- Take steps to enhance relationships with under-served populations.
- Develop ongoing quality and responsive services for better outcomes.
- Build personal relationships with the underserved community.
- Create a welcoming atmosphere.
- Increase accessibility.
- Maintain a presence within the community.
- Partner with diverse organizations and agencies.

Mono County:

- Mono County's primary strategies are to continue to establish and grow relationships with other agencies and to continue to be a leader in local cultural equity efforts.
- In 2021, MCBH launched a Community Program Planning Process (CPP) survey, offered County-wide, as part of the MHSA funding stream. The CPP Survey asked respondents to identify what they thought were the top behavioral health issues affecting Mono County, and to identify areas in which MCBH could offer more representative programming to address these BH issues.

- Results showed that respondents felt that there should be an increase in programming for special population, specifically those for LGBQT+ and older adults. In response to this survey, MCBH has expanded its wellness programs to include those specific to LGBQT+ and older adult groups.
- MCBH will continue to survey participants and county residents to see where further improvements can be implemented and to determine if existing programming is fully meeting the needs of the special populations they serve. At this time, MCBH is currently working on other surveys to further identify needs and drive programming and services.

Monterey County:

- Provide services outside the limited hours of M-F, 8-5;
- Use '*cafecitos*' for informal social outreach;
- Partner with libraries, sports groups, grocery stores and faith-based groups

Napa County:

- Publish a regularly-updated, easily-accessed, community-wide online calendar of public and private behavioral and physical health programs and events and proactively distribute it to community and cultural groups, such as senior centers, schools, churches, 'Circles of Care' (AI), Filipino American Association of American Canyon, *Movimiento Cultura de la Unión Indigena*, Latino Cultural Center of Napa Valley.
- Form a NAMI Napa chapter.
- Subsidize Wi-Fi and tablet/smartphone acquisition among underserved groups to increase ability to access services and learn of their availability.

Nevada County:

- LGBTQ+ efforts- consideration for intersectionality/ intersections of oppression (i.e. when someone is a person of color and is also LGBTQ+)

Orange County**:**

- Telehealth services - Improve access to devices, internet, training and support for all ages/groups. Due to strict income requirements, many people in need do not qualify.
- Look into scalable tele-psychiatry solutions.
- Improve outreach to older adults by increasing capacity of those performing outreach.
- More outreach workers focused on actual engaging, expanding Outreach & Engagement
- Alternative methods of contact
- Timing and offering resources at appropriate times
- Inventory all communication materials for online and in-location (county and city facilities) distribution (e.g. OC HCA Behavioral Health Training Center, city and county libraries).

Placer County: As shown in the Board's adopted Goals for 2021-22, the following items are considered for improving services to our underserved groups:

(1) Decrease possible Racism in Placer County with these Activities:
a. Look at anti-racism policy, review diversity and equality, and how the board can take

proactive steps to make sure that this is occurring possibly prevent incidents from happening.
b. This should be centered around the specific population of Placer County and the alleged incidents.

(2). Focus on Diversity, Equity, and Inclusion Activities:
a. Focus on the need for diversity and views for the requirement for workforce as being a key piece for all the agencies providing mental health services within Placer County.
b. Board members may put together a task force to investigate how to move forward in terms of being more diverse, equitable, and inclusive.

(3). Improve Outreach and Collaboration to Consumers and Family Members, and Increase Community Communication Activities:
a. Solicit consumer feedback at board meetings.
b. Create a community calendar on the website so that Community Members can view events.
c. Create a consumer-friendly presence on county social media.
d. Working to meet the family where they are at during Whenever possible provide services at the home to assist and educate the family of their loved one's treatment and family support needs.
e. Board members should attempt to attend community mental health advocate's meetings to listen to others in the community.
f. Schedule the full board meetings in the community.

(4). Invite an arts group and let them perform about mental health; this activity could be a way to communicate to people we serve and to try something different, another way of representing mental health needs and services.

<u>Sacramento County:</u>

- 'Refugee Enrichment and Development Association', a non-profit organization that serves the Middle Eastern / Arabic speaking community suggests the following to improve outreach and programs for its underserved group:

  1. Providing incentives to encourage culturally and linguistically sensitive therapists and mental health practitioners to become Medi-Cal providers,

  2. Facilitating/shortening the licensing process for mental health practitioners who share the same cultural background as the underserved group but who obtained their qualifications in a different country.

  3. Encouraging MH practitioners to offer more internship opportunities to MH students from diverse backgrounds.
- 'Asian Pacific Community Counseling', a non-profit organization that serves the API community suggest the following to improve outreach and programs to the API community:

1. Community Outreach programs must be specific for different Asian and Pacific Islander communities as their needs are varied.

2. The needs are time-specific and change from time to time so service providers must have the ability to address specific needs as they come up. Because County-sponsored programs are program and goal specific and determined more than 18 months in advance, the process does not allow for flexibility for providers to make any meaningful changes in service provision or respond to rapid changing needs within a fiscal year.

3. 'Asian Pacific Community Counseling' continues to address and provide linkages to community members as their needs change, or they have new needs come up due to a changing landscape in the community.

- *'La Familia* Counseling Center' – a non-profit organization that serves the Spanish speaking community-- suggests the following to improve outreach and programs to the Spanish speaking community:

  1. Many Latino families do not have access to the internet or to digital devices where they can access virtual classes and events or complete surveys.

