OVERVIEW REPORT

2022 DATA NOTEBOOK PROJECT

ON CALIFORNIA BEHAVIORAL HEALTH:

IMPACT OF THE COVID-19 PUBLIC HEALTH EMERGENCY ON BEHAVIORAL HEALTH NEEDS AND PROVISION OF SERVICES IN CALIFORNIA

California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

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AND

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.

Acknowledgements: The 2022 Data Notebook and the Overview Report were developed with the assistance of the Performance Outcomes Committee 2021 – 2023.

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Acknowledgements

We greatly appreciate the local behavioral health boards and commissions and their Departments of Behavioral Health who participated in the preparation and discussion of their 2022 Data Notebook reports (listed below).

Counties That Submitted 2022 Data Notebooks

Reports Received: 52 Data Notebooks (represent 53 Counties + 1 Other DN)[1,2]

Small Population Counties (N=26 reports for 27 counties + 1 report from other MHB)

Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter-Yuba, Trinity, Tuolumne, and one from Tri-City MH Board (a sub-region of LA county).

Medium-sized Population Counties (N=12 counties)

Butte, Marin, Merced, Placer, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo

Large and Extra-Large Population Counties (N=13 counties)

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

[1] 2022 Data Notebook Summary Notes: These 52 reporting counties represented **90%** (or 89.6%) **of the 58 total counties**, and together comprised **90.5% of the population** of California in 2022.

[2] Missing data: six counties did not submit Data Notebook reports for 2022, including: Inyo, Modoc, Monterey, Riverside, San Mateo, Tehama. Some counties began work on this project but were unable to complete due to pandemic staffing issues, weather, and/or fire-related emergencies, etc.

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[3] MAT: Medication assisted therapy as part of substance use treatment services.

CBHPC 2022 Data Notebook: Introduction

What is the Data Notebook?

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

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council)[3]. To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

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

- To help local boards meet legal mandates[4] to review and comment on county performance outcome data, and to report their findings to the Planning Council,
- To serve as an educational resource on behavioral health data,
- To obtain opinion and thoughts of local board members on specific topics,
- To identify unmet needs and make recommendations.

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

What's New This Year?

The topic selected for 2022 addressed "The Impact of the Covid-19 Public Health Emergency addressing the behavioral health of vulnerable populations in CA, and the ability of counties to provide mental health and substance use treatment disorder (SUD) treatment in 2020 and 2021.

[3, 4] W.I.C. 5604.2, regarding mandated reporting roles of Behavioral Health Boards/Commissions in CA.

How the Data Notebook Project Helps You

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

Based on the responses of more than 52 counties, the Planning Council will provide our annual Overview Report, which is a compilation of information from all of the counties who completed their Data Notebooks. These reports may be found on the website[5] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to the Substance Abuse and Mental Health Services Administration (SAMHSA)[6].

Example of Statewide Data for Specialty Mental Health and Access Rates

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

Data for FY 2020-2021 typically would have been released by DHCS in August 2022. Some readers may seek to extract more current data using the DHCS web site and data portal[7].

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

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

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[8] Fiscal Year 2019-20.

Age	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	7,777	801,586	1.00%
Children 3-5	19,206	841,770	2.30%
Children 6-11	79,256	1,706,727	4.60%
Children 12-17	118,686	1,717,523	6.90%
Youth 18-20	31,460	724,208	4.30%

Ethnicity	Totals and Average Rates of Access (%)	Certified Eligibles	Rate
Alaskan Native or American Indian	1,200	18,572	6.50%
Asian or Pacific Islander	7,109	373,754	1.90%
Black	26,745	390,574	6.80%
Hispanic	153,661	3,369,129	4.60%
Other	10,689	365,314	2.90%
Unknown	13,657	497,605	2.70%
White	43,324	776,866	5.60%

Gender	Totals and Average Rates of Access (%)	Certified Eligibles	Rate
Female	122,205	2,837,274	4.30%
Male	134,180	2,954,540	4.50%

Overall Data	Number of Clients with MH Visits	Certified Eligibles	Rate
Totals and Average Access Rates (%)	256,385	5,791,814	4.43%

Notes: The first column presents the demographic groups of interest. Next, there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to receive health care paid by Medi-Cal. The third

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

column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number of Clients with MH visits by the total number of Medi-Cal Eligibles, multiplied by 100 to express the result as a percentage, which is taken as one measure of "Access Rates."

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2019-20.[9]

Age	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	96,242	2,639,420	3.60%
Adults 33-44	84,145	2,052,352	4.10%
Adults 45-56	78,314	1,633,359	4.80%
Adults 57-68	64,195	1,410,393	4.60%
Adults 69+	12,957	1,024,999	1.30%
Ethnicity	**Totals and Average Rates of Access (%)**	**Certified Eligibles**	**Rate**
Alaskan Native or American Indian	2,270	37,482	6.10%
Asian or Pacific Islander	19,583	1,035,431	1.90%
Black	51,180	676,335	7.60%
Hispanic	96,024	3,779,762	2.50%
Other	29,540	734,979	4.00%
Unknown	31,204	611,186	5.10%
White	106,052	1,885,348	5.60%

Gender	Totals and Average Rates of Access (%)	Certified Eligibles	Rate
Female	172,484	4,916,908	3.50%
Male	163,369	3,843,614	4.30%

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

Overall Data	Number of Clients with MH Visits	Certified Eligibles	Rate
Totals and Average Access Rates (%)	335,853	8,760,522	3.83%

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

CBHPC 2022 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

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

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

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[11] at the CA Department of Social

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

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

Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed by the Governor that requires the collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

We continue to receive an alarming number of anecdotal reports regarding financial pressures on ARFs that have resulted in multiple closures of facilities in various parts of the state each year. A better financial model and more resources are needed.

The Planning Council seeks to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[12] available to serve individuals with SMI, and how many of these individuals (for whom the county has fiscal responsibility) are served in facilities such as ARFs or IMDs. "Bed day" is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

The following is a summary of the survey questions for Part I of the 2022 Data Notebook. Please note that the questions will be presented here in summary form along with the aggregated response data from the local boards.

Questions:

1) **Please identify your County / Local Board or Commission.**
   The list of total responding counties (n=52 plus one non-county MHB) are tabulated in the acknowledgements at the front of this report. The purpose of this question in the Survey is to reliably organize the data collected within the survey.

   In the following questions, we asked the counties and their BH boards for data pertaining to 'the last fiscal year', defined as the most recent fiscal year of FY 2021-2022. Where available, data are shown for the preceding FY of 2020-2021, to provide an idea of whether there were changes from one year to the next. Note that these are not the exact same counties or even the same number of counties from one year to the next. Thus, even though numerical data are presented, any such comparisons must be considered qualitative, but nonetheless may be informative.

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

2) **For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year [FY 2021-2022]? Six counties answered '0' clients, out of 51 respondents.**

Thus, in FY 2021-2022, 45 county BH departments paid either some or all of the costs for 8,171 individuals to reside in an ARF during that year.

For comparison, in FY 2020-2021, 40 county BH departments paid either some or all of the costs for 9,225 individual clients to reside in an ARF.

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year, [FY 2021-2022]?**

A total of 1,604,302 ARF bed-days were paid for by 45 county BH departments during the most recent fiscal year,

For comparison, in FY 2020-2021, 40 county BH departments paid either some or all of the costs for 956,933 bed-days.

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

For FY 2021-2022, out of 50 responses received, 13 counties indicated that this number is unknown, or is not tracked by their BH department. Also, some responses noted that there were often lengthy delays waiting for an opening to get placements for clients in need of an ARF. A total of 1,772 persons were stated to be in need of an ARF placement, at any given time, based on numbers supplied by 25 responding counties at the time that this survey was completed.

For FY 2020-2021, 27 counties entered 1 or more persons. These counties' best estimates added up to a total of **4,052 persons** in need of ARF living facilities or similar services at any given time. Eight counties entered 'unknown' or 'not applicable', and another one county entered zero cases.

5) Does/did your county have any 'Institutions for Mental Disease' (IMD) in FY 2021-2022?

a. **No**. A total of 29 respondents (counties) answered No.
b. **Yes**. A total of 22 counties answered Yes.
If Yes, how many IMDs? The responses indicated that 79 total IMDs were within the 22 counties that responded 'yes' in 2022.
The accompanying text responses were variable (and potentially confusing), indicating that counties included MH rehabilitation facilities, specialized skilled nursing facilities, and both acute and sub-acute facilities. In this question we did not ask how many counties utilized out-of-county IMDs, which was implicitly included under the next question.

c. For comparison, in FY 2020-2021, out of 44 counties that responded, 21 counties reported there were 41 IMDs within their counties.

6) For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during FY 2021-2022?

In-county: **1,231,841 unduplicated clients**

Out-of-county: **908,912 unduplicated clients**

Total unduplicated clients: 2,140,753.

For comparison, in FY 2020-2021: **a total of 7,601 clients** received IMD services that were paid by 43 counties. Of all these IMD patients, 44.0 % received services out-of-county.

A re-examination of these data suggests that discrepancies arose in part due to different counties that submitted data were included in FY2020-21 compared to FY2021-2022. Although more than one county's data may be implicated, there were no Part I data for L.A. County for FY2020-21 due to a technology issue. This county's overall population was 9.83 million (2021), approximately 40% of whom were on Medi-Cal (approximately 3.93 million). An examination of their data submitted to SurveyMonkey for the 2022 Data Notebook cited:

IMD clients served within L.A. County: 1,225,403 clients
+ L.A. residents served in an out-of county IMD: 905,572 clients
Total L.A County clients served in an IMD: 2,130,975

Those numbers provided for unduplicated clients for L.A. County are improbable, as they would suggest that half of all of L.A. County's Medi-Cal population were served in an IMD that year.

The total number provided for IMD bed-days in L.A. County was given as 2,034,975 total bed-days, which is only slightly less than the alleged number of unduplicated IMD clients given above. Statewide totals certainly need to be adjusted after seeking other data (e.g., other CA agencies having hospital data).

These data illustrate the challenges that any of us may encounter with very large data sets. This outcome may be attributable in part to our lack of built-in math logic screens incorporated into SurveyMonkey questions. This example illustrates the need for each of us to carefully scrutinize all data.

7) What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during FY 2021-2022?

Total IMD 'bed-days' paid for by the responding counties: **2,876,088.**

Aside from the effects of missing data (counties which did not submit a 2022 Data Notebook), we conclude that the total statewide numbers for question #6

and #7 are unreliable (as explained above). These numbers would lead to a calculated average of 1.34 bed-days per unduplicated client.

For comparison to the prior year of FY 2020-2021, a total of 41 counties paid for 718,608 bed-days in IMDs for a total of 7,601 clients, which yields an average of 94.5 bed-days per unique individual served.

Next, we consider point-in-time homeless counts for February 2022.

Homelessness: Programs and Services in California Counties

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

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

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Planning Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges. At the time of writing this report, the state of California is in the process of proposing major changes to how we fund and address homelessness among those with mental health and/or substance use challenges, or those who may be chronically homeless.

Every year, the states, counties, and many cities perform a "Point-in-Time" (PIT) count[13] of the homeless individuals in their counties, usually on a specific date in January. Such

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

data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.

Preliminary data for January 2021 were posted in early February 2022, but only contained data for the individuals in shelters or temporary housing. No data were collected for California's unsheltered population due to the protocols necessary to protect against COVID-19. These disruptions in usual practice make it difficult to assess trends in the homeless population, both unsheltered and sheltered. More recently, there were also severe weather-related issues during January of 2022 that required a delay in the PIT count in many California communities to the last week in February 2022.

Table 3: State of California Estimates of Homeless Individuals PIT[14] Count

January-February 2022 PIT Counts

Summary of Homeless individuals	Emergency Shelters	Transitional Housing	Unsheltered	TOTAL
Homeless Individuals (not in families)	28,103	6,442	110,888	145,433
People in families with children	16,257	4,996	4,285	25,538
Unaccompanied homeless youth[15]	1,478	1,350	6,762	9,590
Veterans	1,394	1,609	7,392	10,395
Severely Mentally ill	9,717	2,230	27,774	39,721
Chronic Substance Abuse	5,566	1,531	28,999	36,096

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

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

Chronically homeless individuals	**15,605**	**168**	**45,132**	**60,905**
Total (2022) Homeless Persons in CA	**44,553**	**11,477**	**115,491**	**171,521**
Total (2022) Homeless Persons, USA[16]	**285,470**	**63,160**	**233,832**	**582,462**

Questions, continued:

The data shown above has broken out data for a number of subgroups. In particular, families with minor children, and unaccompanied youth <18 represent groups of special concern for present and likely future needs for BH services. Some of these youth are those who left their families of origin, or their foster placement, or circumstances in which LGBTQ youth were rejected or abused by their families. Some of the youth are themselves parents of young children or have taken responsibility for siblings.

8) **During the most recent fiscal year (2021-2022), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?** (Mark all that apply.) The table below summarizes the responses received.

A variety of responses under "Other" are listed in **Appendix II** at the end of this report and address local needs by working with existing community resources and programs. For example, Tulare County has outreach programs to provide basic healthcare and screening services to persons in encampments. These teams may include other professionals who link people with behavioral health and social services.

Clearly there are many needs for housing, supportive care, linkage to services, and strategies which address the specific needs of those who are unsheltered, families with children, veterans, and those formerly involved with the justice system. These vulnerable groups include homeless youth, some of whom had been in foster care and either left (while under 18) or those former foster youth that have aged out of the system but lack any continuity of support. The needs are great. It is hoped that some of the recently proposed reforms to behavioral health care and to housing programs may improve the overall situation in California. However, advocacy groups continue to make their concerns known to the administration and to the Planning Council.

[16] All U.S. States, Territories, Puerto Rico, and District of Columbia. https://files.hudexchange.info/reports/published/Coc_PopSub_NatlTerrDC_2022.pdf

Child Welfare Services: Foster Children in Specialized Congregate Care

In 2023 in California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more specialized services.

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

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

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

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

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

Note that the fiscal year for our look at Child Welfare data is 2020-21, not 2021-22, due to the customary delays in the CWS data set. We are, however, prepared to discuss information about services or programs which may span 2020 through 2022, depending on preference of the counties that submitted data for 2022.

Questions (continued):

9) **Do you think your county is doing enough to serve the foster children and youth in group care?**
    a. **Yes**. Response chosen by 22 counties or 44% of respondents.

b. **No.** Response chosen by 28 counties, or 56% of respondents.
If no, what is your recommendation? Please list or describe briefly. These responses are summarized in detail in **Appendix III** at the end of this report. Common responses emphasized a critical lack of the following: resource (foster) families, insufficient STRTP facilities or beds, insufficient staff with adequate training for such facilities, insufficient MH and SUD services for youth, and few or no therapeutic foster care homes.

10) During the most recent fiscal year (FY 20-21), has your county received any children needing "group home" level of care from another county?

a. No. This answer was chosen by 18 counties, or 37.5% of respondents.

b. **Yes**. This answer was chosen by 30 counties, or 62.5% of respondents.
If yes, how many? 1,461 children/youth received by 30 counties.
Three counties skipped this question, and a fourth entered 'unknown.'

11) During FY 20-21, has your county placed any children needing "group home" level of care into another county?

a. **No**. This answer was selected by 5 counties (or 10.4 % of respondents).

b. **Yes.** This answer was selected by 43 counties (or 89.6% of respondents).
If yes, how many? 2,777 children/youth were placed out-of-county by 43 counties.
Three counties skipped this part of the question and three others entered non-quantifiable verbal answers.

Summary and Recommendations

There was a lot of variability in the datas the period of the pandemic from 2020 through 2022 was in many respects constantly changing. This period of time challenged programs and service providers to innovate and adapt very rapidly. Part I of this report shows effects of the pandemic, although we intended Part I to focus on specific populations that need specialized care and supports, and a place to house these vulnerable individuals, facilities that cover a span of unlocked, entirely voluntary and community based, all the way to IMDs and other locked facilities.

The recommendations for BH services, foster care, and supportive housing from 2021 continue to be relevant through the present day. We note that some major changes are coming to Medi-Cal supported behavioral health services in 2023 with the initial implementation of the CARE Act in some counties and further implementation planned in the next two years.

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 a qualified workforce is not available, and that youth have 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 the 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:

- **Review ongoing implementation data released by the CARE Act implementation from both counties and the state 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 2022 Data Notebook – Part II:

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

Context and Background

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

The major themes are as follows:

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

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

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

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

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

What were the Behavioral Health Impacts of the Covid-19 Pandemic on Children and Youth? The Pandemic Coincides with a National Emergency for Youth Behavioral Health, per U.S. Surgeon General

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Recently (in 2021), this urgency led the U.S. Surgeon General to issue a special health advisory:[17]

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

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

The pandemic added to the pre-existing challenges that America's youth faced. It disrupted the lives of children and adolescents [including] in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic's negative impacts most heavily affected those who were vulnerable to begin with, such as youth with disabilities,

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

racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall [2021], a coalition of the nation's leading experts in pediatric health declared a national emergency in child and adolescent mental health.

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

The Surgeon General's advisory rated the seriousness of these issues to rise to the level of a national emergency for children and youth mental health that has arisen during the period of the COVID-19 pandemic. There are no indications that the factors and disruptions are any less severe for the present well-being of youth.

We provide some supporting national data for the behavioral health of both children/youth and adults in Appendix I of this document. These are the most urgent and pertinent findings from the National Survey on Drug Use and Health (NSDUH) national survey that collected and analyzed data in successive waves of live data collection to the early years of the pandemic. We included these data extracts for the convenience of stakeholders and the general public.

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

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

In the 2020 Data Notebook, the Planning Council asked questions about the use of telehealth for mental health therapy to adults during initial stages of the pandemic[18]. Some service providers and clients encountered problems of access, such as technology issues, lack of home internet, or lack of adequate bandwidth, especially in rural areas. Other issues included the challenges of learning to work with the virtual therapy platform for both providers and clients. Some individuals had disabilities with impaired hearing and/or impaired vision (hard to see keys to type), which led to

[18] 2020 Data Notebook, and 2021 Overview Report on this project: California Behavioral Health Planning Council, with the California Association of Local Mental Health Boards Commissions: www.calmhbc.com.

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

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

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

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African American, and Native American people.[19] Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. Due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"[20] symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including the need to improve our outreach and messaging.

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

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

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

Part II: Responses Received to the Part II Data Notebook Questions

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

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

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

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

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

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

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

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

h. Other (Please specify). [The responses to 'other' are found **in Appendix IV** at the end of the Report]. **Note that a number of counties cited increases in eating disorders and in concerns about social isolation in responses under 'other'.**

i. None of the above.

Note: 51 counties (including one non-county MHB) responded to this question, and these responses are summarized in the figure below as a percent of total respondents.

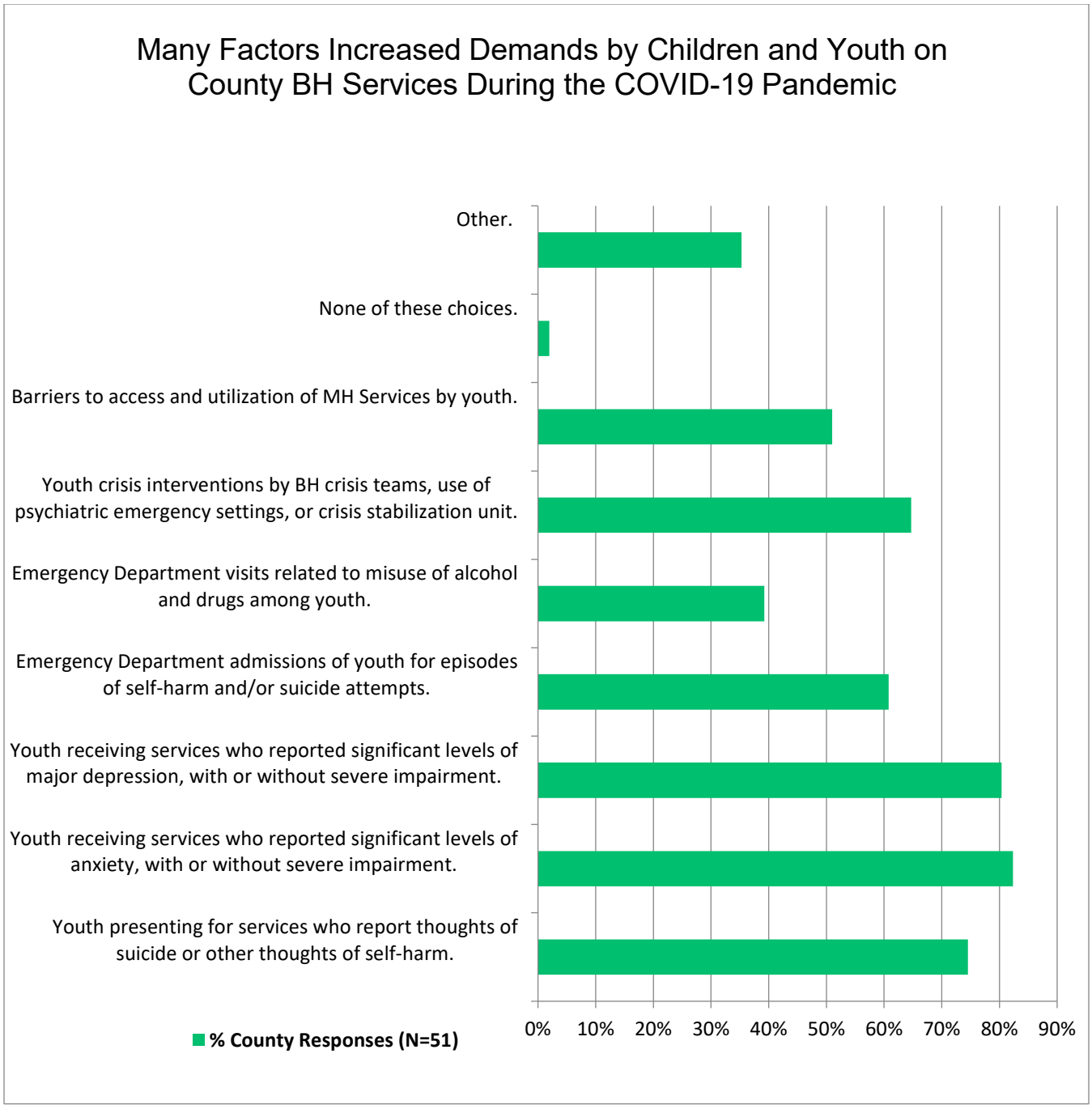


Figure 1. Major Points of Stress on County Behavioral Health System Services for Children and Youth During the COVID-19 Pandemic in California

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

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

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

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

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

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

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

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

h. None of the above

i. Other (Please specify).

One county skipped this question, and 50 counties responded.. Answers are shown below in the next figure by percent of Counties in which the listed items were in the top three priorities (or concerns) for children and youth who needed and received BH services.

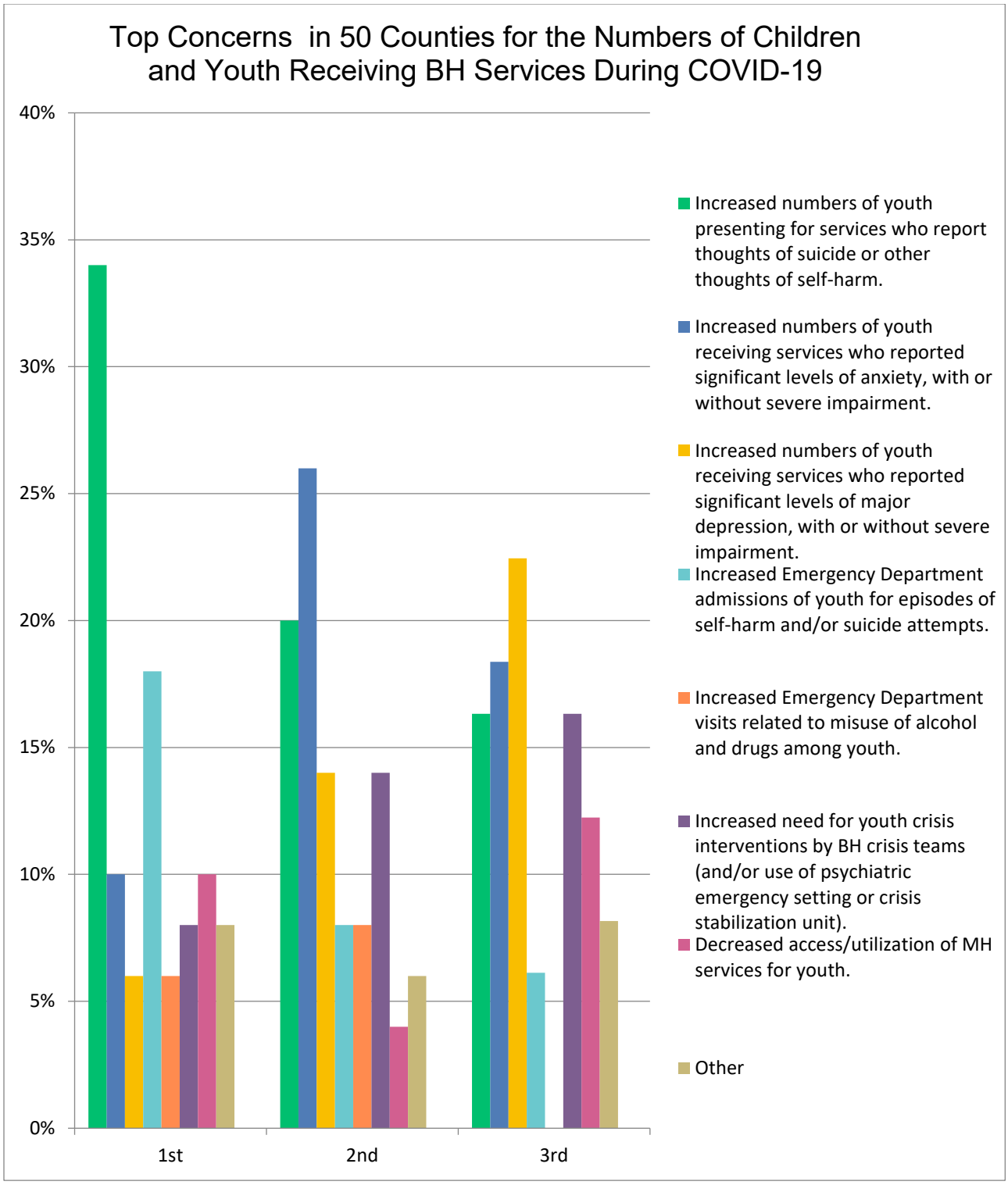


Figure 2. Identification of Top Priorities for Children and Youth Behavioral Health Services in California During Covid-19.

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

See the comments and concerns listed in **Appendix V** at the end of this report. These notes contain important information to provide a more complete understanding of what has been happening with the behavioral health of children and youth and the problems that have placed severe strains on the systems to provide timely, and adequate resources for care. These concerns also confront the issue of effective care, because not all youth and children were able to relate well to either telephone sessions (telephonic care) or the Zoom (or similar telehealth) video sessions.

15). Please identify the points of stress on your county's system for all adult [21] behavioral health services during the pandemic *(multiple checkboxes; mark all that apply).*

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

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

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

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

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

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

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

h. None of the above

i. Other (Please specify). Answers are listed in **Appendix VI** at the end of this report.

[21] We have commonly used the term "all adult care", in references to both adults age 18 to 64, as well as adults age 65 and above. In some systems of care, older adults may be defined as age 60+, depending on how local programs may choose to organize their services.

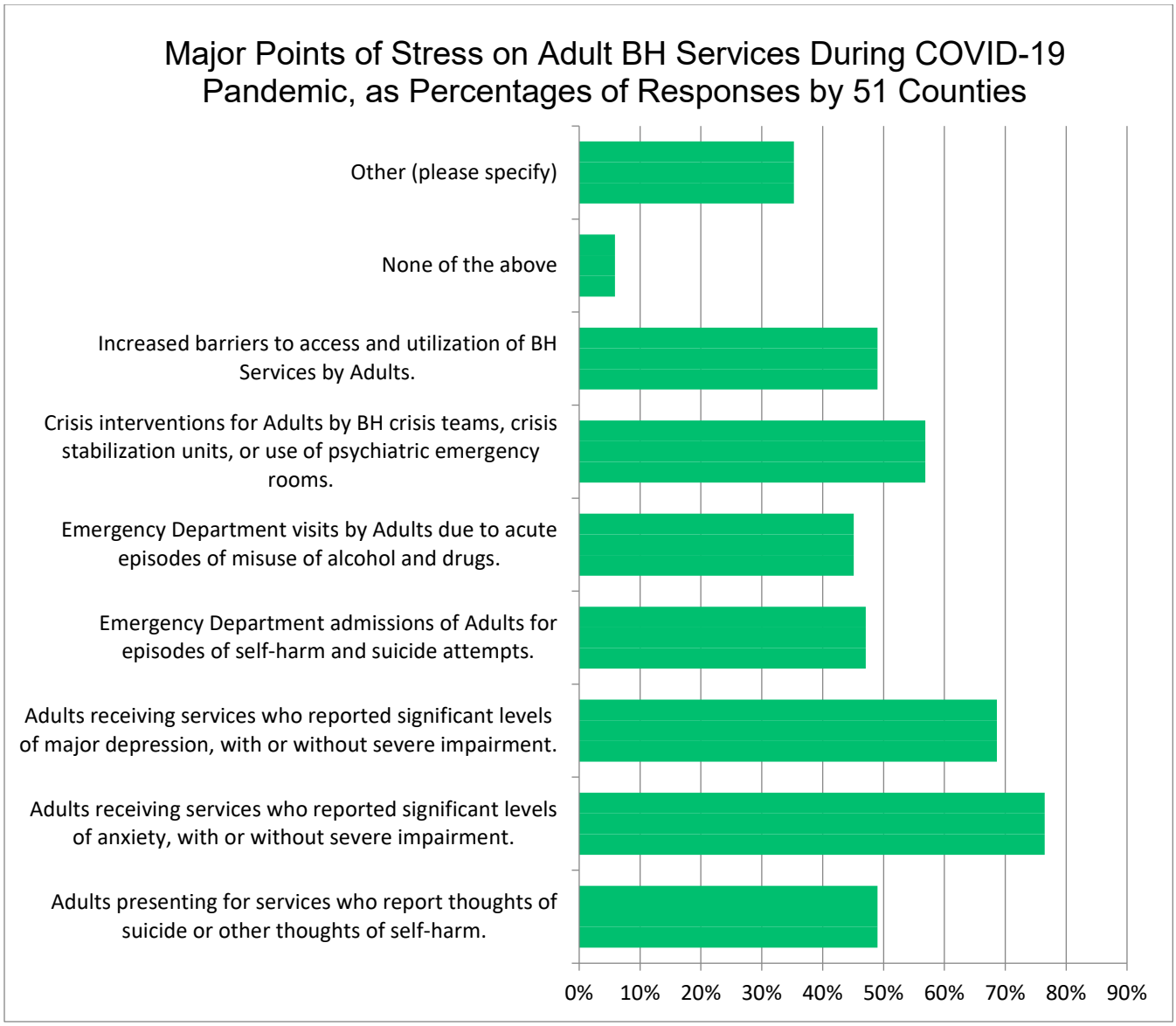


Figure 3. Major Points of Stress on Adult Behavioral Health Services During the COVID-19 Pandemic in California Counties.

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

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

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

c. Increased numbers of adults reporting significant levels of major depression, with or without severe impairment.

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

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

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

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

h. None of the above

i. Other (Please specify).

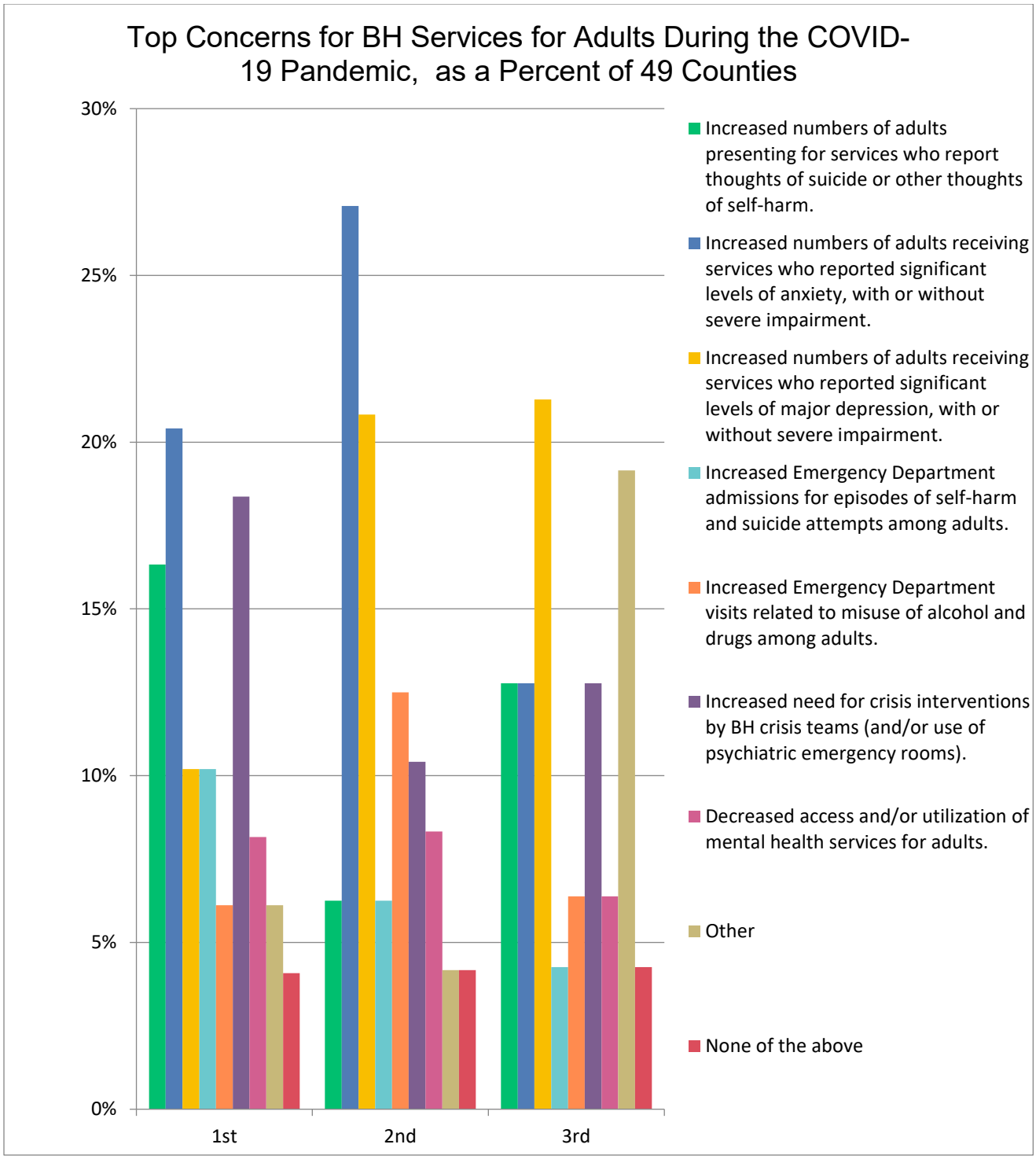


Figure 4. Identification of Top Priorities for Demands on Adult Behavioral Health Services During the COVID-19 Pandemic in California Counties.

17). Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for all adults in your county during the Covid-19 pandemic?
See detailed responses tabulated in the **Appendix VII** at the end of this report.

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

- **Yes.** This response was selected by 49 counties (or 96% of respondents).
- **No.** This response was selected by 2 counties (or 4% of respondents).

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

- **Yes.** This response was selected by 47 counties (or 92% of respondents).
- **No.** This response was selected by 4 counties (or 8% of respondents).

20). Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders? A total of 51 responses were received. No one skipped this question.

- **Yes.** This response was chosen by 31 counties (or 61% of respondents).
- **No.** This response was chosen by 13 Counties (or 25% of respondents).
- **Not Applicable**: if your board does not oversee SUD along with Mental Health. This option (N/A) was supplied by 7 respondents (or 14% of the total).

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

We received a total of 49 responses; two respondents skipped this question.

- **Yes**. This answer was chosen by 25 respondents (or 45%).
  If so, how has this been useful in promoting successful outcomes? (text answer).
  [See detailed listing in **Appendix VIII**].

- **No. 16 respondents (or 31% of total)**
  If not, do you have alternatives to help clients succeed? *(*text answer).
  [See detailed listing in **Appendix VIII**].

- **Not Applicable**: if your board does not oversee SUD along with Mental Health.
  This selection was chosen by 8 (or 16%) of the total respondents.

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

a. Increase in funding for crisis services.

b. Decrease in funding for crisis services.

c. Issues with staffing and/or scheduling.

d. Difficulty providing services via telehealth.

e. Difficulty implementing Covid safety protocols.

f. Other (please specify). (See details in **Appendix IX**).

g. None of the above.

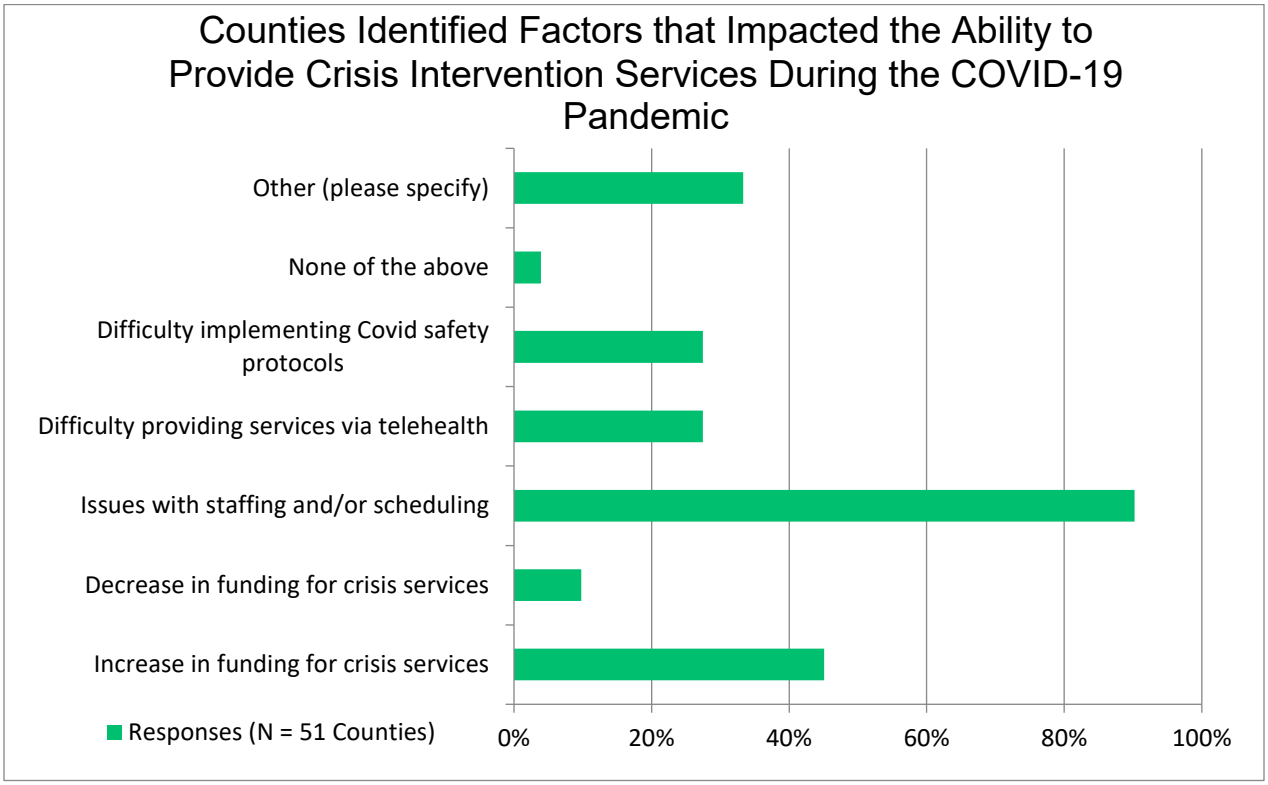


Figure 5. Multiple Factors Affected the Ability of Counties to Provide Crisis Intervention Services by During the COVID-19 Pandemic in California

The most serious impact on the BH services of 46 counties (90% of those responding) were issues with insufficient staffing and/or limited appointments available for scheduling. Interestingly, we saw that 10% of the responding counties experienced a decrease in funding for crisis services, whereas 45% of the counties received an increase in funding for crisis-related services. Finally, difficulties providing services via

telehealth and/or difficulties implementing COVID safety protocols were each identified as important factors by 7 counties (14% of respondents).

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

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

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

c. Staff out to quarantine for self

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

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

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

g. Staff out due to burnout

h. Staff out due to inability to manage telework environment

i. Staff unable to obtain daycare or childcare

j. Other, please specify. The most common response here related to staff burnout, as those who remained and continued to work were often overloaded as their colleagues became unavailable to treat clients, for all of the reasons addressed in this question.

k. None of the above.

We received responses from N = 50 respondents, and only 1 participant skipped this question. The prioritization of COVID19-related factors considered to have had a negative impact on the counties' ability to maintain staffing and provide BH services are shown in the figure below as a percent of total responses received, with the top priority being number one, followed by number two, and so forth.

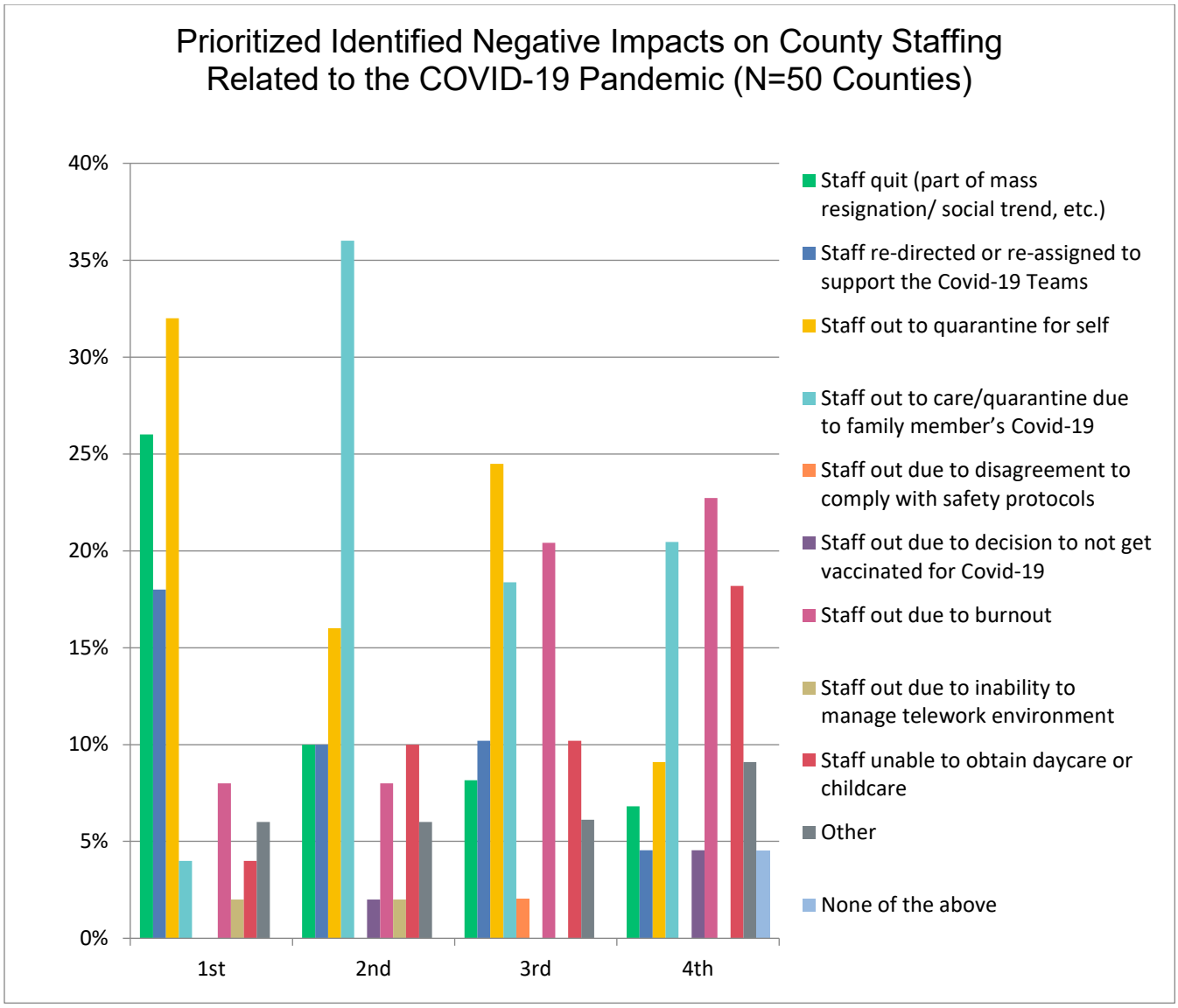


Figure 6. Top Priorities Identified in the Negative Impacts on Staffing of County BH Departments During the COVID-19 Pandemic in California.

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

a. Utilizing telework practices

b. Allowing flexible work hours

c. Bringing back retired staff

d. Facilitating access to childcare or daycare for workers

e. Hiring new staff

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

g. Other (please specify). Some responses indicated hiring incentives and educational support to further train individuals involved with either education or county programs who had the desire and talent to retrain to become direct service providers (therapy, case management, etc.) See **Appendix X** at end of report.

h. None of the above.

We received responses from 51 participants/counties.

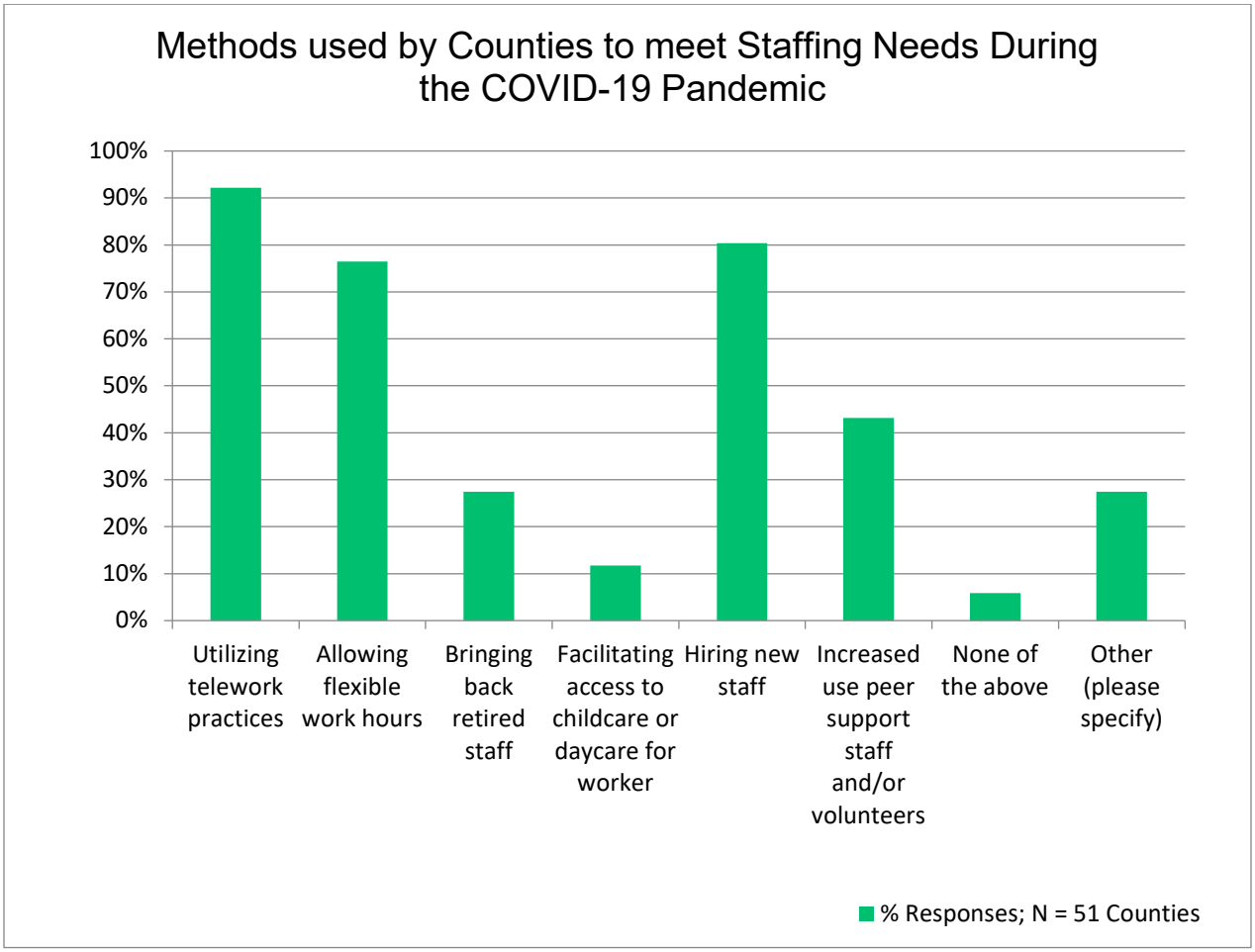


Figure 7. Methods used by County Behavioral Health Departments to Meet Staffing Needs During the COVID-19 Pandemic in California

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

a. Asian American / Pacific Islander

b. Black / African American

c. Latino/ Hispanic

d. Middle Eastern & North African

e. Native American/Alaska Native

f. Two or more races

g. Other, please specify. See **Appendix XI**,

h. None of the above.