  2. There is a need to do more targeted outreach using ethnic media, TV, Radio, etc. to let people know of services and also normalize getting help.

- 'Iu Mien Community Services', a non-profit organization that serves the Iu Mien community suggest the following to improve outreach and programs to the Iu Mien community:

  1. Providing more culturally relevant materials regarding different sexuality and developing more culturally relevant education material for traumatized communities (refugees).

  2. Provide better trauma-informed care training and resources to service providers.

- 'Cal Voices Older Adult /Warm Line', a non-profit organization that serves older adult communities and those seeking services through their Warm Line suggest the following to improve outreach and programs to the those communities:

  1. Social Media

  2. Cross refer across the program

- Sacramento Native American Health Center, a non-profit organization that serves the Alaskan Native / American Indian community suggest the following to improve outreach and programs to the Alaskan Native / American Indian community:

1. Since in-person outreach has been on hold due to the pandemic, we have been able to outreach to the community about our activities on Zoom and provide education and information on domestic violence, suicide prevention, etc.

2. Use every opportunity to push social media posts as a source for outreach.

3. It would be ideal to provide space and opportunity to do more collaboration with partner agencies to discuss how to best reach community that we are not able to reach.

San Benito County:

- We need to provide more ways to outreach to seniors using more innovative ways; more educational opportunities for the community; senior classes on mental health; mental acuity activities; health factors; support for veterans;
- Brainstorm how we can collaborate with other community groups to enhance what they are doing to support mental health;
- Expand suicide prevention activities; reach out to local businesses to help them know about mental health services and how to make referrals to assist people in accessing services.
- Reach out to the New Amazon warehouse to help them learn about mental health resources.

San Bernardino County:

- Increase public/private partnerships (i.e. coordinate service promotion or delivery in grocery stores, swap meets, etc.).
- As COVID-19 restrictions loosen there is a need to focus efforts on re-engaging the community and stakeholders by having more representation at local events or even hosting local events in hard to reach remote/ rural areas of the county (e.g. Mountain and Desert).
- Offer additional community-based programs where underserved communities feel more comfortable receiving services. For example, expand Family Resource Centers (FRC) and allow FRCs to bill Medi-Cal so they can serve more people (but don't require they only see Medi-Cal population).
- Build more Clubhouses in additional areas of the County. Expand *Promotores/*Community Health Workers in terms of more Asian and Pacific Islander language capacity and scope of responsibilities to include peer navigation services that offer support for folks navigating healthcare and other systems. Improve coordination and awareness of Prevention and Early Intervention continuum with the system of care.
- Collaborate with District English Learner Advisory Committees (DELAC) and similar African American groups at each public school district to reach these underserved groups.

San Diego County:

- In addition to those providing County contracted services, the County should engage in outreach services with those receiving services, family members and the community.
- Outreach should meet people where they are (homeless encampments) as well as being directed to Chaldean Church leaders.
- There is a need to increase recruitment and hiring of community health educators from diverse communities.

San Francisco County:

- More diverse and cultural competency staffing needs to reflect constituency.

San Joaquin County:

- Suggestions include extending clinic hours to enable working families to access BHS clinics after hours;
- Expand outreach efforts to include universities, flea markets, advertise campaigns and promote services in Spanish speaking publications, partner with the Health Plan of San Joaquin and San Joaquin County Public Health at community events; and activate the Latinx faith-based community.

Santa Barbara County**:**

- Establish specific annual budgets for targeted outreach.
- Use the city transportation system as a method to send behavioral health messaging about Behavioral Wellness, how to and where to access behavioral healthcare (signs on buses/benches that include Access Line number).
- Continue to collaborate with trusted community leaders, they can be our behavioral health ambassadors and contact with the community based providers for treatment services, linkages and referrals.
- Improve media presence throughout the county in various platforms (web based and non-web based) such as radio, TV, social media. Focus on specific cultural groups that use these channels of communications.
- Establish a local behavioral health psychoeducation campaign to increase understanding about mental health, decrease stigma, increase knowledge, awareness about community resources and where to access mental health care.

Santa Clara County:

- Increase in attendance of community/social/cultural events and meetings.
- Attend meetings and outreach to network providers/CBOs to talk about BHSD services.
- Outreach to media, i.e. radio/TV to different cultural/ethnic groups.
- Evaluate and implement targeted outreach for specific populations and communities of concerns.

Shasta County:

- Help people understand how to become patients

- There's been a large uptick in children in the emergency room for mental health reasons, which should be the place of last resort, so increase outreach into the school system

Sonoma County:

- Additional funding and outreach to the AAPI community.

Sutter and Yuba Counties**:**

- Our PEI staff could expand to improve outreach for underserved groups by: 1) Incorporating a heavier use of targeted community campaigns informed by data and best practices and 2) addressing access and cultural competency gaps.

Tulare County:

- Continue with PSA's (Radio and Television announcements), flyers and social media messages in the language of the consumers we serve (English and Spanish). 'The Source' is contracted to put together LGBTQ+ training for our staff through the 'Connectedness to Community' program.
- We also completed a Consultant contract to help us organize our Cultural Competency Committee so that we can better determine training needs throughout the MHP.
- 'New life Ministries' is providing outreach to our Black community.
- Going out into the communities instead of expecting them come to us,
- Get out in their community and where they go shopping, etc.

Ventura County:

- Improve opportunities for participating in decision-making at all stages of program and service planning, delivery, and evaluation.

*** * * THE END * * ***