We received 51 responses. The following graph shows the demographic groups by race/ethnicity that individual county Departments of BH perceived that they had difficulty in both reaching and serving specific groups of people and their families. Based on the responses below, many counties perceived that they had greatest challenges in reaching out to and providing services for Latino/Hispanic clients and families, and also to Native American/Alaskan Native clients and families. They clearly identified the need to improve both outreach and provision of services.

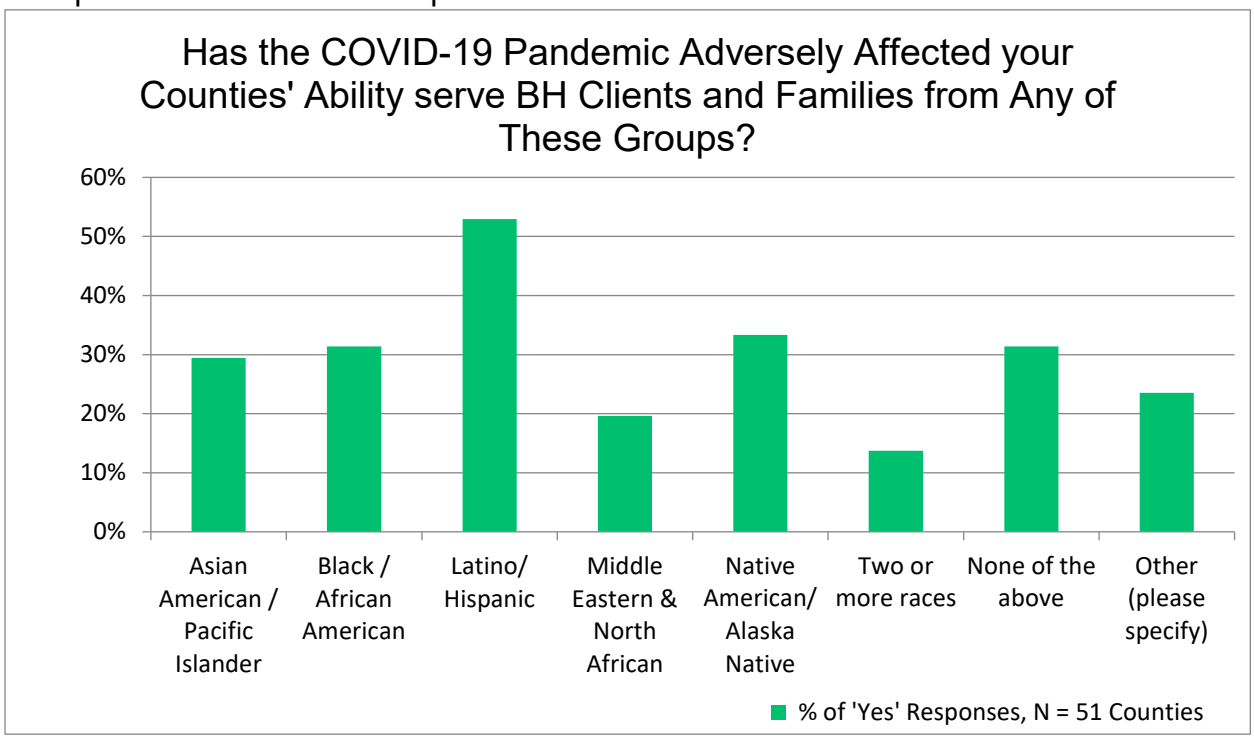


Figure 8. Did the COVID-19 Pandemic Adversely Affect Counties' Ability to Reach and Serve BH Clients and Families from Various Demographic Groups?

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

a. Children & Youth

b. Foster Youth

c. Immigrants & Refugees

d. LGBTQ+

e. Homeless individuals

f. Persons with disabilities

g. Seniors (65+)

h. Veterans

i. Other, please specify. See **Appendix XII for details**.

j. None of the above.

We received responses from all 51 Counties. Counties identified a number of vulnerable groups and communities for whom they experienced challenges in being able to adequately reach out to and provide BH services. The results below are expressed as a percent of the total responses received. Children and youth (which we note includes foster youth as a vulnerable subcategory) and Seniors aged 65 and over, followed by homeless individuals all presented challenges for outreach and service provision. Planning Council members also noted the difficulty of adequately reaching and serving those with disabilities, especially hearing-impaired or vision-impaired. All of these groups deserve special attention and effort to reach and provide BH services, for example, veterans, persons with disabilities, LGBTQ persons, and immigrants and refugees; regardless of whether these individuals are also part of another larger or more numerous group.

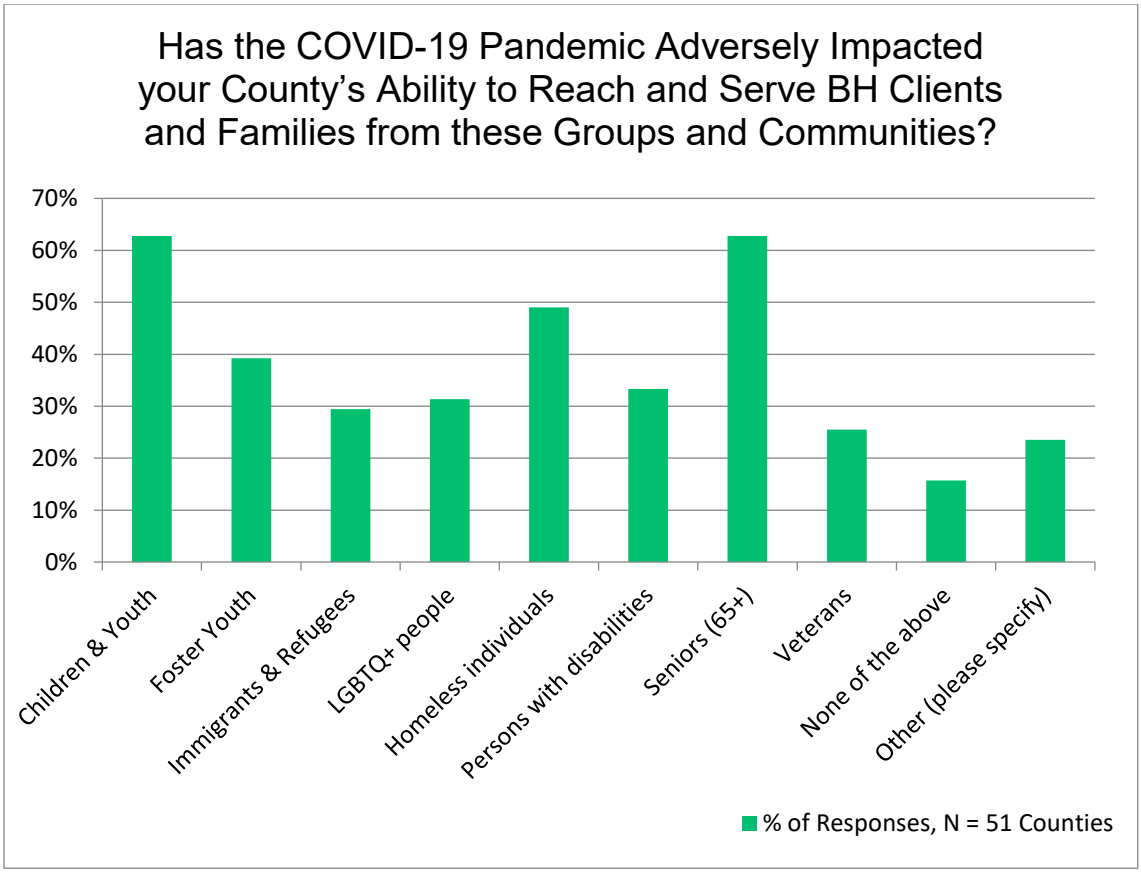


Figure 9. Did the COVID-19 Pandemic Adversely Affect County BH Departments' Ability to Reach and Serve Clients and Families from Several Vulnerable Groups and Communities in California?

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

a. Difficulty with, or inability to utilize, telehealth services

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

c, Inadequate staffing to provide services for all clients

d. Lack of transportation to and from services

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

f. Client disability impairs or prevents access

g. Mistrust of medical and/or government services

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

i. Other (please specify). (These responses most often included factors that are well-known as presenting challenges to county departments of behavioral health and/or public health in California). See details in **Appendix XIII** at end of report.

We received responses from all 51 counties. Results in the graph below represent a percent of the total responses received. COVID-19 related safety concerns, illness of clients/family members and issues of adequate staffing were major concerns in this area of health service provision. These concerns parallel those which occurred throughout the entire health care system impacting all possible areas of care including pediatrics, dental , veterinary, and elective surgical procedures.

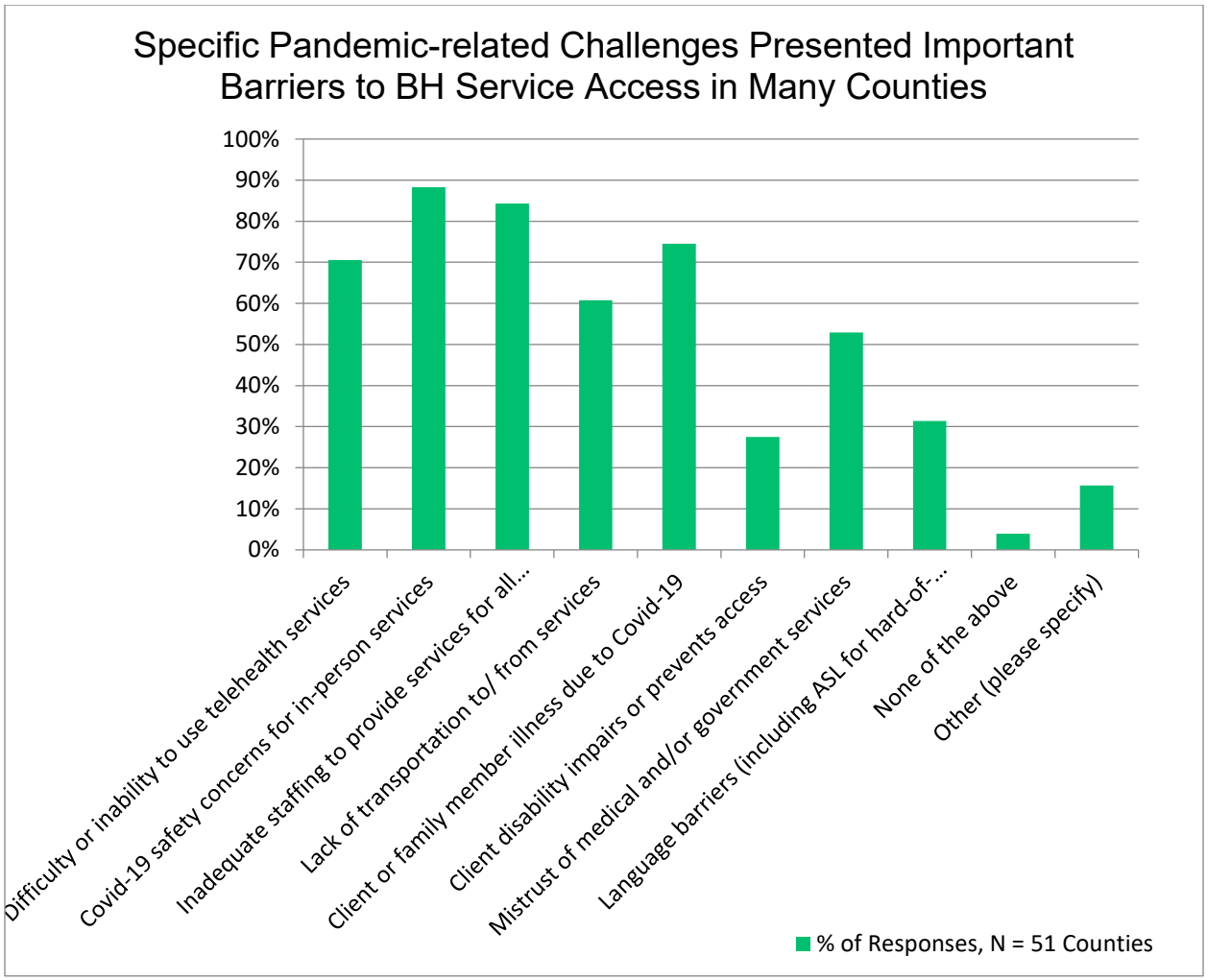


Figure 10. Barriers to Accessing BH Services Were Perceived to Increase as a Result of COVID-19 Pandemic Effects on County BH Departments in California.

Summary, Conclusions, and Recommendations

The long-term consequences of three years of COVID-19 continue to be felt throughout our society and communities all across the nation. Typical effects are illustrated in the survey data from the NSDUH (see Appendix I, following). These effects were similarly seen throughout communities in the state of California. These data extracts perform a crucial function in education about the extensive behavioral health needs during the pandemic. There is no question that many adults and older adults are still experiencing significant stressors and after-effects of the pandemic, even in some individuals who previously had never been diagnosed with either a mild or serious mental health disorder.

However, the most urgent long-term consequences are observed in those most vulnerable members of society: children and youth who experienced isolation, loneliness, educational disruption, and consequences to their normal social and emotional development. There remain a significant number of youth and children who lost one or more primary caregivers whether that was a parent, foster parent, grandparent, or other members of the community who provided guidance and emotional nurturing. The U.S. Surgeon General's report provides good information on the effect of the pandemic on children and youth. The report identifies youth mental health as a serious public health emergency and includes recommendations for action.

Important points reflected in the data collected are:

- Every county indicated that there were workforce issues in their mental health/behavioral health departments during the pandemic. This was also an issue for contracted services/providers. This was an issue prior to COVID and continues to be an issue post COVID.
- Telehealth was used by almost all counties to provide a wide variety of services including counseling, medication appointments, and crisis intervention. Issues continue in the use of telehealth: access to the internet; access to devices for communication; telehealth conversations are compromised by lack of privacy, particularly for children and youth; and telehealth is a relatively new method of service and some of the population is not willing to participate. *It should be noted that our survey is two years old and the technology of telehealth and telemedicine access has grown exponentially since we administered this survey.*
- Access to services was identified as an issue by most counties in a variety of different areas including: emergency departments at acute hospitals; mental health hospital beds; various congregate living situations (ARFs, IMDs, crisis intervention sites; and temporary and emergency housing for those identified without housing.

Facilities had significantly different and individualized rules for access due to COVID. There were fewer beds available in many types of facilities due to staff shortages and the closure of some businesses.
It was difficult in many counties to provide wrap-around services due to the lack of facilities and providers.

- It was more difficult than usual for providers to access children and youth to provide services. Schools were closed or used virtual teaching services. Children and youth lacked transportation to access centralized offices. Children and youth lacked interest in using virtual methods to access services.
  Children and youth presented with an increase of need and different diagnoses including anxiety, depression and suicidal ideation.
- Older adults were also identified as highly vulnerable populations in the overall statistics for COVID-19 cases of illness, hospitalizations, "Long Covid," and deaths. Deaths from Covid were disproportionately high in the elderly and particularly in those elderly living in congregate care settings[22].
- Older adults have been similarly vulnerable to the consequences of long-term social isolation and a nearly perpetual quarantine-like state due to the 'lockdown' effect needed to protect elderly individuals from infection and severe physical outcomes. Individuals' customary social supports were often disrupted or absent. Some elderly had difficulty accessing tele-therapy due to technology issues or disabilities or could not travel to in-person services for either mental health or substance use services.
- Some counties commented on an increase in anxiety, depression, and drinking in those over age 65. However, the numerical data available for behavioral health did not separate out numbers for older adults from 'all adults.' Long term effects may now be emerging in public health reports addressing behavioral health issues. Suicide rates in adults over 65 increased by 8.6% in 2022[23] relative to 2021, by 6.6 % in those age 45-64, and by 2.6 % in all age groups, relative to suicide deaths in 2021 as 2022 marked an all-time record number for the U.S. (49,449).

RECOMMENDATIONS:

1. Many counties have reported high levels of staff shortages and vacancy rates, secondary to the Covid pandemic, in key roles that impacted access to needed services. It is noted that staff shortages were an issue prior to the pandemic and continue to be an issue. To address staff shortages counties might consider the following:

[22] www.cdph.ca.gov, and also see most recent data summarized at www.covid19.ca.gov.
[23] www.cdc.gov, newest mortality and suicide data posted this month (November 2023).

- Develop plans for staffing in times of emergency, which identifies the resources necessary to meet the levels of service for consumers.
- Use flex staff scheduling to serve consumer needs.
- Expand the role of Peer Specialists to fill gaps in service with their lived experience and training.
- Provide self-care and other supports for staff, consumers, and families.

2. Communities of diverse populations need support to access and effectively use mental health and substance use disorder services. To adequately meet the needs of communities with diverse populations, counties may consider the following:
   - Provide training on access to services and advocacy for navigators, community health workers, peer support specialists, and other supportive members of the community.
   - Develop strategies to improve and enhance the use of telehealth in the diverse populations represented in the county. (See # 3 below)
   - Provide self-care and other supports for staff, consumers, and families.

3. The development of telehealth services between staff and clients was an indispensable service during the pandemic. Counties continue to use this strategy and to develop ways to enhance the services by telehealth. To address telehealth services counties might consider the following:
   - Develop strategies to improve and enhance the use of telehealth according to the cultures of their county. Possible strategies include the development of teams that include a variety of specialists to handle the issues presented by a consumer.
   - Contract with telehealth providers to serve consumers at the times the consumer is available. Provider contracts need to assure adequate hours of service and a variety of necessary services are available to consumers at convenient hours for the consumer.
   - Use of ‘telehealth coordinators’ within the clinic to assist with scheduling sessions, answering questions, requests for medication refills, interfacing with doctors and pharmacy, and providing technical support to assure the quality of the telehealth platform.
   - Evaluate each consumers’ ability to use the telehealth platform including access to equipment, knowledge about how to use the equipment, access to the internet, knowledge about how to use the internet to access telehealth services, and other needs. It is important that privacy for the consumer is available and respected at all times.

4. Adults, particularly older adults, often have unidentified mental health and/or substance disorders that need treatment. During Covid adults with those needs were identified with higher rates of anxiety and depression. Approximately 15.3 million

Californians, which is more than a third of California's population, (October 2022), rely on the Medi-Cal program for health insurance coverage. Others have private insurance. Establishment of mental health/substance use disorder treatment and payment may be difficult for those not familiar with the systems and insurance. To address services for adults, and particularly older adults, counties might consider the following:

- Develop and maintain accurate information about monies available by each funding source. For example Medicare Part B helps to pay for outpatient mental health services for eligible individuals one depression screening per year (screening must be in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referral).
- Managed Care Plans (MCP) provide mental health services for individuals with a mild to moderate disability. MCPs must increase entry points to provide consumers with necessary services including preventative and early intervention care. This data needs to be evaluated on a regular basis to assure that appropriate services to address mental health and substance disorders are provided as needed.
- Focus on providing self-care and other supports for staff, consumers and families.

5. Children and youth had difficulties during Covid. Many schools were closed, and children/youth had virtual classes. Their opportunities for socialization with adults, teachers and peers was limited. Access to services for mental health were not available. The result has been an unprecedented incidence of anxiety and depression in youth, and an increase in suicidal thoughts and suicide rates. The Children and Youth Behavioral Health Initiative (CYBHI) is part of the Master Plan for Kids' Mental Health, a historic investment by the State of California that takes a "whole child" approach to address the factors that contribute to the mental health and well-being of our children and youth. To address services to children/youth during an emergency counties might consider the following:
   - Develop plans for staffing in times of emergency, which identifies the resources necessary to meet the levels of service for consumers.
   - Develop effective early intervention and prevention programs to refocus funding and staffing to assure that children/youth receive necessary services and supports.
   - Develop effective communication between clinicians who work with children/youth, appropriate individuals at school sites, and community providers to develop effective communication channels and appropriate services to provide support to children/youth.
   - Ensure that clinicians and school personnel reach out to parents to provide assistance and support with their children/youth who need mental health/substance use disorder services. One possible method is to provide back-to-school nights to support parents in understanding the issues with their child.

- Focus on providing self-care and other supports for staff, consumers and families as needed. Children/youth need training to know to provide self-care and learn exercises that are effective for them.

APPENDIX I.

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

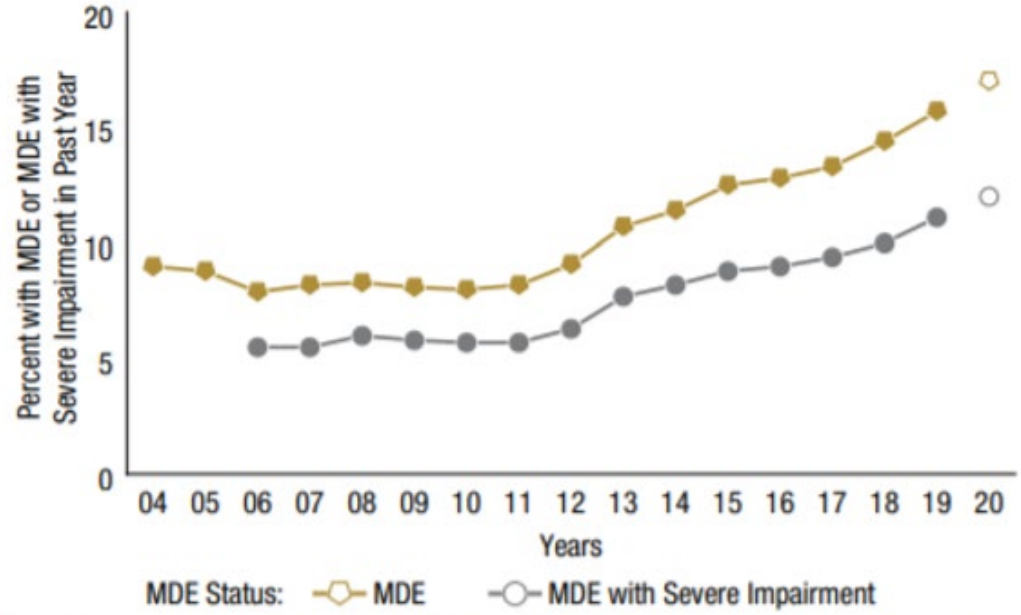
The Behavioral Health problems in youth include, but are not limited to, the issues highlighted by the following series of data and figures taken from the National Survey of Drug Use and Health, (NSDUH Survey)[24] published in October 2021, regarding data collected in 2020, which overlaps the first year of the pandemic. **Their methods of data collection changed in 2020 due to the public health restrictions and safety protocols**. Their methods changed from telephone surveys to include online survey methods in early 2020. **As a result, the data shown for 2020 are not connected by a solid line to the data for prior years**. Also, the study authors did not perform certain tests of statistical significance between 2020 and prior years because the tests might not be valid due to the changes in methods.

Note that national data is very timely because they are based on live surveys. Most other behavioral health data for our state and counties rely on 'paid claims' data derived from billing records that have built-in reporting delays of 18-24 months. Thus, they would not yet show the impacts of the pandemic which began in early 2020, nor in the ongoing 'paid claims' data in 2021.

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

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

Figure A1. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year; Among Youths Aged 12-17; 2004 – 2020 (NSDUH).

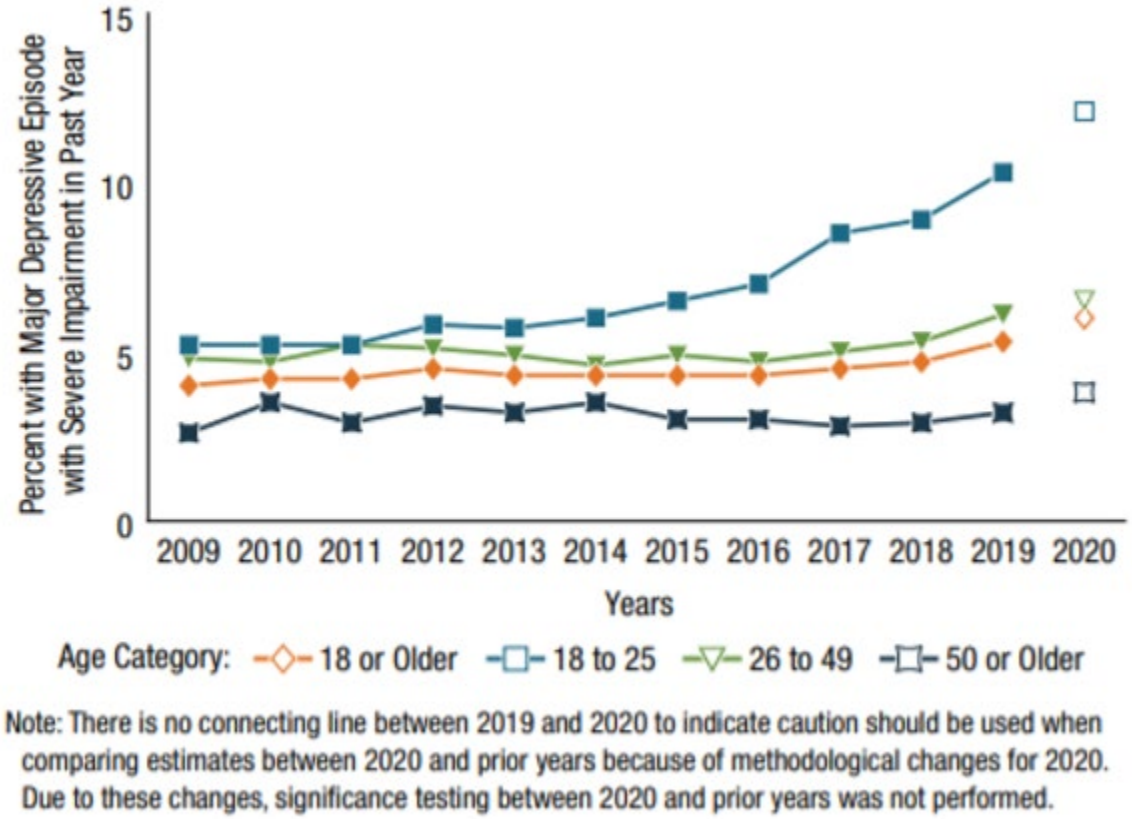


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The following series of data and figures show some of the impacts to adults and older adults. These data represent excerpts from the 2021 NSDUH Survey[25] on survey data collected in 2020. Nonetheless, the data are illustrative of trends during this challenging period of time. As an example of concerning trends, we note that October 2021 marked the highest 12-month loss of American lives to drug overdoses, in excess of 100,000 total. Numbers of adults experiencing major depression also increased.

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

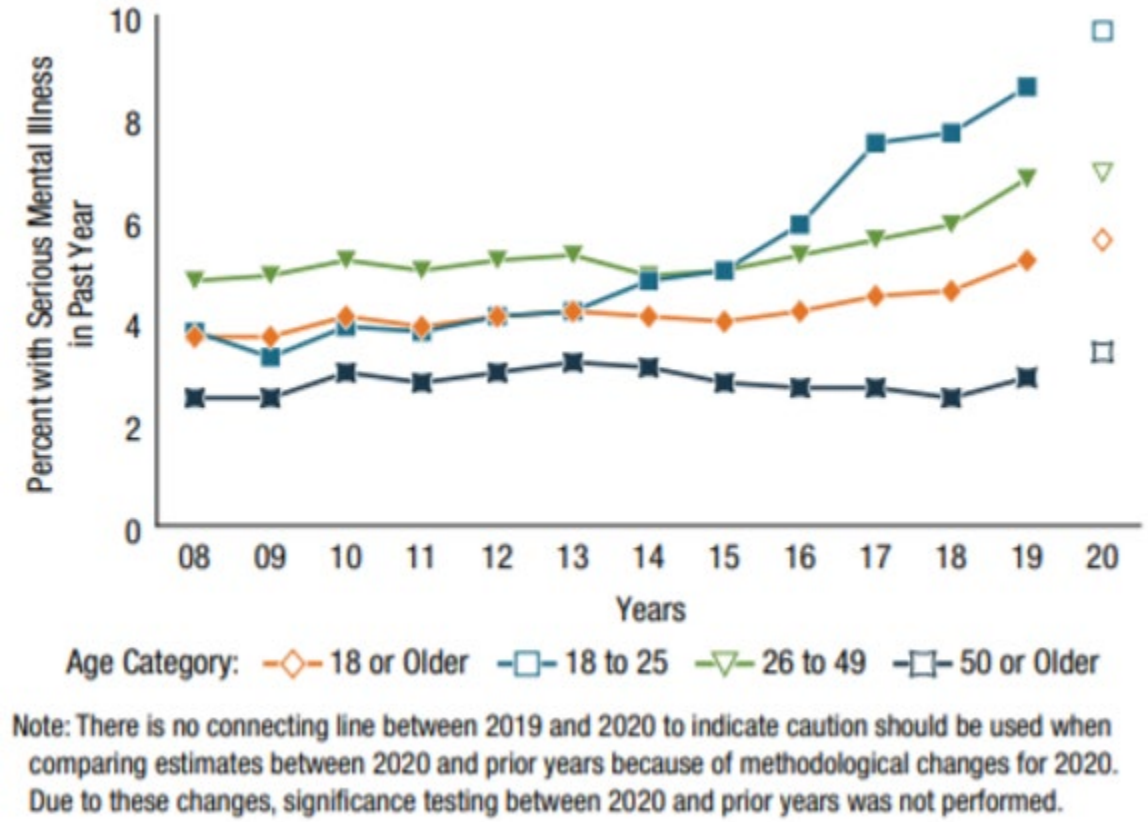
<u>Figure A2</u>. Major Depressive Episode with Severe Impairment In the Past Year: Among Adults Aged 18 or Older; 2009 – 2020 (NSDUH).



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

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

<u>Figure A3</u>. Serious Mental Illness in the Past Year; Among Adults Aged 18 or Older; 2008-2020 (NSDUH).

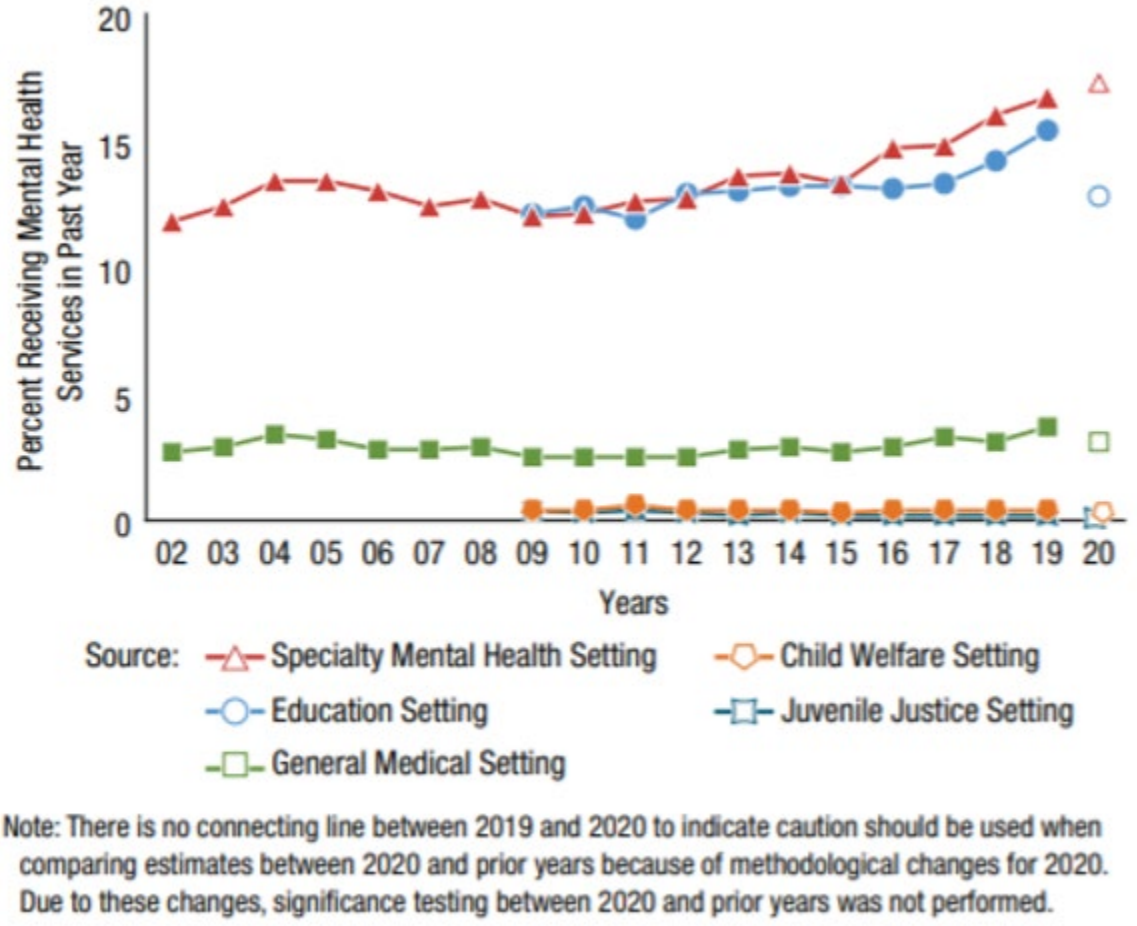


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

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

The next figure addresses the trends in how youth aged 12 – 17 received BH services, in terms of the place where the person is most likely to have received services. For more information refer to the 2021 NSDUH Survey, which contains extensive tables.

<u>Figure A4</u>. Sources of Mental Health Services in the Past Year: Among Youths Aged 12 – 17; 2002 – 2020 (NSDUH).



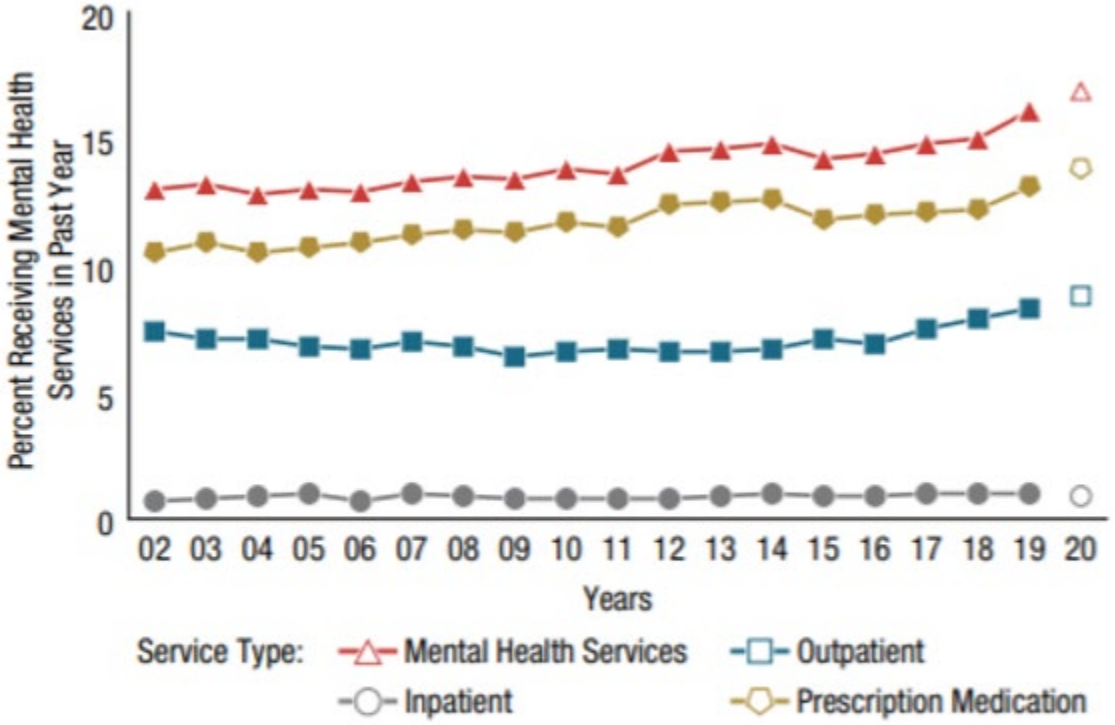
Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

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

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

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

<u>Figure A5</u>. Type of Mental Health Services Received in the Past Year by Adults Aged 18 and Over, 2020. (NSDUH).

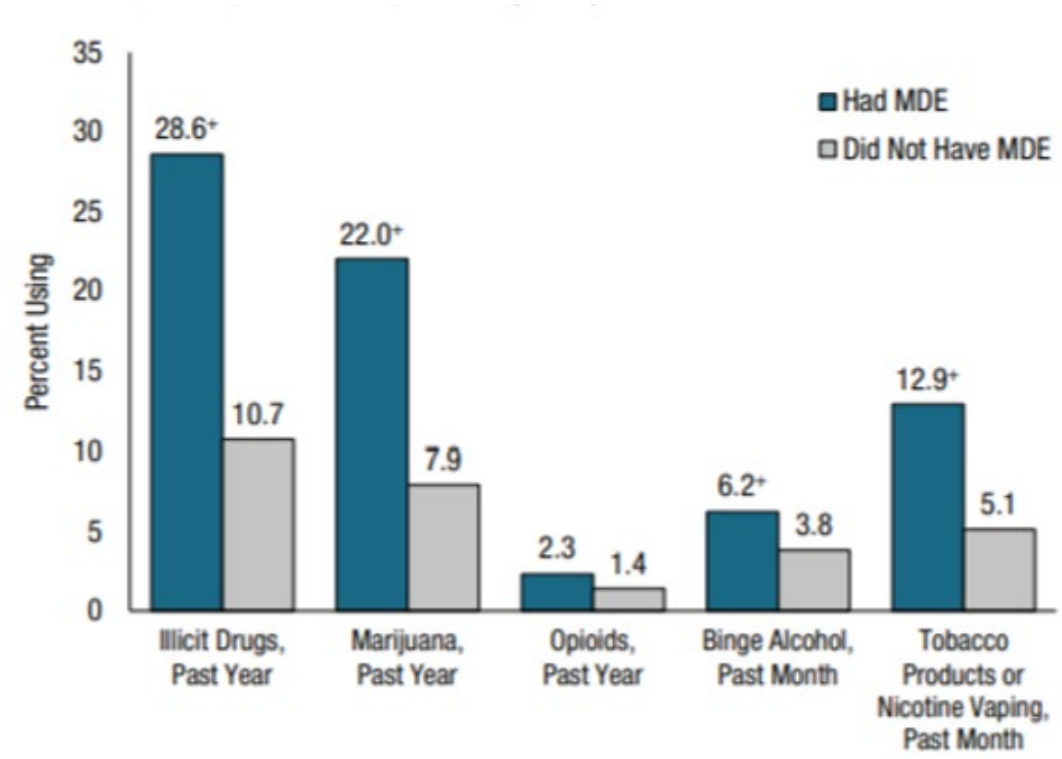


Note: Mental Health Services include any combination of inpatient or outpatient services or receipt of prescription medication.

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

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

<u>Figure A6</u>. Substance Use among Youths Aged 12-17, by Past Year Major Depressive Episode (MDE) Status, 2020. (NSDUH).



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

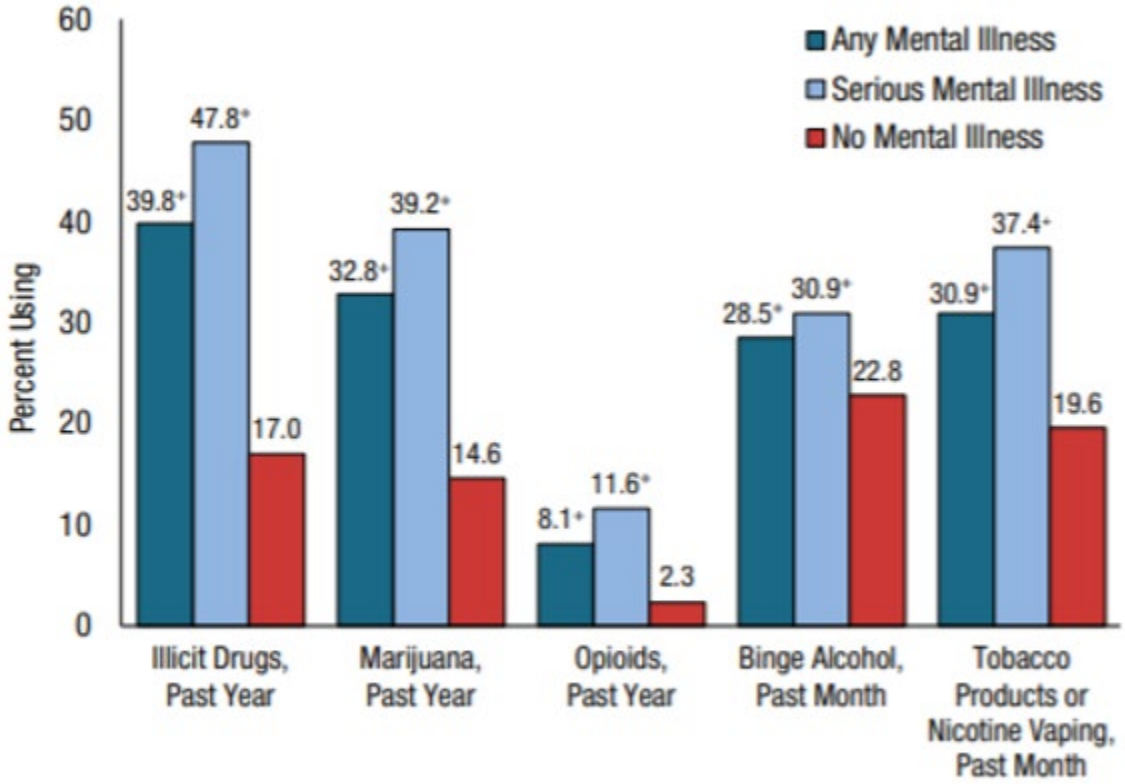
Note: Youth respondents with unknown MDE data were excluded.

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

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

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

<u>Figure A7</u>. Substance Use: Among Adults Aged 18 and Older; by Mental Illness, 2020 (NSDUH).



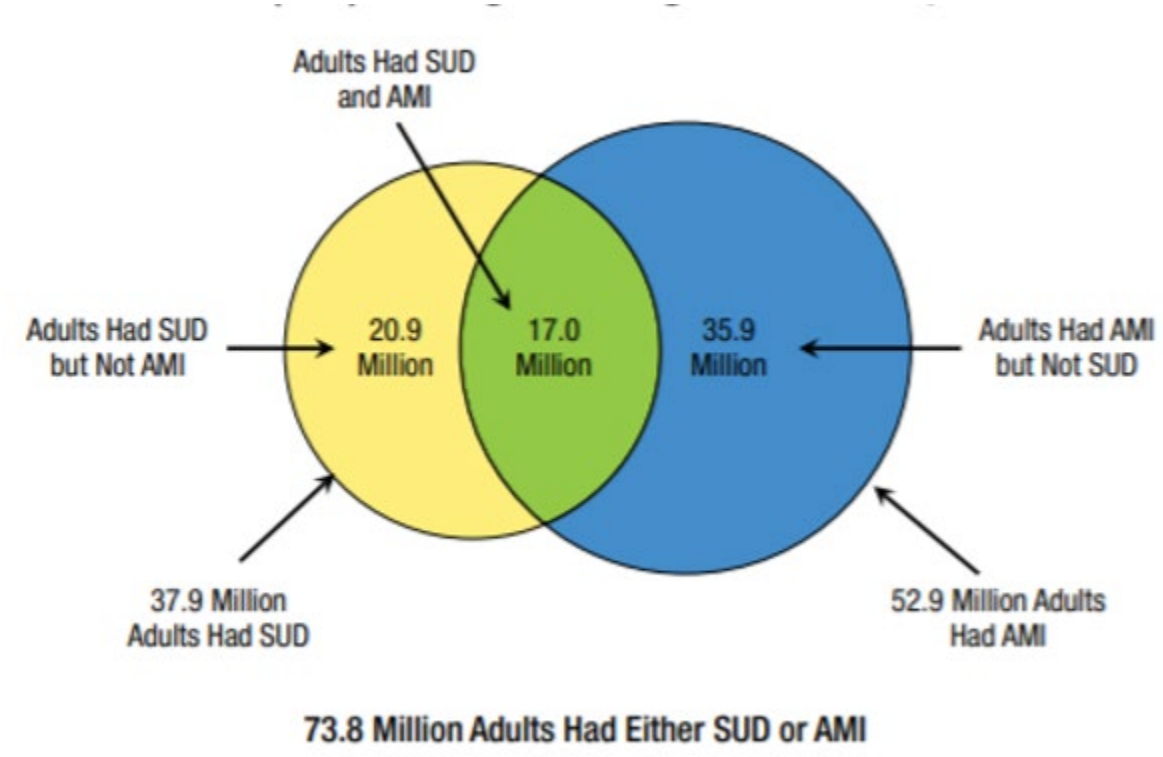
* Difference between this estimate and the estimate for adults without mental illness is statistically significant at the .05 level.

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

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

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

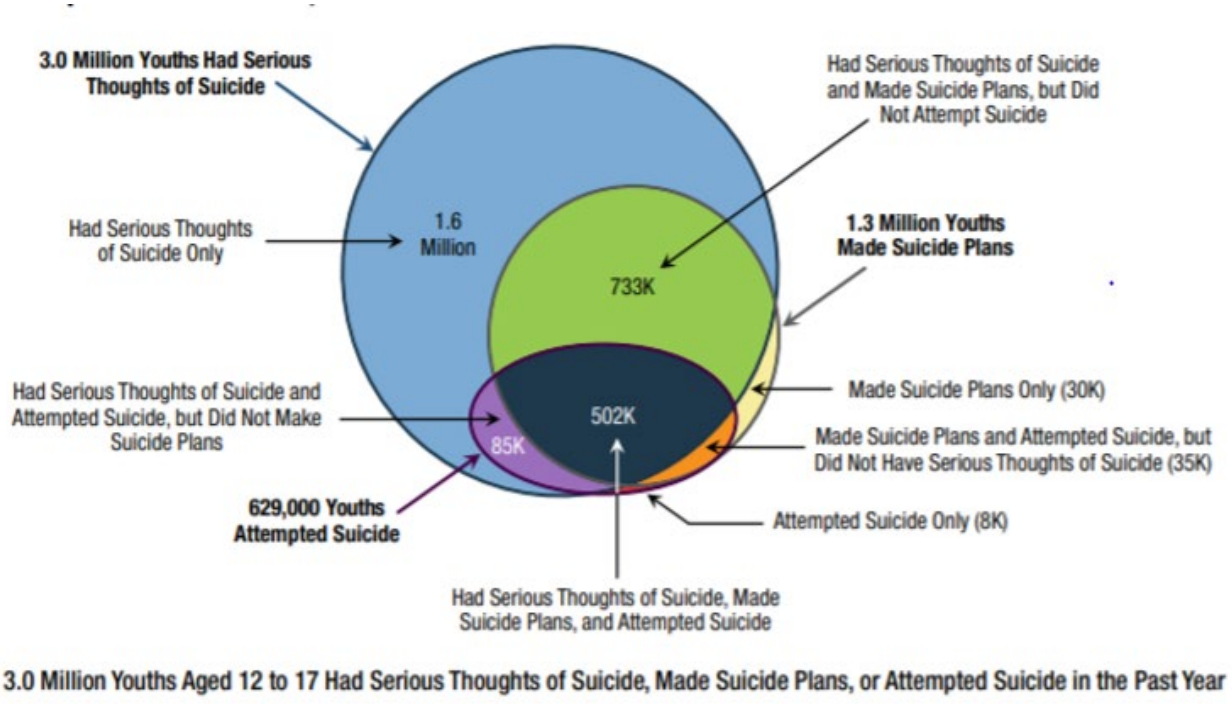
<u>Figure A8</u>. Past Year Substance Use Disorder (SUD) and Any Mental Illness (AMI): Among Adults Aged 18 or Older, 2020 (NSDUH).



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

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

<u>Figure A9</u>. Youths Aged 12-17 with Serious Thoughts of Suicide, Suicide Plans, or Attempted Suicide in the Past Year; 2020 (NSDUH).



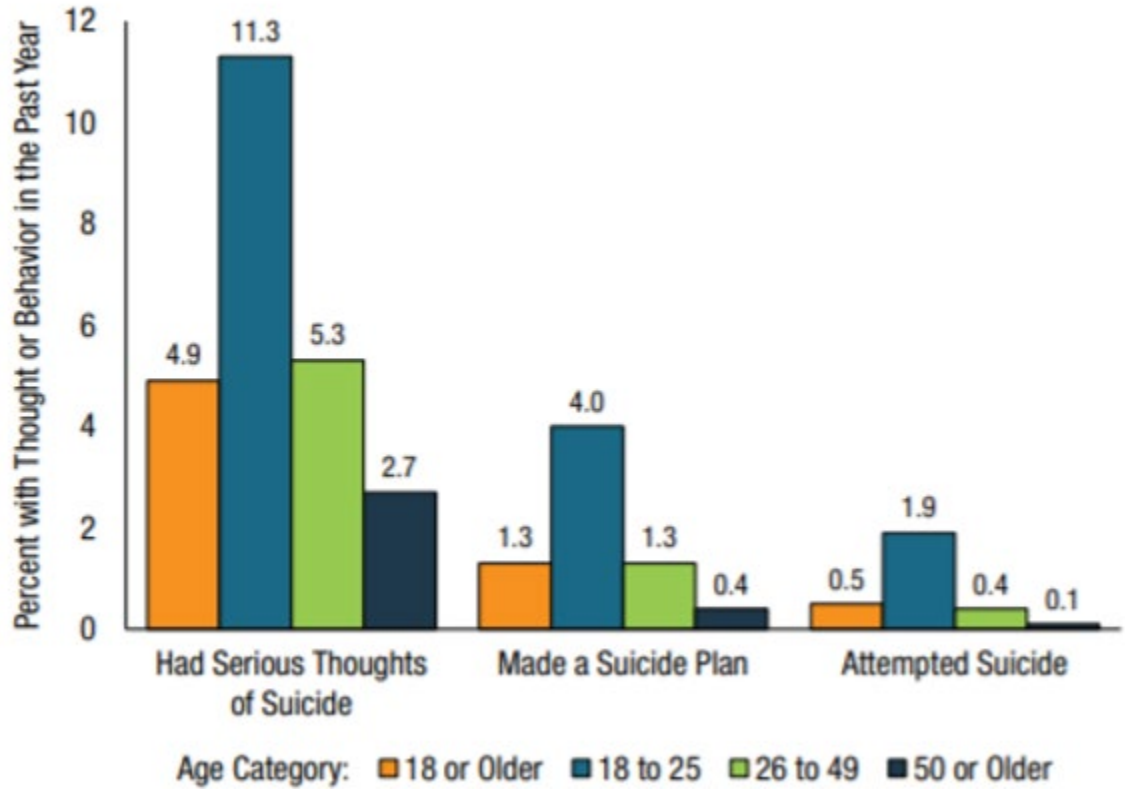
We can conclude from this figure that issues of suicidal thoughts, plans, and attempts comprise a significant risk among youth aged 12 to 17.

Data in California for 2015 showed that there were 36.5 hospitalizations for self-inflicted injuries per 100,000 persons in the age group 5 - 20[26]. In the year 2019, there were 525 deaths by suicide in CA for persons aged 5-20. Strategies are needed to reduce negative outcomes, including publicizing links to help-lines and reducing barriers to the access of mental health services.[27]

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

[26] www.kidsdata.org, accessed 2/3/2022.
[27] Please refer to the US Surgeon General's report and recommendations for suicide prevention, referenced later in this report in the section addressing BH in adults. The Report was release in early 2020 and addresses needs and programs for both youth and adults.

<u>Figure A10</u>. Had Serious Thoughts of Suicide, Made a Suicide Plan, or Attempted Suicide in the Past Year: Among Adults Aged 18 or Older, 2020. (NSDUH).

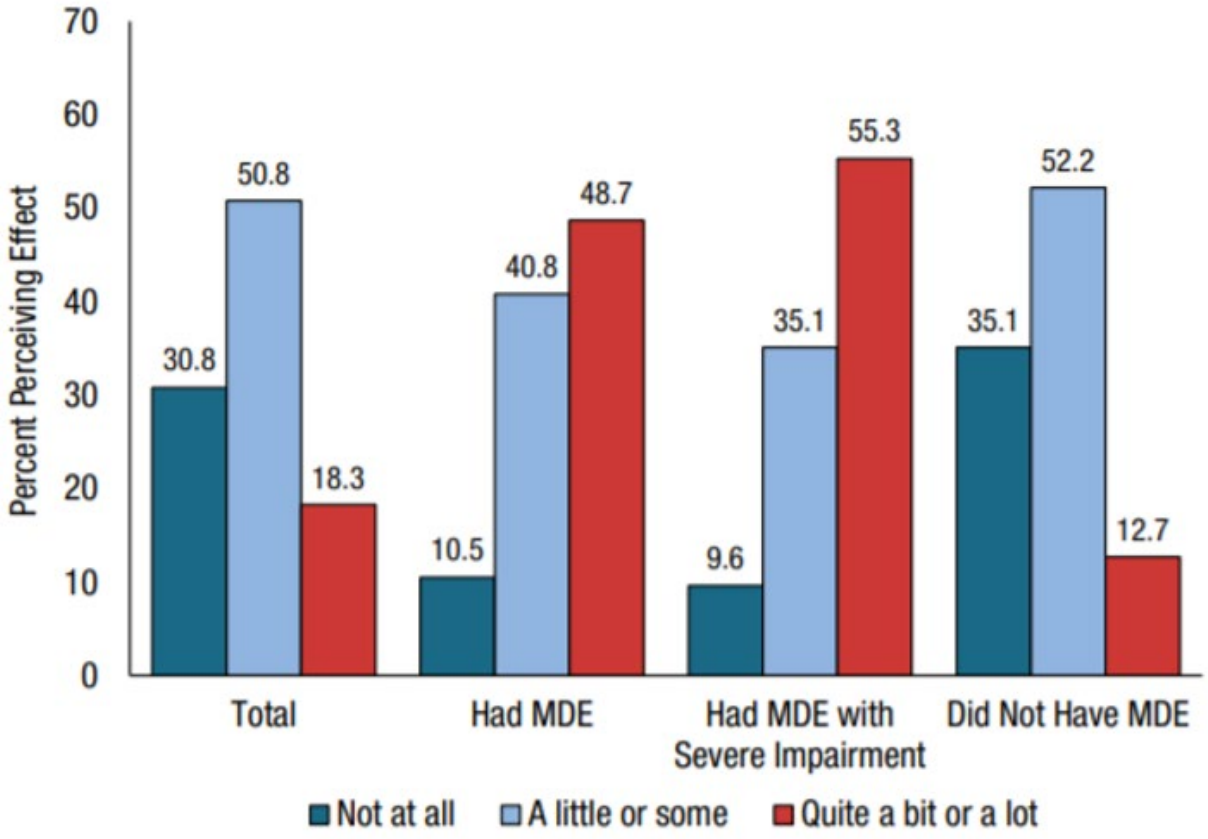


The data above show that in any given year, suicidal thoughts, or plans are perhaps more common than people might think, especially in those age 18 to 25. These data reinforce the need to have strategies[28] and programs[29] in place to help people in crisis and to publicize helplines and other resources for those of all age groups. The strategy document states:

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

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

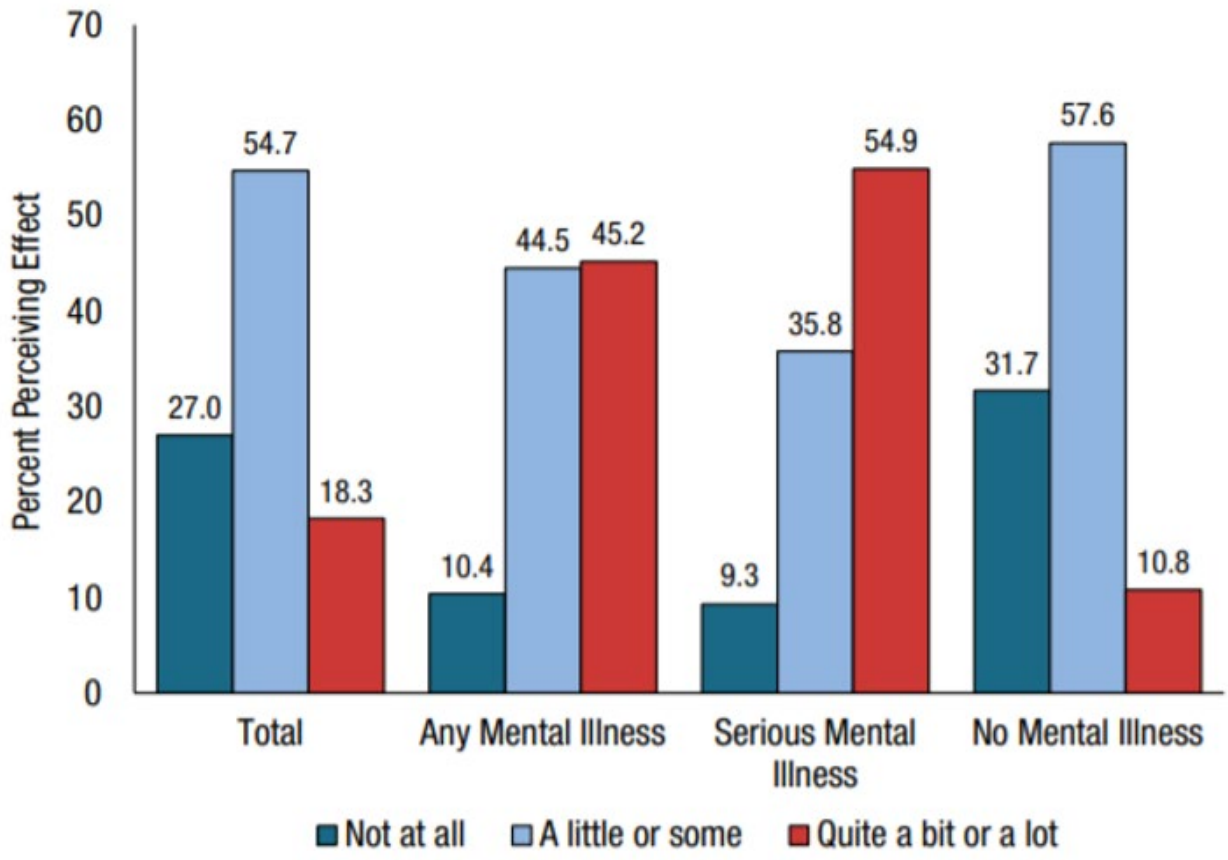
<u>Figure A11</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) States, Quarter 4, 2020 (NSDUH).



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

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

<u>Figure A12</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Adults Aged 18 and Older; by Past Year Mental Illness Status, Quarter 4, 2020 (NSDUH)

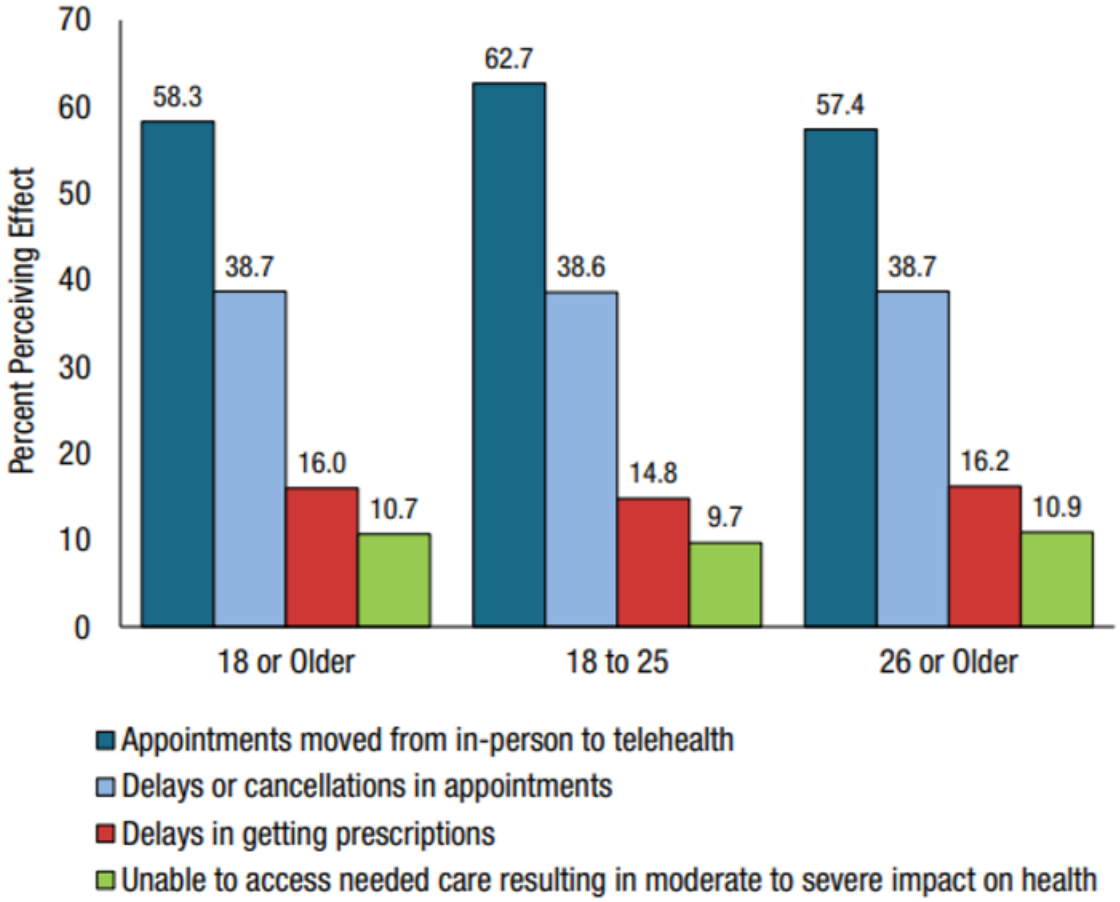


Note: The percentages do not add to 100 percent due to rounding.

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

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

Figure A13. Perceived Covid-19 Pandemic Effect on Mental Health Services, Among Adults Aged 18 and Over Who Received Services; Quarter 4, 2020. (NSDUH, 2021).



During this period, similar to the challenges at the national level depicted in the figure above, those effects and many other factors were found to have impacted mental health service delivery in California. External Quality Review Organization's (EQRO)[30] review of services that had been provided during the first half of 2020 by county behavioral health departments found that operations were affected by multiple factors. These factors included changes in methods of service delivery and procedures, rapid shift to telehealth, impacts to the workforce, changes in timeliness of appointments for services, suspension of focus groups and impaired ability of advisory boards to meet as desired, and other factors. Further details are included in the Cal-EQRO report for each county for 2021.[8]

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

APPENDICES II through XIII: LISTS OF QUALITATIVE RESPONSES for "Other", etc, Organized by Question Number and by County.

Appendix II. The descriptive responses listed under "other" in response to Question #8 regarding county programs for housing and homelessness.

Colusa County

- Adult Drop-In Center was re-opened.
- A county-wide Housing Program Manager was hired.

El Dorado County

- Compassion Pathways program.

Fresno County

- The PATH Program (15-257-4) received Community Development Block Grant for rural outreach, via expanded homeless Mentally Ill Outreach Treatment funds.

Lake County

- During 2020-21 fiscal year, Behavioral Health Services continued to provide housing support for our FSP clients. This included temporary support, such as motel stays, to more permanent housing where LCBHS subsidized rent while the client applied for affordable housing. Supportive services were provided during their housing.
- Additionally, LCBHS also paid for motel stays, if needed, for someone coming out of an acute hospital, on a temporary basis.
- Any client who is on a Lake County LPS conservatorship, LCBHS also paid for a "patch" for any Adult Residential Care wherever the client was placed, whether that was an in-county Board and Care or out-of-county psychiatric facility.
- Finally, LCBHS was the Lake County 'Continuum of Care Administrative Entity' during this time period.
- As the Administrative Entity, LCBHS helped write for and administer grants for Emergency Shelter, Rapid Re-housing, and Outreach Services. Those services aren't necessarily targeted to our clients, but our clients often partake of these.

Madera County

- Permanent supportive housing - 16 units Sugar Pine NPLH
- And 7 units Esperanza (MHSA housing).

Marin County

- PHF, Carmelita House, SSA
- Project Home Key
- Homeward Bound Independent Living Apartments (Casa Buena).

Merced County

- Navigation Center.

Napa County

- 54 units of permanent supportive housing funded by $18MM from Project Home Key and more than $2MM each from Napa City and County; expected availability Q1 2023.
- 8 unit/14 bed permanent supportive housing for elderly, medically frail individuals exiting homelessness, opened in Jan. 2022.
- Renovation commenced in June 2022 for 88 unit low/very-low income affordable housing, with 32 of the units dedicated as permanent supportive housing for individuals exiting homelessness; full occupancy expected by Q2 of 2023.
- Napa County was approved for an 80% increase in HUD Permanent Supportive Housing expansion grant funds.
- Napa County and City collaborated to obtain 45 Emergency Housing Vouchers from HUD, of which 11 were reserved for families or individuals fleeing domestic or sexual violence, stalking or human trafficking.

Sacramento County

- Invested in permanent supportive housing dedicated apartments.

San Benito County

- Helping Hands program
- Housing vouchers
- Help with utilities.

San Joaquin County

- Funding for Board and Care homes.

Santa Clara County

- In process of developing a 28-bed facility; completion expected in April 2023.

Santa Cruz County

- COVID alternate shelters in various locations.
- Also: Adult Residential Care ‘Patches’ to assist with obtaining housing.

Shasta County

- Basic household items were available.

Sierra County

- Homeless Housing Assistance & Prevention grant program.

Tri-City area (in one part of L.A. County)

- Homeless Prevention funds: security deposit, rental assistance, utility assistance

Tulare County

- The Homeless MDT was implemented and staffed within this fiscal year.
- This team is comprised of team members from Tulare County Health & Human Services Agency's three main service branches: Public Health, Human Services, and Behavioral Health.
- This team conducts direct street and encampment outreach, partners with other homeless services providers, supports our Room Key participants, and coordinates response efforts with all jurisdictions across Tulare County.
- The team includes two AOD Counselors and a Clinical Social Worker to provide SUD services, screenings, assessments, linkage and supportive services.

- Regarding Emergency Shelters and Supportive Housing, we have had significant changes to the structure of our housing programs. These changes are targeted to providing services to individuals experiencing homelessness, many of which have co-occurring conditions such as severe mental illness.

- 'Home Key' is permanent supportive housing.

- 'Room Key' is temporary non-congregate emergency shelter. We have been operating Room Key at two motel sites. One site will close on June 30 to begin renovation from Room Key to Home Key which is anticipated to take approximately one year. Our second site is currently operating at an alternative motel site while the primary site is undergoing active renovation from Room Key to Home Key, with anticipated completion in August of 2022.

Tuolumne County

- Resiliency Village
- GSAC Shower Bus
- Tuolumne County Commission on Homelessness
- Expanded Meal Programs through Interfaith organizations.

Appendix III. These are the qualitative or descriptive responses to Question #9, regarding recommendations or comments about needed improvements to behavioral health services for children and youth in foster care.

Alameda County

- Several new laws and regulations occurred in 2021 causing all counties to restructure their services to foster children and youth in group care. The laws changed as of October 1, 2021.
- Our County has spent the last several months developing Infrastructure, protocols, and hiring staff to meet the new mandates under the Families First Prevention Services Act (FFPSA) which was adopted under California's AB 153.
- This Act requires County mental health plans to provide assessments for all youth coming in and out of placement and to make placement recommendations, and to track all cases.
- The MHP must attend and facilitate Child and Family Team (CFT) meetings.
- It has been a great learning curve to take on these placement responsibilities and coordinate with Child Welfare, Probation, and the Juvenile Court systems.
- We are still developing the program and necessary services at this time.

Alpine County

- We do not have any group care in Alpine County.

Amador County

- There are no STRTP's or group homes for youth in Amador County.
- We place very few foster youths in STRTP's due to our small county size.
- If it is determined that this level of care is needed, Amador County Behavioral Health will work with Social Services and/or Probation and the facilities to ensure placement.
- With the Family First Prevention Services Act (FFPSA) Qualified Individual (QI) process in place, an assessment is completed to assist with determination of appropriate level of care.

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 in our county.

Calaveras County

- Our county is in the process of implementing wrap-around services.

Contra Costa County

- We need additional resources for children with intensive treatment needs (i.e., minors whose clinical status is too acute for a community setting).
- We recommend building out residential care resources for youth with high and complex treatment needs, such as short-term residential treatment programs, enhanced therapeutic foster care, and crisis residential programs.

Del Norte County

- We are under the belief that we can always improve our services.
- In order for our county to properly serve the foster youth we would need to have additional foster homes in which to place these at-risk children.
- We would like to expand our foster services program to have more options to keep siblings together.
- Further, we currently have a waiting list for CASA. Expanding our volunteer base would be desirable.

Fresno County

- Our county is addressing the needs of the foster youth in group care to the best of our ability.
- More resources are needed to support STRTP's, such as more staff, more training for STRTP staff and more mental health services.

Glenn County

- There is a need to identify more foster care homes in-county.
- We will identify TFC (Therapeutic Foster Care) homes in the region to meet the needs of this unique population.

Humboldt County

- We do not have any group care homes.
- However, one will be coming online in 2024, but we already need more capacity than what is planned in that project.

Imperial County

- We need to implement TFC homes and have more RFA homes.
- Department within our County needs to implement components of CCR.

Kern County

- We gave this negative response because we believe the objective of "enough" can never be achieved on behalf of foster children.
- There will always be opportunities and motivation to do more.

- We believe our behavioral health system is a wonderful program that works tirelessly. However, given the importance of children's needs, even the most valiant actions will never hit the marker of "doing enough."

Kings County

- We only have one STRTP on Kings County for up to 6 females, all other placements are out of county.
- Kings County does not have therapeutic foster care (TFC) Homes.
- Additionally, all psychiatric hospitalizations are also out of county.
- Increased trainings for children's counselors, increased need of counselors.
- We need to provide additional family therapy and training for specialty services for psychoeducation.

Lake County

- The need is greater than our staff can meet.
- We need better access to MH services, as there is no local group residential care available.

Lassen County

- There are not enough STRTP facilities in California.

Madera County

- We have made progress currently establishing a mobile crisis unit which will serve all ages as part of our Crisis Continuum expansion; this was identified as a gap last year.
- This year we are working with CWS to find a WRAP vendor and on partnering with local agencies to establish Therapeutic Foster Care Homes.

Mono County

- We do not believe this question is applicable to Mono County as we do not have any children in group care.

Plumas County

- Not enough foster homes or TFC homes.
- Not enough WRAP Community Supports/Partners.

Orange County

- Don't know, as most of these foster care MH issues fall outside of our BH Advisory Board purview.
- We will continue to ask and follow up with SSA and Probation Services.

San Benito County

- At present, we are doing all that we can.
- There is a new opportunity to meet the needs of foster children that require this level of services. Additional services are being developed that may help potentially to meet the community's needs.
- Currently, children and youth who need this higher level of care are served in contracted STRTP facilities in neighboring counties.

San Diego County

- More robust family support services like Therapeutic Behavioral Services (TBD) and parent support services are needed.
- We should allow facilities such as San Pascual Academy to continue in its present form and to offer ‘wrap-around’ services.
- We need to ensure that enough resources are allocated for these facilities to hire the appropriate staff needed, as many of the facilities are having staffing issues, such that some facilities cannot perform proper checks or give appropriate treatment as needed.

Santa Barbara County

- While we believe the quality of mental health care provided by our County is adequate, sometimes the STRTPs struggle with adequate staffing and having sufficient adequately trained staff.
- Staff may struggle to manage the degree of acuity of the clients being referred which in turn decreases length of client's stability in placement.

Santa Cruz County

- Santa Cruz County Children Behavioral Health in partnership with Juvenile Probation and the Human Services Department, Family and Children's Services are working to implement components of the Families First Prevention Services and other best practices to support these youth and their families/caregivers. Recent efforts include:
- Restructuring Interagency placement committee.
- Provision of Qualified Individual Assessments for all youth being considered for initial placement/transitions between STRTPs.
- Provision of aftercare services for youth stepping down from STRTP level of care to home-based placement.
- Promotion of the Family Urgent Response Services program, for youth at risk of going to congregate care settings.
- Greater collaboration with Substance Use Disorders Division to ensure youth in Residential MH programs have access to SUDS treatment.
- Exploring plans for a new building for a Youth Crisis Stabilization Center.

Shasta County

- Shasta County is doing the best possible with current resources and system limitations.
- However, more foster parents/resource families are always needed, as well as more beds in all other setting levels.
- We need more 'ILP' services to successfully transition youth into thriving in independent living, and an expansion of wellness programs.
- We need more focus on reducing ACEs to provide upstream intervention before long-term issues are created.

Solano County

- We have made significant improvements to our group care. For example, in 2021 our in-county STRTPs started providing in-house SMHS.
- However, due to lack of providers and lack of willing foster homes in our area, there is a gap- we could do more to attract organizations, increase rates with Bay area 'comps', and increase/attract therapeutic foster home families.
- And we could request CGF to support our gap services such as a CCRT or an Enhanced Complex Care program where there is a 'no eject - no reject' policy.
- Statewide, we need to do a better job to integrate MH and SUD care; many of the youth who need congregate care have co-morbid mental health and SUD issues.
- And, until very recently, there were almost no SUD services for the kids in Solano. Kids will often be kicked out of STRTPs if they come back to the facility intoxicated or if they bring drugs/alcohol into the facility and give those substances to other kids.

Stanislaus County

- Our County has outpatient, Therapeutic Behavioral Services (TBS), and Family Urgent Response System services available to support youth in group care.
- We have contracted with three local Short-Term Residential Therapeutic Programs (STRTP) that provide residential and treatment services to youth placed in our county.
- The gap for our county is related to youth with complex needs, especially during a time of crisis or an unexpected placement disruption and potential increase in the behavioral health needs for the child/youth.
- The recommendation would be to develop a crisis continuum for this population that includes specialized services, including Enhanced Intensive Services Foster Care, STRTP of One, Crisis Residential, Crisis Stabilization, and Psychiatric Health Facility services.
- All of this will be possible only if funding can be secured.

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 and 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 and youth, with the outcome of frequently disrupted placements that exacerbate the very behaviors that the STRTPs are supposed to be addressing.
- We will note that we have had some success in the past when we have provided Wraparound and/or Wrap-like services to youth to ensure that they remain connected to consistent behavioral health providers while in STRTP placements. This process ensures a smoother transition when youth step down from that level of care. However, there is no formal funding mechanism that allows for these services while the youth are in STRTPs, so it would be helpful if there were a way to fund this approach to treatment.
- Our local efforts around this issue have included ensuring that youth that 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 prioritize assignment of court appointed special advocates for youth in STRTP placements.
- However, it should be noted that Yolo County has made significant strides regarding this issue in the past two years and has reduced the number of youths that typically are placed in congregate care settings by almost half since 2019.
- The County has revamped the Interagency Placement Committee process and has made a commitment to ensure that youth are only placed in congregate care settings when necessary because of significant behavioral health challenges or an emergency that prevents placement at a lower level of care.
- Additionally, the IPC seeks to ensure that youth placements are short-term and focused on therapeutic interventions to ensure that youth step down to lower levels of placements by providing additional support to cases through an assigned behavioral health “liaison” (a county behavioral health clinician that is assigned to the case to provide support to the social worker/probation officer and who coordinates with the facility regarding treatment status).
- All youth cases are reviewed by the IPC at least monthly and receive second-level reviews in accordance with ACL 17-22. The County has implemented the “Qualified Individual” requirements of FFPSA Part IV and continues to make active efforts through IPC and other means to ensure that we are complying with all relevant statues and regulations related to congregate care placements.

Appendix IV. Descriptive or narrative responses for "Other", in response to Question 12, part h, regarding major points of stress in BH for children and youth.

Alameda County

- Decreased number of clinicians and staff to serve youth.
- High numbers of staff turnover and numerous staff vacancies across the system.

Fresno County

- At the beginning of the pandemic, access to behavioral health services decreased, but soon after increased.

Glenn County

- Adults are having a harder time helping children cope with stressors because of COVID and home schooling.
- Parents are feeling helpless.

Imperial County

- Increased utilization of Crisis Care Response Team and Mobile Response Team.
- Increased number of cases of youth presenting with substance use-related extreme behaviors.

Kern County

- Transportation, family stress, basic needs, unemployment.
- And due to many school systems being shut down, there was decreased ability to monitor child and youth well-being.
- One problem was a lack of BH inpatient bed availability for COVID positive youth.

Kings County

- With respect to children's Full-Service Partnerships (FSPs), we have seen an increase in anxiety expression, suicidal ideations, and reported self-harm.
- Many of the symptoms were linked to social isolation and social restriction.

Orange County

- #1 Point of Stress: Decreased workforce due to fewer qualified behavioral health professionals seeking employment with OC HCA and OC contract agencies.
- #2: Increased numbers of staff out sick with COVID and requiring quarantine.
- #3: Recruitment challenges due to highly competitive salaries offered by other organizations and contiguous county Mental Health Plans.

Placer County

- We don't have access to ED data, but we know opioid-related deaths increased.
- While mobile crisis calls decreased, 5150s increased.
- The pandemic impacted our access to youth, and we had to change approaches to reach them.

San Luis Obispo

- Increased requests for eating disorder treatment.

Santa Barbara County

- Increase in eating disorders.

Santa Cruz County

- Increase in eating disorder treatment needs in all levels: intensive outpatient, partial hospitalization, and residential treatment.

Shasta County

- While “Increased ED visits related to misuse of alcohol and drugs among youth” was not selected in our top choices, it is still an issue and major concern for members of the board in Shasta County.
- There simply was not a large increase in numbers seen over the course of the pandemic.
- However, any number of visits for this reason, large or small, is still problematic and not something we want to see affecting the youth in Shasta County.

Sonoma County

- Severe staffing shortage.

Stanislaus County

- As a department, we did not track data for options a-g specifically.
- However, anecdotally, children’s leadership staff received information that children, youth and caregivers were experiencing more anxiety during the pandemic and increased feelings of isolation.
- BHRS also observed a decrease in children’s crisis referrals in the first 3 months of the pandemic, followed by an increased number, but no specific trends over time.
- BHRS saw a decrease in the referrals coming from schools during the pandemic since children and youth were engaging in school remotely for a period of time.
- Our local Child Welfare referrals were decreased, which in turn also impacted referrals coming to Behavioral Health from Child Welfare.

- Service providers reported “higher acuity” as far as symptoms of youth who have been presenting to services during the pandemic and currently. However, we do not have specific numerical data to support these reported observations.

Tri-City MHB (in a region of L.A. County)

- Based on diagnosis data for anxiety and depressive disorders, there was a slight increase in both anxiety and depression during the pandemic.
- Emergency Room data from our local hospital revealed there was a decrease in ER visits.
- However, this may be due to people's fear of going to the hospital rather than a lack of need for ER services.
- Conversations with the clinical department indicate that most of these were points of stress during the pandemic.

Tulare County

- While general admission for SMHS was lower than expected, those youth that did engage in services had high risk factors associated with crisis states.

Tuolumne County

- #1 Point of Stress - An increasing incidence of youth considering suicide.
- #3 Point of Stress - Increased use of alcohol and drugs by youth,
- Includes a wave of overdoses and fentanyl use.

Ventura County

- Staff shortage.
- Emergency department data are unavailable.
- Data sharing agreements and systems are under development.

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

Alameda County

- Serving children and youth during the Covid-19 pandemic has been a challenge.
- With school closures, youth became less accessible, so relying on telehealth and/or virtual platforms for clinical services presented challenges.
- Engagement for younger children during the pandemic has been hard as they don't always have access to electronic devices for clinical services. Also, many children and youth did not have private settings to engage in therapy during the initial isolation periods and school closures.
- During the pandemic, our system lost many staff at many levels from administration to direct services and many of those vacancies remain open as recruitment has been a significant challenge.
- In relation to clinical services, our system both internal and external providers have been doing all they can to meet the growing service needs that we've experienced during the pandemic as well as the increase to service access as ushered in by the changes in Medi-Cal regulations.
- We continue to work hard to meet the need and keep up with all the new regulatory requirements that impact child and youth services within specialty mental health.
- We are hopeful that we can strengthen our infrastructure to meet the demands.
- We continue our system wide recruitment efforts to increase the number of available clinicians to provide services.

Amador County

- There were difficulties initially with telehealth due to lack of equipment.
- There was also resistance from youth to utilize telehealth.
- Youth were attending school virtually and they didn't seem to want to do therapy this way as well. This changed how clinicians interacted and provided treatment.
- There were also issues of privacy and confidentiality, as clients were not in the office with the clinician but in their homes and often had other family members nearby when they were trying to engage in their sessions.

Butte County

- Ongoing recruitment and retention challenges with behavioral health and health care workforce.
- Ongoing stress, burn out, and management of services in a complex time continues to increase the need for mental health and substance use disorder services.
- These conditions prevail concurrently with decreased provider capacity and less network access to meet needs and demands.

Calaveras

- Our county found it helpful to have a contracted provider (Sierra Child and Family) present on campus' as a student resource.

Colusa County

- Has expanded staff to meet the needs of youth.

Contra Costa County

- Several factors impacted access to mental health services during COVID, including school closures, access to telehealth-capable devices, and limited privacy for telehealth sessions.
- Due to diminished visibility of youth at schools or clinics, many with mental health were not identified or referred for services.

Del Norte County

- Our Children's Service provider has had significant staffing shortages which have impacted access to mental health services.

El Dorado County

- Expanding access to telehealth was valuable during the pandemic and helped to get services to children.
- The Wellness Centers were expanded quickly to respond to the need of children and youth when they came back to school in person.
- Suggestions include discussions between school and Behavioral Health to provide a strong foundation to create a resilient model to quickly deliver services to help children and youth, and their families, to get the services they need to respond during the next crisis.
- This would include a Rapid Response Model to coordinate with EDCOE to expand services across the county.

Fresno County

- Access to services was impaired due to technological difficulties and insufficient internet access for our community. These were concerns during the COVID-19 pandemic.

Glenn County

- We continue to make suicide prevention trainings more accessible for teachers, school staff, and partner agencies.
- With the recent Mental Health Services School Grant, we are identifying more office space for staff on school campuses to improve access for children, youth, and families.

- Mental health staff continue to support parents in the community to ensure they are part of the treatment team and have skills to support children at home.
- Behavioral Health continues to expand activities to promote Suicide Prevention information and training. This includes social media, information tables in the schools, and through local radio and television advertising, including Spanish networks.
- We are identifying opportunities to partner with other counties to promote the use of the new 9-8-8 Suicide Crisis line. The 9-8-8 line will be forwarded to the Glenn County crisis line to help link callers to local resources.
- GCBH will also collaborate with 2-1-1 information line to obtain data on the number of requests for mental health and/or substance use services each year.

Imperial County

- Clinician shortage due to the 'great resignation' produced increased caseloads for those who stayed.
- That caused delays in providing needed services to clients.

Kern County

- Protective factors for children decreased with other child-serving entities doing remote work.
- Schools, community-based programs, and behavior health staff had less face-to-face contact and were often the ones to detect MH risk factors for children.
- Each school district authored their own protocols for student contact, leading to inconsistencies in on-site service delivery.
- This has led to delays in ensuring appropriate linkage for children and youth who need additional support.
- In the last six months, all of these entities have increased face-to-face contact.

Kings County

- Children's FSP (Full Service Partnership) maintained a majority of services (68%) in the field at the height of the pandemic.

Lake County

- Major recruitment of mental health workers is essential.

Lassen County

- Many children/youth could not be admitted to psychiatric hospitals because many psych hospitals closed their youth unit during COVID.

Los Angeles County

- Access to Care – The workforce shortage has had significant impact on timely access to mental health services and community engagement.
- Schools remain a vital space for children and youth to access mental health services.
- However, the workforce shortage and school district restrictions on allowing outside partners on campus has impacted students' access to mental health services.
- Workforce shortage in directly operated clinics, which provided access to youth and families, has had significant impact on providing timely, quality services.
- Work force shortage with LEs, which provide school-based, community, and home-based services had significant impact on services.
- Many programs moved to telework services; however, this impacted those who were unable to secure stable internet services and/or computer devices.
- Data Collection – There is a need to improve data collection to better understand youth mental health needs, such information can enhance service delivery.
- Low research on high-risk populations creates barriers to engaging funders.
- HIPAA and FERPA laws may create barriers to gathering data to evaluate effectiveness of services.
- Sustainable Funding – Although there is a large push for increasing funding, there is concern how to sustain funding after time-limited funding expires.
- Need for flexible funding – Some funding sources specify what types of services and activities can be billed which may create barriers for personalized treatment.
- Improve collaboration between private and public partners to enhance access to mental health services.
- Recommend that all schools participate in the Healthy Kids Survey yearly; this will provide more information on youth mental health and the needs of students for MH services.
- Recommend screening for mental health in ER, hospitals; need better communication between hospitals and schools for re-entry plan.
- Recommend mapping of resources and services within County to increase collaboration and prevention services, and intervention programming.
- Increase arts programming in mental health services within prevention and intervention services.
- Identify and increase more non-traditional interventions and programming to communities (spiritual healers, arts and culture, animal therapy, sports).

Madera County

- During this time our department worked to ensure that clients had access to necessary services in all clinically appropriate settings which included In-Person, Telephonic, and Tele-Health.
- Our department worked in collaboration with partner agencies in the effort to ensure that community members were aware and had access to our services.

- Our department did have challenges securing placement in psychiatric facilities and residential placement during the initial start of Covid-19 Pandemic with limitations of availability of facilities.

Mariposa County

- During Covid-19, one concern was limited access to children in need of mental health services when school campuses were closed, and classes were 'virtual.'
- Teachers were not able to see students in-person and more accurately assess their needs, and the number of referrals for MH services decreased.
- Also, existing connections between child clients and behavioral health staff were lost. In these conditions, we feel that staff need to monitor client connections and raise concerns if not being contacted.

Marin County

- During COVID, utilization of mental health services for youth decreased initially for a variety of reasons.
- There appears to be a delayed impact of pandemic effects on youth and we are now seeing a return to robust referrals for youth in distress.

Merced County

- During the pandemic, prevention and early intervention services were increased county-wide to ensure reduction of stressors and a focus on 'help first.'

Mono County

- A local school administrator reported having "seen a number of young adults – ages18-21 – with anxiety and depression. Some in this age group have voiced that they are reluctant to go to MCBH because they see people they know and are afraid of confidentiality issues."

Napa County

- The Napa County Mental Health Division moved from telehealth to more in-person meetings with youth during the 2nd year of the pandemic.
- Youth had wearied of Zoom meetings for school and for therapeutic services during the previous year.
- Families and youth began asking for masked visits in their backyards, porches and schools.
- When positive test results required, Napa MHD pivoted to telehealth when the youth was well enough.
- Comments from educators, parents and providers also reflected the negative impact of "Zoom fatigue" across age groups, from primary school to college age, attributing to it an increase in child/youth stress, disengagement from education and interruption in essential developmental skills.

- "Distance learning" made it difficult to identify and engage with students in distress.
- Professional and community comments include specific concerns that negative educational and developmental impacts will outlast currently planned pandemic remediation efforts and funding.

Nevada County

- During the height of the pandemic, we really struggled with finding and connecting with youth. The schools are typically our largest referral source, and because they were not seeing youth in-person, they were not making referrals for MH services.
- Recently, that has changed, and our numbers are now increasing again.

Orange County

- Greater awareness of services is needed.
- An understanding of the needs and gaps analysis combined with sharing outcomes across the continuum of care continues to be a challenge for the community.

Placer County

- Youth are struggling due to lack of socialization during the pandemic, and lack of emotional coping strategy development.
- Funding is coming from many different locations for services to youth, but there is such a severe shortage of mental health professionals that it is going to take much time and effort to curtail this downward trajectory.
- County service providers are leaving to pursue careers in schools for fewer days worked (summers off) and in hospitals (offering large hiring bonuses).
- It is a severe strain on county services as we are the safety net provider.
- All community non-profit organizations with whom we contract for services are also suffering from this disappearing workforce.

Sacramento County

- We are having a workforce crisis. Our Mental Health Plan providers and the County are having significant staffing shortages, even though BHS has increased contract maximums to require increased salaries and incentives to attract and retain staff.
- We meet with providers every month to discuss hiring, retention, and recruitment strategies. Our provider network is trying very hard to address this workforce crisis, but we are not gaining ground.

- Our system is losing the most qualified staff, most of whom have a behavioral health license, to Managed Care Plans, schools, private practice, or leaving the workforce altogether.
- Managed Care Plans can offer salaries and often telehealth options that we cannot match.
- Schools require a mental health license, but pay significantly more and offer summer vacation, plus paid time off benefits.
- Private practice allows professionals to work at their kitchen table as they provide telehealth services. Online platforms are managing all the "back office" components, so all the professional has to do is open Zoom and do therapy.
- As a result of these attractive non-public behavioral health job options, we are losing our most seasoned and qualified staff and having to hire staff newly out of graduate school.
- Our BHS programming is set up to provide services to clients with moderate to severe intensity needs, while our partners are responsible for the milder needs.
- This means that our most acutely impaired clients are being served by less experienced staff and our clients with milder needs are served by the most qualified.
- Additionally, the exodus of staff from our system leaves those remaining to carry the large caseloads, which creates burnout and another reason to leave our mental health plan. Meanwhile, the referrals keep coming.
- Now that children are back to school, we are experiencing fewer suicide attempts than the prior year, but we also have an increasingly large referral flow for our short-staffed mental health plan.
- Additionally, COVID illnesses take the short-staffed programs down to skeleton crews as staff take time to recover and to isolate.
- These variables create longer times to get first appointments and higher caseloads that cut back the frequency and length of services necessary to address the acute needs of our population.
- Our providers have also lost staff that they have trained in evidence-based practices, so that expertise leaves with those staff, leaving a gap in service offerings.
- Recent increases to our FIT contracts have helped our public mental health sector a little bit with attractive salaries and signing bonuses, but that was only for MHSA-funded programs.
- 'CalAIM' is something our provider network hopes will result in less documentation burden, which has been a historical "turn off" for prospective and current staff.
- Our providers appreciate the ability to address homelessness with flex funds.
- While we have experienced a few positives, the workforce crisis overshadows our system and is a constant threat that keep our providers and County staff up at night, per their reports.

San Benito County

- The BHB had a discussion about the availability of MH services in the schools.
- It was noted that once students returned to “in-person” classes, there was an increase in the availability of MH services in the schools. This included both the PATH services delivered by SBCBH staff and MHSSA-funded services in the schools.
- There were also discussions about the increase in youth crisis interventions in the high schools.
- There was also concern over youth self-medicating with alcohol and drugs due to anxiety and depression exacerbated by COVID.

San Bernardino County

- The COVID-19 pandemic illustrated how crucial it is to maintain a cohesive network of community-based agencies collaborating to facilitate access to behavioral health care.
- In late March of 2020, providers began to adopt Telehealth services for Assessments and Treatment. Many community-based programs moved to 90-95% telehealth services.
- In the initial stages of the pandemic, ‘Children and Youth Collaborative Services’ (CYCS) put together a weekly “Telehealth Workgroup” with our children’s providers regarding the provision of telehealth services via a virtual platform. This allowed the providers to share ideas, tools, and techniques to use to engage children and youth via a virtual format.
- CYCS Staff worked with families, youth, and providers to address the fear and uncertainty and to provide resources to families who lost income or even their jobs.
- Upon the closures of the schools, CYCS met with school-based behavioral health providers [Student Assistance Programs (SAP) and School Aged Treatment services] to design a system where SAP served as an entry point into school-based behavioral health services.
- SAP providers also increased their engagement with their local schools by providing in-service trainings to the teachers, which included but was not limited to, how to identify youth struggling with behavioral health issues via a virtual format.
- The closure of schools during the pandemic led to a significant decrease in Community Crisis Response Team (CCRT) referrals, because at-risk students did not have contact with school personnel who may have been able to identify a need for crisis services.
- With limited/no access to the CCRT mobile response teams, Triage, Engagement and Support Teams (TEST) encounters increased, which could be interpreted to mean that more crisis calls were routed through law enforcement, indicating that the need remained despite the reduction in access.
- Similarly, utilization of other crisis services, such as Crisis Stabilization Units (CSU) and Crisis Walk-In Centers (CWIC) were reduced.

- Law enforcement limitations on welfare checks or calls wherein danger to others was not evident, further reduced linkage to crisis services.
- Additionally, throughout the pandemic, most of the Children's Residential Intensive Services (ChRIS) clinical staff continued with their in-person sessions. One major challenge for ChRIS staff was to address the emotional and behavioral upheaval of the pandemic and the associated quarantine with their youth in the group home.
- All programs experienced some barriers due to limited physical space and technology limitations, which resulted in restricted Telehealth services, especially with Child and Family Team meetings.
- Some providers solved this difficulty by purchasing digital tablets for youth, having the parents use their cell phones to participate, and they explored ways to ensure a confidential, secure space for therapy.
- By December 2021, many of our children's CBOs were providing 25% of their services in-person rather than by Telehealth. The clinical staff of these programs indicated that the clinical impact of Telehealth was mixed, and certainly varied by youth and therapist.
- Some clinicians reported that initially it was novel and successful despite the chaotic nature of the newly-COVID world.
- However, as the months passed, an increasing number of clinicians found that the youth wanted the personal touch of a face-to-face session.

<u>San Diego County</u>

- School support services were not robust.
- Since many kids receive MH services at their school site, and most schools were closed, many children did not get continued services just as they were isolated from their peers.
- The MH fallout from the pandemic exacerbated the mental health needs.
- Lack of clinicians amplified the problems.

<u>San Francisco County</u>

- Covid, the racial tension across the nation, political climate, and poor air quality given wildfires, all impacted staff and families throughout the pandemic.
- Compared to the same time period prior to the pandemic, we saw a 10% increase in suicide risk among our youth clients referred for crisis.
- We also had an increase in referrals to ICM level of care.
- We continue to manage risk as a system very well and intervene with appropriate services and supports to prevent harm, including expansion of 24/7 Mobile Response Team.
- Our providers immediately responded to the need to shift our services to Tele-behavioral health after shelter in place orders.
- Tele-heath therapy went from 30% use at the start of the pandemic to over 70% during the shelter in place within 2 weeks.

- We maintained face to face services to youth that were at risk or high acuity or for youth/ families not able to effectively engage in telehealth Services.
- We monitored access and engagement of clients in our services through Tableau © dashboards.
- There were also some trends of shorter sessions, but for more frequent contact, in that youth /families had Zoom fatigue given being on Zoom all day for school.

San Luis Obispo County

- A number of clinical staff have left to work for schools or private practice.
- Teletherapy has been effective but needs to be balanced with in-person care for our populations.
- The number of Medi-Cal eligibles has increased in our county.
- Mental health service requests also continue to increase.

Santa Barbara County

- 'Wait lists' with CBOs related to staffing impacts.
- Telehealth didn't work as well for kids with virtual school.
- No in-person groups were held.

Santa Clara County

- The penetration rates for youth services have been very positive for youth services, and we continue to develop programs that address the specific needs of various populations.
- We are intentionally designing programs that allow for flexibility and continuity of care for our target populations.

Santa Cruz County

- Increase in request for services, at the same time that we experienced staffing challenges across our system of care with severe issues for recruitment, hiring, and staff retention.

Shasta County

- COVID-19 created staffing challenges both in Children's Services and across organizational providers.
- There were high turnover rates reported in many of our 'Org' providers, and difficulty recruiting new staff.
- Referral times may have been longer, and there were increased caseloads.

Sierra County

- In-person, face-to-face interactions with counselors and other partners of care were dramatically restricted during the Covid-19 pandemic.
- As a result, the challenges of receiving services remotely were keenly felt by children and youth.

Siskiyou County

- The use of telehealth services for youth during the initial months of than pandemic resulted in a significant drop-off of service participation rates despite the observed increase in mental health issues among youth.
- Youth continued to decline (refuse) in-person services and we've found telehealth to be ineffective with many youth clients.

Solano County

- During Covid our county implemented two types of mobile crisis services: community-based and school-based. For the school-based team specific to children/youth, our Solano County office on Education oversees the staff, and our data show that both the utilization and acuity is high, and there is still a need for 'early intervention and diversion' from EDs.
- A critical area is the need for parent education, support and follow up- 'what to do, who to call.' Family-specific interventions and peer-support represent critical gaps in service.

Sonoma County

- Since the pandemic began, we have experienced an on-going and severe staffing shortage which decreases the quantity of services available and impacts our clients' ability to access adequate services in a timely manner.
- This has also had a significant negative impact on staff morale.
- The cumulative impact of repeated wildfires in this county along with the pandemic, has resulted in a significant increase in requests for services for children and youth, and in the acuity of youth requesting MH services.

Stanislaus County

- In the Children's System of Care, when the pandemic began, we quickly shifted to allow options for telehealth and telephone services to ensure continuity of care and continued access to services.
- We also operated an in-person clinic.
- The pandemic had a significant impact on staffing, creating workforce shortages that required management on a daily basis to ensure services continued across the system of care.

- This required a great deal of collaboration and flexibility, emergency planning meetings, cross-system communication, monitoring, and a willingness to operate very differently than was typical.

Sutter-Yuba Counties

- As with all agencies, at the beginning of the pandemic, we lacked the resources to provide consistent supportive services to both existing and new clients.
- However, the county quickly responded and provided the equipment required to deliver telehealth services.
- Staff worked diligently to develop clinical skills in delivering effective telehealth treatment.
- For many clients and their families, that required more intensive services. Telehealth services alone were found to be a marginal or poor substitute to in-person services.

Tri-City MHB

- Adapting to the changes and the increased need for various services was challenging.
- Trying to meet the needs of children and families with limited staff was difficult.

Tulare County

- With less face-to-face engagement of youth in the schools and outside of the home, there were also fewer referrals for MH services.
- Then, youth often were only being connected when they were significantly struggling or in crisis.

Tuolumne County

- The source of referrals during the pandemic dropped (from schools).
- Initially, youth were accepting of the telehealth modality. According to staff, youth enjoyed it. However, a drop in interest occurred as youth became tired of telehealth.

Ventura County

- The Youth & Family Division has sought to be responsive, nimble and creative in continuing to create access for youth and their families during the COVID-19 pandemic.
- All programs and staff have been available in-person throughout the last fiscal year.
- Telehealth therapy, case management and psychiatry remain options, as clinically appropriate, for youth and family members that have transportation challenges, other barriers, or are not comfortable with in-person services.

- During the pandemic there has been a significant increase in youth served in our clinics and programs. Likely factors include expansion of Medical Necessity, increased outreach efforts and the ongoing stressors of the COVID-19 pandemic.
- The Division continues to receive trauma-informed and evidence-based training to meet the complex clinical needs of the client population.
- Staffing of our programs and clinics is a current concern. There is a shortage of mental health workers nationwide; the County of Ventura is impacted as well.

Yolo County

- A major concern since the beginning of the Covid-19 pandemic has been the challenge in hiring and retaining mental health staff to serve the needs of our community.
- All of our E.P.S.D.T. contracted providers have shared that it is has been difficult to hire mental health staff, including clinician and MHRS positions.
- Due to the lack of therapists, there have been occasions where providers have been unable to take on referrals because they didn't have a therapist available to complete the assessment and to provide services.

Appendix VI. Descriptive comments submitted under "other" for Question 15 regarding major points of stress on the system for Adult BH needs and services.

Calaveras County

- We have seen a larger than usual number of non-Medi-Cal beneficiaries seeking services.

El Dorado County

- Individuals who were already receiving mental health services did not experience a decrease in services.
- However, for new clients to the system of care, it was more difficult to access services because the majority of services were through telehealth. Some clients initially did not have the capacity to participate in telehealth because of limited broadband and limited access to computers.

Glenn County

- Persons without housing and living in the community experience additional stress. It is difficult to obtain benefits without an address, and to secure basic living necessities (e.g., phone; medications; refrigeration; food; hygiene).
- GCBH continues to identify housing opportunities for these individuals to support their health and wellness.

Fresno County

- The number of individuals utilizing DBH services increased following the onset of the pandemic and has remained stable in the time since.
- However, we do not have an ongoing mechanism for tracking individuals receiving services by diagnosis (e.g., anxiety, depression as noted above).
- Due to the manner of which diagnosis is tracked in our EHR, our data on ED admissions is based on follow-up appointments with DBH post ED admission.

Humboldt County

- Lack of crisis triage, limited space in treatment facilities, and lack of housing.

Imperial County

- There was a considerable decrease in utilization of services.
- ICBHS made telehealth services available for clients but still some of them did not feel comfortable receiving services via telephone/ zoom.
- An increased number of individuals presented with substance use problems.

Kern County

- Inpatient bed availability for COVID-positive adults.
- Placement availability for long-term clients needing locked facilities.
- Increased acuity in clients accessing BH services.

Kings County

- Staff shortages with possible explanations such as budget decreases/position cuts, employee attrition due to burnout for personal reasons.
- Inability to fill open positions due to increased recruitment competition.
- Caseload size limits the quantity and frequency of services.

Lake County

- Increased stress due to multiple exposures (to covid and trauma) of patients using emergency services.

Napa County

- Responses from community members included increased social isolation and depression, and increased anxiety.
- Increased self-medication with drugs and alcohol, especially among older adults.

Nevada County

- Increased drug overdose deaths.

Orange County

- Recruitment and retention challenges due to highly competitive salaries offered to candidates and longer response times to find and secure talent.

Santa Barbara County

- Increase in aggressive behaviors observed.

Santa Clara County

To identify stress points, we examined intake information and diagnostic codes related to admissions in BHSD programs and emergency rooms. And we examined causes of death from the County morgue. These data indicate that the County of Santa Clara experienced several stresses on the system for Adult Behavioral Health, as follows.

- The first is decreased access/utilization in SUTS programs. The County experienced declines in enrollments in almost all modalities of SUTS programs due to distancing requirements and the use of telehealth.
- Second, the County also experienced an increase in the number of people presenting with anxiety related diagnoses as the pandemic proceeded. The numbers averaged around 400 patients per quarter prior to the COVID outbreak.

They stayed stable throughout 2020, but since the beginning of 2021 cases have increase to about 600 cases per quarter.

- Third, there was a spike in self-harm related admissions to the ER that began in November of 2020 and abated in the spring of 2021. During the same time there was also a spike in admissions to Emergency Psychiatric Services.
- In contrast, self-harm related calls to the Call Center did not increase nor did the incidence of suicides. For the other points of stress referenced in the question, the County did not experience significant increases in visits or calls for help.

Shasta County

- While only two categories were identified as having increases great enough to create additional stress on Shasta County's services, all these issues remain problems, and were already at concerning levels in our county, and deserve attention.

Stanislaus County

- Data reviewed indicate an increase in client access but a decrease in client utilization of Mental Health Services.

Sutter-Yuba Counties

- Being a rural community, our population has limited to no access to technology to offer or facilitate telemedicine.

Tri-City MHB

- Based on diagnosis data for anxiety and depressive disorders, there was a slight increase in both anxiety and depression during the pandemic.
- Emergency Room data from our local hospital revealed there was a decrease in ER visits; however, this may be due to people's fear of going to the hospital rather than a change in need for ER services.
- Conversations with the clinical department indicated that most of these were points of stress during the pandemic.

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Appendix VII. Descriptive information under "other Comments or concerns" about Adult Behavioral Health services and needs, in response to Question 17.

Alameda County

- The pandemic put a great deal of strain on both beneficiaries and providers. Individuals are seeking more therapy services.
- The workforce capacity issue is so significant now that we are having difficulty getting beneficiaries timely appointments to services at all levels of the system.
- In turn, this resulted in slower access to care and lower performance by providers.
- 'Burn out' is a significant issue due to low staffing and the effects of the pandemic on providers themselves who have concerns for their own health and that of their families.

Amador County

- Initially, there was an adjustment to telehealth services for both clients and clinicians.
- Due to lack of telehealth equipment, sessions were initially being conducted by phone only, so it was difficult to get an accurate assessment as we could not see the clients and much of an assessment is what is observed during a session.
- Privacy and confidentiality were concerns, as clients were not always in a private place to engage in their telehealth services.

Butte County

- Ongoing recruitment and retention challenges with behavioral health and health care workforce.
- Ongoing stress, burn out, and management of services in a complex time continues to increase the needs for mental health and substance use disorder services, concurrently with less provider capacity and limited network access to meet these service needs.

Calaveras County

- It is becoming increasingly more difficult to hire qualified staff.

Colusa County

- Crisis team was created to address the increased need for crisis services.

Del Norte County

- We continue to evaluate the impacts of COVID-19.
- However, the pandemic continues to be on-going at this time [editor: 2022-early 2023].

El Dorado County

- It is important to have access to BH services at the ED 24/7 to respond to all BH crisis situations.
- This includes having the capacity to call the Access Line during a crisis; having a mobile crisis team to respond to the crisis in the community; staff on-site in both Hospital Emergency Departments to respond to any BH crisis.

Fresno County

- Yes, to question 16 above.
- 1st priority points of stress: Staffing issues, inability to hire, quarantine and remote services.
- 2nd: Facility limitations (spatial) so no walk-ins, also no transportation (bus).
- 3rd: Technology challenges (not yet fluent in Teams, Zoom etc.

Glenn County

- There is concern for ensuring adequate nutrition and housing for the unhoused community.
- In addition, as funding and services are expanded, there is a need for additional office space for BH staff and partner agencies to deliver services.

Imperial County

- Increased number of clients reporting being homeless.
- Lack of beds or places to be able to house (temporarily) clients.
- Clients were referred to Home Energy Assistance Program and Homeless Task Force during pandemic, which assisted clients with temporary placement.
- Workforce challenges related to staff leaving then resulted in clinicians having high caseloads and delays in providing needed services.

Kern County

- Needing services for adults decreased with the transition to remote work.
- Social service agencies, community-based programs and behavioral health staff had less face-to-face contact, and therefore adults with needs that would have otherwise been identified may have been missed.
- In addition, sober living environments, room and boards, adult residential facilities and skilled nursing facilities implemented different levels of restrictions at different times which made it difficult to deliver face-to-face services in client's homes.
- Inpatient psychiatric beds and other enhanced placements were also a challenge due to facility shutdowns as a result of client and staff outbreaks of COVID.
- Also, facilities not being able to accommodate COVID positive clients in need of inpatient psychiatric care.

Kings County

- Staff shortages impacted our adult providers in many ways, specifically staff shortage, resulting in an influx of consumers seeking services and not having staff to be able to serve in a timely manner caused long wait times.
- Based on staff shortages, this contributed to burnout of the remaining staff, resulting in further staff attrition.

Lake County

- Continued lack of assistance for family and volunteer caregivers who support individuals suffering from aging-related mental health issues.
- The county needs do a better job at allowing patients access to care. It is hard for anyone in Lake County to get seen for mental health. There are not enough providers or facilities.
- Behavioral Health Department was near impossible to reach for Mental Health Services and Crisis teams would not provide MH services.
- We do not have enough services in this county to meet the acute need of the community.
- Crisis and drug and alcohol services are dangerously lacking in their ability to meet the need of the community.
- We need 100 community health/peer support workers in Lake County.

Lassen County

- Many could not be admitted to psychiatric hospitals because many psych hospitals would not accept a person if they tested positive for COVID even though they had no signs or symptoms of illness.

Los Angeles County

- As a result of the Covid-19 pandemic, DMH experienced challenges in terms of recruiting and retaining mental health professionals.
- This challenge was in part due to staff leaving the profession or deciding to exit the public mental health system. This shift made the corresponding increase for mental health services difficult to address.
- Currently, the department is leveraging recruitment and retention strategies to ensure that the workforce is adequate to meet the expanding needs within Los Angeles County.

Madera County

- Covid-19 triggered the ‘great resignation’ which later resulted in staff shortages state-wide; Madera County is not the exception to these challenges.
- Additional resources and approaches to reach potential candidates have been implemented to create interest in current vacancies.

- Some of these efforts include sending communications to all potential clinical candidates state-wide, distribution of a hiring flyer, leveraging of social media platforms, spreading the word in the agency and community.
- Retention strategies have also been implemented in the form of incentives for hard-to-fill direct service vacancies, bilingual pay opportunities, and internal lateral transfer opportunities.
- Our department did have challenges securing placement in psychiatric facilities and residential placement in the initial start of Covid-19 pandemic with limitations in the availability of facilities.

Marin County

- The pandemic increased the number of Medi-Cal beneficiaries, and the increased numbers both eligible for MH treatment and seeking services meant that more people qualified for services in our system of care than previously.
- This has had ripple effects into the system of clients with high needs with diagnostic pictures that were different than pre-pandemic in terms of trauma, depression, anxiety, and personality disorders.

Mariposa County

- In some areas of the county, older adults needing treatment were fearful of in-person services due to underlying medical conditions, but they also had difficulty using telehealth due to poor internet connectivity.
- Another issue was that engaging new clients proved difficult during transition from in-person to telehealth.

Merced County

- Each behavioral health program created a plan for increasing adult engagement and serving them to strengthen protective factors and function as a buffer.

Mono County

- A local school administrator provided this extended observation, having *"seen many young people become discouraged with school (post high school) and want to take one or more gap years, or drag out their completion by dropping courses, or drop out. I'm not at all sure that gap years are a bad thing. That may be very healthy for these students. However, the students that were at home for a chunk of high school, often seem disorientated with the world. They perhaps did not get the support and socialization both with peers and supportive adults during high school, and now really need both even though they might not even realize it! I believe MCBH has done an incredible job of reaching out with a variety of programs, as we came out of the pandemic and could start being more active again. Sometimes it is very difficult to get those who need it the most to become involved!"*

Napa County

- Comments from community members reflect that the pandemic increased stress and anxiety for parents and caregivers who did not work remotely, due to the lack of access to daycare and child-care resources.

Nevada County

- The rise in fentanyl-related drug overdoses and deaths has been horrifying over the past three years.

Orange County

- Greater awareness of services.
- An understanding analysis of the needs and gaps analysis combined with sharing outcomes across the continuum of care continues to be a challenge for the community.

Placer County

- We need increased access to Substance Use residential, MH beds, and shelter space (although project Room Key helped).
- Covid reduced our number of "beds" available and increased wait times to needed care, in particular SUD.
- We had to space people out to isolate with Covid cases.

Sacramento County

- The adult outpatient mental health system did not experience a significant decrease or increase in services during FY 2019-20.
- The data show a slight decrease of 2.8% in overall utilization, Anxiety diagnosis increased from 14% to 16%, and Depression diagnosis increased from 21% to 23% during this period.
- The system was able to implement a flexible delivery approach offering services in person, or via phone as well as through telehealth.
- The crisis continuum was impacted during this period, for example the Crisis Residential Programs and the Mental Health Urgent Care Clinic capacity and hours of operation were impacted by COVID outbreaks and staffing coverage issues. All of these factors resulted in limiting access to these resources.

San Benito County

- BHB members discussed the concern about an increase in anxiety and depression for adults during and after the COVID-19 pandemic.
- It was also noted that adults coped with the increase in anxiety and depression by an increased use of alcohol and drugs.

San Bernardino County

- The COVID-19 pandemic illustrated how crucial it is to maintain a cohesive network of community agencies collaborating to facilitate access to behavioral healthcare.
- With limited/no access to the CCRT mobile response teams, TEST[31] encounters increased, which could be interpreted to mean that more crisis calls were routed through law enforcement, indicating that the need remained despite the reduction in access.
- Similarly, with fewer referring community agencies in contact with potential adult consumers, linkage to and utilization of Crisis Stabilization Units (CSU) and Crisis Walk-In Centers (CWIC) were reduced for three out of four facilities.
- Additionally, law enforcement limitations on welfare checks or calls wherein danger to others was not evident, further reduced linkage to crisis services.
- Finally, increased placement barriers to stepdown facilities following inpatient psychiatric treatment led to an increase in inpatient lengths of stay when an alternative level of care may have been more appropriate for consumers' needs.

San Diego County

- No. Clearly, the same problems caused by the pandemic exists for all adults, but specifically the lack of wraparound services for the unhoused.
- Programs need to become more accessible for children in group care especially since they do not use private insurance and many services are restricted because of this.
- More behavioral health programs also need to be available and adequately staffed.

Santa Barbara County

- 3rd priority concern above indicated as "Other" is: Increase in Aggression.

Santa Clara County

- BHSD saw a decrease in the number of adult and older adults accessing services in-person during the pandemic based on fear of contracting the virus.
- As public health restrictions were reduced, there was a rebound effect in clients accessing BHSD services, far exceeding the previous year during lockdown.
- See our county's response to Question 23 for more information about staffing.

[31] Need definition of TEST acronym, maybe with a supporting reference.

Santa Cruz County

- COVID outbreaks in MH facilities limited the capacity for new admissions.
- Shifting to Telehealth or Telephonic services was challenging for adults experiencing homelessness.

Shasta County

- Lack of adequate staffing was, and continues to be, a major problem, although the board recognizes this is not limited just to adult behavioral health programs.
- An additional concern for the board is that telehealth services are not always the most appropriate or effective, especially for individuals with psychotic disorders.
- While it was understandable, particularly in the early stages of the pandemic, that in-person services were not always available, they are sometimes the best or only way to ensure adequate levels of care and emotional support for many consumers.

Sierra County

- Sierra County Behavioral Health maintained both clinical sites and all services throughout the Covid-19 pandemic.
- We successfully implemented telehealth services with support access in the office and out in the field. Transportation services were demised due to safety protocols but have since been fully reinstated.

Siskiyou County

- We have had a significant rise in the number of people living unhoused since the beginning of the pandemic, and a significant influx of fentanyl.
- Our system is inundated with people seeking housing services, which has impacted our ability to provide timely access for those seeking behavioral health services.

Solano County

- During Covid our county implemented mobile crisis services, 2 types: community-based and school-based.
- For the community-based mobile crisis used by adults, the prevalence of drug use and mental health symptoms are high, and law enforcement training needs to be expanded (we will be implementing CIT soon).
- Expansion of crisis/peer respite funding would be ideal.

Sonoma County

- Staff burn-out increased, which created shortages and capacity issues.

Stanislaus County

- Due to the limitations and challenges presented by COVID-19, several services were provided via telehealth in accordance with local safety guidelines.
- In-person services were provided when clinically indicated.

Sutter-Yuba Counties

- During the Covid-19 pandemic and the transition to telehealth services, our more rural and isolated partners faced the most challenges.
- Those with a larger socioeconomic barrier or rural location had an easier time with a telephone only appointment versus using an online video conference appointment.

Tri-City MHB

- Our agency was very adaptive to the needs of the community.
- However staffing and reduced services from other agencies presented challenges.

Tulare County

- Adults increased their access of SMHS.
- Additionally, the MHP opened services to more adults due to significant risk factors and potential deterioration.
- This was in parallel to more adults presenting in crisis, many with no previous MH services.

Tuolumne County

- During the COVID-19 pandemic, it was necessary to close the department's Enrichment Center (for clients), and the Lambert Center (for the homeless).
- There was a loss of volunteers to work with the adult programs.
- It was helpful for staff to become familiar with other organizations and partners to assist adult behavioral health clients.
- During the pandemic, State and Federal funding were "thrown" at various programs/services. What was needed was a master plan, a ‘needs assessment’ process, and determination of which areas had the highest need for services.

Ventura County

- Ventura County Behavioral Health continued to provide direct mental health services and treatment throughout the pandemic, including in-person contacts when the circumstances warranted (i.e., crises/5150, administration of injectable medication, and administration of benefits.

Appendix VIII. Descriptive responses or comments to Question 21, regarding availability of certain laboratory services associated with MAT and SU treatment and whether those services were useful in assisting clients' recovery. The following responses dressed the follow-up questions: "If yes, how has this been useful in promoting successful outcomes? If no, do you have alternatives to help clients succeed?

Alameda County

- Yes, we coordinate with clinics to the extent that testing is available.
- While we have not formally completed an analysis of this manner, anecdotal evidence would suggest a positive correlation with success.

Alpine County

- Ability to find out levels of medications that client is on.
- Also, to find out whether clients are staying on the course of treatment.

Amador County

- At the start of the pandemic our offices were closed to the public and services were not provided in-person, which resulted in lack of routine drug testing, and which seemed to negatively impact the success of clients.
- Later, counselors were then able to schedule in-person drug testing which seemed to result in clients taking responsibility for their recovery with more accountability to treatment.

Butte County

- Yes, this has promoted successful outcomes because having clinic near the client opens an opportunity to have access to resources.
- Having a clinic near the client reduces the barrier to accessibility for clients that may lack transportation.

Contra Costa County

- Yes, it has facilitated access and decreased barriers.

Del Norte County

- MAT is provided outside of the county through a contracted provider.
- Suboxone is the only medication available in the county through the FQHC and clients are referred when appropriate.

Fresno County

- In regard to testing at five clinics in Fresno: MedMart, ART E. Street and Aegis- the testing is performed on-site.
- ART Cartwright and Van Ness - Not able to coordinate services with other clinics.

- However, our County would be able to provide testing through Quest, available UA tests for patients in online MAT services.
- Alternative to help clients succeed (response from BayMark = MedMark and the 3 ART clinics): Many of our clients are more successful when they are able to access medical transportation services. All of our counselors are trained on how to assist or walk our patients through utilizing transportation services to one of our locations.
- We encourage new clients to schedule the intake appointment and transportation in advance. Intakes can be lengthy, which is a barrier to treatment for patients who are employed or have other responsibilities like caring for children. We reduce the time a new patient has to spend during the initial visit when appointments are scheduled in advance.

Glenn County

- Our county utilizes in-house drug testing with clients for therapeutic purposes.
- We do not provide drug testing for use in courts, with Probation, or with primary care.

Humboldt County

- Unknown for our county.

Imperial County

- ICBHS conducts routine drug testing onsite using oral swab tests.
- Additionally, we conduct testing as part of MAT services for adherence to medication and monitoring clients taking buprenorphine as prescribed.

Kern County

- Not for drug testing.
- Clients participating in MAT programs are required to present in person for dosing and counseling.
- Drug testing is completed according to Title 9 requirements.

Kings County

- MAT programs are all out of county.
- If providers do not refer out due to refusal of client, they are referred to a local clinic.

Lassen County

- LCBH does not provide MAT.
- However, the local Federally Qualified Health Clinic does provide MAT and already provides drug testing.

Los Angeles County

- Urine drug screening has been helpful for the clients to achieve success and is an opportunity for contingency management.
- However, obtaining urine drug screens was challenging for some clients during the pandemic (shelter lockdowns, limited in-person staff, and patients' reluctance to come to clinic).

Madera County

- The SUD program does not require routine testing.
- However, BHS is committed to the successful recovery of all our clients and to assist in coordination of various services as needed.
- It is important to note that the majority of our clients are referred by the legal system such as probation who do conduct testing functions.
- The SUD Program does contract with MAT providers in neighboring counties for our clients. Local MAT provider is 'in process.'

Marin County

- We have clients in the clinic at least one or more time a month and obtain monthly urinalysis testing from them.
- Emergency regulations due to COVID PHE allows only 8 urine tests a year per patient; usually, (pre-pandemic) we almost always got 12 or more.
- Urine tests are generally helpful in guiding patients towards recovery as they are a basis for who gets how many 'take-homes'. Under COVID that linkage is no longer in place and urine testing is of more limited value.

Mariposa County

- We utilize supportive case management services, community partners such as the Heritage House, and support individuals with Substance Use Navigator.
- We have contracted with Aegis to provide MAT services (they test as needed) and other contracted providers can test if needed.

Merced County

- Our county has a collaboration with Aegis Treatment Centers.

Mono County

- MCBH refers all MAT clients to an outside agency.

Nevada County

- Yes, the drug testing program helps with honest dialog about ongoing needs and for adjusting the treatment plan.

Orange County

- Yes. Drug testing is performed in clinics where clients are receiving treatment plus clients can have drug testing at other clinic locations if needed.
- This allows clients to complete drug testing whenever and wherever necessary and with no interruption to their treatment.
- Additionally, labs can be done and sent out for confirmation.

Placer County

- Regular testing is a critical part of MAT treatment.

Plumas County

- Working now to start partnering to provide those services.

San Benito County

- Yes, our County contracts with Valley Health Associates to offer MAT services.
- This is helpful to clients who need this level of treatment, so they do not need to drive to another county to receive treatment.

San Bernardino County

- Best practices in providing MAT includes regular testing.
- When testing can be provided on site by point of care testing, results can reliably be obtained.
- When clients are required to go offsite to a laboratory collection center, they typically require assistance from a case manager to successfully complete labs.

San Diego County

- No, all SUD programs are expected to provide individual treatment plans to address individual barriers.
- Our programs have increasingly been delivering case management services which do help clients succeed.

San Francisco County

- Our Opioid Treatment Programs have on-site drug testing.

San Luis Obispo County

- Testing helps the prescriber determine the effectiveness of the current dosage. For example, if the client indicates that they are still having symptoms, but the testing is negative, then the prescriber can ask more questions to see if dosage needs to be adjusted.
- It also helps to determine negative outcomes, for example, diversion of medications by the client.

- If drug testing is positive (meaning the client is taking the medication appropriately), then positive outcomes can be attributed at least in part to the use of the medication.

Santa Clara County

- We offer drug testing in all our Addiction Medicine Clinics.
- We assign patients to any clinic that is close to their place or work or residence.
- By giving clients choices it has help us to stay in compliance with state and Federal regulations and promoted successful treatment outcomes towards recovery and ensuring to address their needs more in timely manner.

Shasta County

- Shasta County does not offer MAT in our clinic.
- We do offer routine drug screening for many of our other programs.

Solano County

- We are in process of expanding MAT within our MH clinics.
- We do already offer supports and drug testing when needed.
- However, few of our psychiatrists are suboxone-waivered. More advocacy is needed to have MDs take this on.

Stanislaus County

- Narcotic Treatment Programs (NTP), office-based opioid treatment 'spokes', and non-NTP additional medication assisted treatment sites are located within time and distance standards for all Medi-Cal beneficiaries in Stanislaus County.
- In addition, Medi-Cal beneficiaries are entitled to transportation services under the Plan.
- BHRS provides care coordination to ensure clients are able to utilize transportation services to attend medication counseling and other appointments, including routine drug testing.

Sutter-Yuba

- The routine drug testing is helpful for the providers. It helps to determine if the patient needs an increase in medication due to relapse, and to better manage their medications and therapy.

Tulare County

- Each medication has different precautions and significant considerations for medical providers, based on a patient's unique needs and circumstances.
- An important factor in promoting successful outcomes is for the provider to have the routine drug test results for continued monitoring of progress.

Ventura County

- Testing promotes candor. If the client tests positive, clinician may adjust treatment and medication.
- Negative tests provide positive reinforcement to continue recovery.

Yolo County

- Clients are being held accountable due to the results of their routine drug tests.

Appendix IX. **For Question 22: "Have any of the following factors impacted your county's ability to provide crisis intervention services? (Check all that apply)" one of the options was "other". Listed below are various answers received for this option.**

Alameda County

- Recruitment and retention of staff and our very long HR process.
- We lost a few great candidates because our HR process takes months.

Fresno County

- Inability to access 'Care Mobile Unit' grant fund awarded 09/2021 for expanded crisis services (case management and CIT for youth training) in FY 21-22 due to contract delays from DHCS contract grant administrator. Contract was finally scheduled to be presented at 9/2022 BOS meeting.
- Clarification to Rural ED's in 12/2021 of contracted Rural Triage CIT Program's intent to provide mobile CIT services out in the field with law enforcement and other first responders.
- Thus, they discontinued CIT services at hospital facilities.
- Also, Fresno Police Department CIT changed data systems, therefore it has been difficult to gather information and outcomes of FPD CIT encounters after 02/2022.

Glenn County

- There are fewer organizational providers to contract for crisis intervention services.
- Also, there is limited ability to hire trained bilingual staff.

Lake County

- Access to services

Los Angeles County

- Difficulty with ongoing operational funding for crisis services, including urgent care services, crisis residential treatment programs, short term inpatient programming, and
- Funding and staffing for crisis mobile response for shifts that are difficult to fill like nights, weekends and holidays.

Madera County

- In October 2021, MCDBHS received notification that it was awarded $3M in funding to expand its crisis continuum of services through the DHCS 'Crisis Care Mobile Units Program' funding as part of the larger State Behavioral Health Continuum Infrastructure Program.

Napa County

- Difficulty in recruiting and retaining staff.

Orange County

- Long ambulance wait-times resulted in delayed psychiatric hospitalization.
- Delayed access to hospitalization decreased accessibility of lower level of care treatment for clients when discharged from crisis services due to capacity issues.
- In addition, there is an increasing trend with law enforcement of hesitancy to assist mobile crisis staff gaining entry to dwellings to assess individuals in crisis.

San Joaquin County

- Difficulty finding psych placements (hospitals) for detained clients as a result of hospitals that closed units due to COVID-19.

Santa Barbara County

In-person activity never stopped, including going to ERs for evaluations. Answers for #23: Negative effects of staffing issues led to the following:

- 1st Impact: Inpatient and crisis services staffing impact.
- 2nd Impact: Loss of shelter/placement options due to COVID lock downs.
- 3rd Impact: Crisis residential treatment impacted.

Santa Clara County

- Note, the following relates to the selected option above.
- The Department continues to recruit for the open positions.
- Due the 24/7 nature of the work environment it has been a challenge to find candidates.

Santa Cruz County

- Loss in revenues and reduced in-person services.

Shasta County

- An additional issue identified by the Shasta County board is the lack of beds to place people, particularly during the pandemic when moving consumers between counties or facilities was not always possible.
- Emergency Departments and other areas where crisis services are offered were easily backed up for this reason as well, besides just issues with staffing.
- Staffing in turn affected how many additional people could be quickly evaluated.

Siskiyou County

- Challenges due to local hospital not wanting Behavioral Health clients in the ED.

Tri-City MHB (for region in L.A. County)

- At times there was a lack of ambulance resources, and it was difficult to transport people in a timely manner.
- Additionally, during the pandemic, Tri-City continued to provide crisis services both in the community and on-site.

Tulare County

- While one-time funding has been released, we are unable to add staff as needed.
- Sustainable, identified funding streams are needed (beyond Medi-Cal) to support comprehensive community crisis services.
- Also, in collaboration with our ERs and hospitals, tele-health has not been acceptable at some sites (outside of the MHP).

Tuolumne County

- Hospital COVID protocols/safety measures.

Appendix X. Responses supplied to the "Other" option, for Question 24: Has your county used any of the following methods to meet staffing needs during the pandemic?

El Dorado County

- Supplemental Paid Sick Leave for COVID-19

Fresno County

- The Department utilizes various strategies to attract qualified candidates with increased paid marketing, strategies for greater social media presence, promotion of County benefits, and inclusion-focused efforts, which are described in job flyers.
- The HR Dept. participates in general job fairs and collaborates with college universities to attend their job fairs.
- Other efforts include the hiring of new staff, utilization of contracted (non-county) positions for difficult to fill classifications.
- Participation in student work experience-contracted help and CalWORKs work experience in certain positions.
- As government institutions, we are bound by civil service processes and county wide policies, so the department use of retired staff, flexible work hours, or facilitating access to childcare/daycare are not options readily available.
- The Department offers some form of flexible work hours (start/end times, shorter lunch periods within the defined core business operations hours, and while following federal, state and county rules, i.e., MOU with bargaining labor units).

Imperial County

- ICBHS requested salary increases for Clinicians to offer competitive salaries.

Madera County

- We have worked with human resources to prioritize our recruitments and increased our advertising sites.
- Director worked with Unions to provide incentives for "hard to fill" positions and "hard to fill" locations in the department.

San Diego County

- Use of temp staff.
- Reduction of capacity when adequate staffing wasn't available.

San Luis Obispo County

- Hiring new staff has been challenging depending on the classification.

Santa Barbara County

- Maximize temp workers, traveling nurses, locums tenum (temporary clinicians).

Shasta County

- We asked for other County departments to assist with the COVID effort during the pandemic.
- Most departments in the County either assigned someone to work in the EOC/DOC or had staff in their department with COVID as their priority.

Siskiyou County

- Siskiyou County only allows telework for individuals who are out ill with COVID-19 or at home with children who are ill with COVID.
- We have attempted to hire new staff but have had open recruitments for over one year without any applicants.

Solano County

- Trying to advertise more on social media and other channels.
- We need to redo classifications/salaries to compete with other organizations.
- We barely get any applicants to each round of advertising.

Sonoma County

- Temp agencies.

Tri-City MHB

- Financial incentives: Hiring bonuses, longevity incentives, and an increase in merit pay.
- Also: hazard pay, teleworking reimbursement stipend, and paid administrative leave.

Appendix XI. Responses listed under "Other" for Question 25: Has the pandemic adversely affected your county's ability to reach and serve clients and families from various demographic groups?

Contra Costa County

- It's unclear if any effects on the numbers served in these groups were related to the pandemic.

Fresno County

- For Black/African American Latino/Hispanic populations services increased.
- Note, for Asian Pacific Islander and Native American/Alaska Native populations, there was a small decrease in number of persons served, which has now rebounded to pre-pandemic levels.

Kings County

- Caucasian clients.

Madera County

- The pandemic affected our ability to reach and serve all populations due to lack of information when the pandemic first hit and due to fear of contracting the virus thereafter.
- In 2022 more of the population was open to returning to some level of pre-pandemic normalcy [edit: original answer apparently included a table which was not detected by SurveyMonkey].
- However, the pandemic continues to affect many.
- BHS services are available to all who need them in whichever manner they are most comfortable, from in-person to virtual platform and telephone.

Orange County

- Providers have noted that the pandemic has impacted children and youth in all of these populations.
- At the beginning of the pandemic when many services were being delivered via telehealth, providers expressed challenges in engaging this young population due to lack of access to appropriate devices, no Wi-Fi access, and other technical challenges.
- Providers have also shared that the challenges with engagement and conducting therapy sessions were especially significant with children of younger ages.
- For adults across the board, there were the same challenges related to not having appropriate devices, no Wi-Fi access, inadequate privacy, and other technical challenges.

San Bernardino County

- Based on data for clients pulled on July 28, 2022, for FY 20/21 and comparing it to data for FY 19/20 all racial/ethnic communities were adversely affected by our county's ability to reach and serve those in need of Behavioral Health Services.
- In FY 20/21 we served 5,723 fewer Medi-Cal clients than the previous fiscal year 19/20.
- The following groups were most affected, showing a decline in numbers of clients served for these racial/ethnic groups (total decreases shown in parentheses): Latino/Hispanic (-2,709); Caucasian/White (-2,182); African American/Black (-1,170).

San Francisco County

- There had been some focus on creating culturally congruent BH care (particularly for the African American Community which represents a small proportion of residents in San Francisco but are disproportionately served in community behavioral health, hospital, and jail settings),
- Also there have been effects on community-focused interventions and equity issues related to impacts of Covid and related supports.

Santa Barbara County

- Yes, some families had less access to telehealth and Wi-Fi – especially Latino/Hispanic clients and their family members.

Sierra County

- All Sierra County community members.

Solano County

- We have actually improved access due to telehealth being an accommodating factor.

Sutter-Yuba Counties

- Isolation of rural and low socio-economic status communities due to lack of adequate internet access.

Yolo County

- Multigenerational families under one roof.
- Increased risk of COVID-19 spread across members of the household from different age groups.

Appendix XII. With respect to Question 26: Based on experience in your county, has the pandemic adversely affected your ability to reach and serve several listed vulnerable groups? The following answers were submitted under "other:"

Amador County

- Initially, all populations were adversely impacted as our offices were closed and we did not have telehealth equipment to provide services.

Alpine County

- Couch-surfing individuals.

Fresno County

- Note, services for children and youth and foster children increased.
- However, fewer services were provided in homeless shelters and for seniors 65+

Kings County

- Rural communities or persons with low socioeconomic status.

Lassen County

- People living in the very rural areas of the county.

Madera County

- Although our system is not set up at the moment to pull data by the specific breakdown in this question, we can report age specific data regarding changes in the number of individuals seen by our county BH as shown in table below.
- In FY21-22: 66 fewer in age group 0-21, 866 fewer in age group 22-64 and 31 fewer individuals ages 65+ were seen.
- From FY19-20 to FY20-21 we saw a decrease of 22% in age group 0-21, age group 22-64 decreased by 23%, and ages 65+ decreased by 2%.
- [editor's note: the info provided in the source is somewhat unclear, as the numbers for FY21-22 were given as difference in overall numbers, whereas the data from an earlier time period were listed as overall percent changes].

Sacramento County

- We faced challenges reaching and serving Latino/Hispanic clients, and
- Those who were asylees (refugees seeking asylum).

San Bernardino County

- Clinic-based crisis programs such as CSUs, CWICs, and Crisis Residential Treatment (CRTs) that rely on community partnerships to generate referrals were unable to perform in-person outreach during the height of the pandemic.

- This reduced their ability to raise awareness of their services in key areas wherein they had historically been able to connect with members of vulnerable demographic populations, including all the above groups [as listed in the question].

Sierra County

- All Sierra County Community members.

Sutter-Yuba Counties

- Isolation of rural and low socio-economic status communities due to lack of adequate internet access.

Tri-City MHB

- During the pandemic, Tri-City continued to provide outreach and in-person services.
- Efforts were made to communicate to the community that the agency was open and available to help them.
- Therefore, Tri-City was able to reach the underserved and unserved populations listed above [in the question].

Appendix XIII. Question 27 asked about several categories of potential barriers to accessing BH services during the pandemic. Below, we list the county responses that fell under "Other".

Fresno County

For Children:

- The pandemic limited parents from attending due to COVID protocols,
- Childcare was eliminated during the pandemic,
- Group therapy and family therapy were both affected.

Imperial County

- Clients had limited contact with agencies that generate referrals like Department of Social Services, schools, etc.

Kings County

- Rural communities and those with low socioeconomic status.

Napa County

- For school-age children & youth, "distance learning" hampered identifying and engaging with individuals experiencing behavioral health distress.

Santa Clara County

- Child-care related barriers.
- Finance-related barrier post the 'peaks' of the pandemic.
- Low level of awareness of where to seek help post the 'peaks' of the pandemic.

Tuolumne County

- The challenge for the unsheltered has been access issues due to technology, such as not being able to charge a cell phone.

Ventura County

- Although there were no significant barriers, some populations had difficulty utilizing telehealth services.

Yolo County

- Staff illness due to COVID-19.

APPENDICES: LISTS OF QUALITATIVE RESPONSES for "Other", etc.

<u>Appendix II</u>. The descriptive responses listed under "other" in response to Question #8 regarding county programs for housing and homelessness.

<u>Colusa County</u>

- Adult Drop-In Center was re-opened.
- A county-wide Housing Program Manager was hired.

<u>El Dorado County</u>

- 'Compassion Pathways' program.

<u>Fresno County</u>

- The PATH Program (15-257-4) received Community Development Block Grant for rural outreach, via expanded homeless Mentally Ill Outreach Treatment funds.

<u>Lake County</u>

- During 2020-21 fiscal year, Behavioral Health Services continued to provide housing support for our FSP clients. This included temporary support, such as motel stays, to more permanent housing where LCBHS subsidized rent while the client applied for affordable housing. Supportive services were provided during their housing.
- Additionally, LCBHS also paid for motel stays, if needed, for someone coming out of an acute hospital, on a temporary basis.
- Any client who is on a Lake County LPS conservatorship, LCBHS also paid for a "patch" for any Adult Residential Care wherever the client was placed, whether that was an in-county Board and Care or out-of-county psychiatric facility.
- Finally, LCBHS was the Lake County 'Continuum of Care Administrative Entity' during this time period.
- As the Administrative Entity, LCBHS helped write for and administer grants for Emergency Shelter, Rapid Re-housing, and Outreach Services. Those services aren't necessarily targeted to our clients, but our clients often partake of these.

<u>Madera County</u>

- Permanent supportive housing - 16 units Sugar Pine NPLH
- And 7 units Esperanza (MHSA housing).

<u>Marin County</u>

- PHF, Carmelita House, SSA
- Project Home Key
- Homeward Bound Independent Living Apartments (Casa Buena).

Merced County

- Navigation Center.

Napa County

- 54 units of permanent supportive housing funded by $18MM from Project Home Key and more than $2MM each from Napa City and County; expected availability Q1 2023.
- 8 unit/14 bed permanent supportive housing for elderly, medically frail individuals exiting homelessness, opened in Jan. 2022.
- Renovation commenced in June 2022 for 88 unit low/very-low income affordable housing, with 32 of the units dedicated as permanent supportive housing for individuals exiting homelessness; full occupancy expected by Q2 of 2023.
- Napa County was approved for an 80% increase in HUD Permanent Supportive Housing expansion grant funds.
- Napa County and City collaborated to obtain 45 Emergency Housing Vouchers from HUD, of which 11 were reserved for families or individuals fleeing domestic or sexual violence, stalking or human trafficking.

Sacramento County

- Invested in permanent supportive housing dedicated apartments.

San Benito County

- Helping Hands program
- Housing vouchers
- Help with utilities.

San Joaquin County

- Funding for Board and Care homes.

Santa Clara County

- In process of developing a 28-bed facility; completion expected in April 2023.

Santa Cruz County

- COVID alternate shelters in various locations.
- Also: Adult Residential Care ‘Patches’ to assist with obtaining housing.

Shasta County

- Basic household items were available.

Sierra County

- Homeless Housing Assistance & Prevention grant program.

Tri-City area (in one part of L.A. County)

- Homeless Prevention funds: security deposit, rental assistance, utility assistance

Tulare County

- The Homeless MDT was implemented and staffed within this fiscal year.
- This team is comprised of team members from Tulare County Health & Human Services Agency's three main service branches: Public Health, Human Services, and Behavioral Health.
- This team conducts direct street and encampment outreach, partners with other homeless services providers, supports our Room Key participants, and coordinates response efforts with all jurisdictions across Tulare County.
- The team includes two AOD Counselors and a Clinical Social Worker to provide SUD services, screenings, assessments, linkage and supportive services.

- Regarding Emergency Shelters and Supportive Housing, we have had significant changes to the structure of our housing programs. These changes are targeted to providing services to individuals experiencing homelessness, many of which have co-occurring conditions such as severe mental illness.

- 'Home Key' is permanent supportive housing.

- 'Room Key' is temporary non-congregate emergency shelter. We have been operating Room Key at two motel sites. One site will close on June 30 to begin renovation from Room Key to Home Key which is anticipated to take approximately one year. Our second site is currently operating at an alternative motel site while the primary site is undergoing active renovation from Room Key to Home Key, with anticipated completion in August of 2022.

Tuolumne County

- Resiliency Village
- GSAC Shower Bus
- Tuolumne County Commission on Homelessness
- Expanded Meal Programs through Interfaith organizations.

Appendix III. These are the qualitative or descriptive responses to Question #9, regarding recommendations or comments about needed improvements to behavioral health services for children and youth in foster care.

Alameda County

- Several new laws and regulations occurred in 2021 causing all counties to restructure their services to foster children and youth in group care. The laws changed as of October 1, 2021.
- Our County has spent the last several months developing Infrastructure, protocols, and hiring staff to meet the new mandates under the Families First Prevention Services Act (FFPSA) which was adopted under California's AB 153.
- This Act requires County mental health plans to provide assessments for all youth coming in and out of placement and to make placement recommendations, and to track all cases.
- The MHP must attend and facilitate Child and Family Team (CFT) meetings.
- It has been a great learning curve to take on these placement responsibilities and coordinate with Child Welfare, Probation, and the Juvenile Court systems.
- We are still developing the program and necessary services at this time.

Alpine County

- We do not have any group care in Alpine County.

Amador County

- There are no STRTP's or group homes for youth in Amador County.
- We place very few foster youths in STRTP's due to our small county size.
- If it is determined that this level of care is needed, Amador County Behavioral Health will work with Social Services and/or Probation and the facilities to ensure placement.
- With the Family First Prevention Services Act (FFPSA) Qualified Individual (QI) process in place, an assessment is completed to assist with determination of appropriate level of care.

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 in our county.

Calaveras County

- Our county is in the process of implementing wrap-around services.

Contra Costa County

- We need additional resources for children with intensive treatment needs (i.e., minors whose clinical status is too acute for a community setting).
- We recommend building out residential care resources for youth with high and complex treatment needs, such as short-term residential treatment programs, enhanced therapeutic foster care, and crisis residential programs.

Del Norte County

- We are under the belief that we can always improve our services.
- In order for our county to properly serve the foster youth we would need to have additional foster homes in which to place these at-risk children.
- We would like to expand our foster services program to have more options to keep siblings together.
- Further, we currently have a waiting list for CASA. Expanding our volunteer base would be desirable.

Fresno County

- Our county is addressing the needs of the foster youth in group care to the best of our ability.
- More resources are needed to support STRTP's, such as more staff, more training for STRTP staff and more mental health services.

Glenn County

- There is a need to identify more foster care homes in-county.
- We will identify TFC (Therapeutic Foster Care) homes in the region to meet the needs of this unique population.

Humboldt County

- We do not have any group care homes.
- However, one will be coming online in 2024, but we already need more capacity than what is planned in that project.

Imperial County

- We need to implement TFC homes and have more RFA homes.
- Department within our County needs to implement components of CCR.

Kern County

- We gave this negative response because we believe the objective of "enough" can never be achieved on behalf of foster children.
- There will always be opportunities and motivation to do more.

- We believe our behavioral health system is a wonderful program that works tirelessly. However, given the importance of children's needs, even the most valiant actions will never hit the marker of "doing enough."

Kings County

- We only have one STRTP on Kings County for up to 6 females, all other placements are out of county.
- Kings County does not have therapeutic foster care (TFC) Homes.
- Additionally, all psychiatric hospitalizations are also out of county.
- Increased trainings for children's counselors, increased need of counselors.
- We need to provide additional family therapy and training for specialty services for psychoeducation.

Lake County

- The need is greater than our staff can meet.
- We need better access to MH services, as there is no local group residential care available.

Lassen County

- There are not enough STRTP facilities in California.

Madera County

- We have made progress currently establishing a mobile crisis unit which will serve all ages as part of our Crisis Continuum expansion; this was identified as a gap last year.
- This year we are working with CWS to find a WRAP vendor and on partnering with local agencies to establish Therapeutic Foster Care Homes.

Mono County

- We do not believe this question is applicable to Mono County as we do not have any children in group care.

Plumas County

- Not enough foster homes or TFC homes.
- Not enough WRAP Community Supports/Partners.

Orange County

- Don't know, as most of these foster care MH issues fall outside of our BH Advisory Board purview.
- We will continue to ask and follow up with SSA and Probation Services.

San Benito County

- At present, we are doing all that we can.
- There is a new opportunity to meet the needs of foster children that require this level of services. Additional services are being developed that may help potentially to meet the community's needs.
- Currently, children and youth who need this higher level of care are served in contracted STRTP facilities in neighboring counties.

San Diego County

- More robust family support services like Therapeutic Behavioral Services (TBD) and parent support services are needed.
- We should allow facilities such as San Pascual Academy to continue in its present form and to offer ‘wrap-around’ services.
- We need to ensure that enough resources are allocated for these facilities to hire the appropriate staff needed, as many of the facilities are having staffing issues, such that some facilities cannot perform proper checks or give appropriate treatment as needed.

Santa Barbara County

- While we believe the quality of mental health care provided by our County is adequate, sometimes the STRTPs struggle with adequate staffing and having sufficient adequately trained staff.
- Staff may struggle to manage the degree of acuity of the clients being referred which in turn decreases length of client's stability in placement.

Santa Cruz County

- Santa Cruz County Children Behavioral Health in partnership with Juvenile Probation and the Human Services Department, Family and Children's Services are working to implement components of the Families First Prevention Services and other best practices to support these youth and their families/caregivers. Recent efforts include:
- Restructuring Interagency placement committee.
- Provision of Qualified Individual Assessments for all youth being considered for initial placement/transitions between STRTPs.
- Provision of aftercare services for youth stepping down from STRTP level of care to home-based placement.
- Promotion of the Family Urgent Response Services program, for youth at risk of going to congregate care settings.
- Greater collaboration with Substance Use Disorders Division to ensure youth in Residential MH programs have access to SUDS treatment.
- Exploring plans for a new building for a Youth Crisis Stabilization Center.

Shasta County

- Shasta County is doing the best possible with current resources and system limitations.
- However, more foster parents/resource families are always needed, as well as more beds in all other setting levels.
- We need more 'ILP' services to successfully transition youth into thriving in independent living, and an expansion of wellness programs.
- We need more focus on reducing ACEs to provide upstream intervention before long-term issues are created.

Solano County

- We have made significant improvements to our group care. For example, in 2021 our in-county STRTPs started providing in-house SMHS.
- However, due to lack of providers and lack of willing foster homes in our area, there is a gap- we could do more to attract organizations, increase rates with Bay area 'comps', and increase/attract therapeutic foster home families.
- And we could request CGF to support our gap services such as a CCRT or an Enhanced Complex Care program where there is a 'no eject - no reject' policy.
- Statewide, we need to do a better job to integrate MH and SUD care; many of the youth who need congregate care have co-morbid mental health and SUD issues.
- And, until very recently, there were almost no SUD services for the kids in Solano. Kids will often be kicked out of STRTPs if they come back to the facility intoxicated or if they bring drugs/alcohol into the facility and give those substances to other kids.

Stanislaus County

- Our County has outpatient, Therapeutic Behavioral Services (TBS), and Family Urgent Response System services available to support youth in group care.
- We have contracted with three local Short-Term Residential Therapeutic Programs (STRTP) that provide residential and treatment services to youth placed in our county.
- The gap for our county is related to youth with complex needs, especially during a time of crisis or an unexpected placement disruption and potential increase in the behavioral health needs for the child/youth.
- The recommendation would be to develop a crisis continuum for this population that includes specialized services, including Enhanced Intensive Services Foster Care, STRTP of One, Crisis Residential, Crisis Stabilization, and Psychiatric Health Facility services.
- All of this will be possible only if funding can be secured.

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 and 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 and youth, with the outcome of frequently disrupted placements that exacerbate the very behaviors that the STRTPs are supposed to be addressing.
- We will note that we have had some success in the past when we have provided Wraparound and/or Wrap-like services to youth to ensure that they remain connected to consistent behavioral health providers while in STRTP placements. This process ensures a smoother transition when youth step down from that level of care. However, there is no formal funding mechanism that allows for these services while the youth are in STRTPs, so it would be helpful if there were a way to fund this approach to treatment.
- Our local efforts around this issue have included ensuring that youth that 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 prioritize assignment of court appointed special advocates for youth in STRTP placements.
- However, it should be noted that Yolo County has made significant strides regarding this issue in the past two years and has reduced the number of youths that typically are placed in congregate care settings by almost half since 2019.
- The County has revamped the Interagency Placement Committee process and has made a commitment to ensure that youth are only placed in congregate care settings when absolutely necessary because of significant behavioral health challenges or an emergency that prevents placement at a lower level of care.
- Additionally, the IPC seeks to ensure that youth placements are short-term and focused on therapeutic interventions to ensure that youth step down to lower levels of placements by providing additional support to cases through an assigned behavioral health “liaison” (a county behavioral health clinician that is assigned to the case to provide support to the social worker/probation officer and who coordinates with the facility regarding treatment status).
- All youth cases are reviewed by the IPC at least monthly and receive second-level reviews in accordance with ACL 17-22. The County has implemented the “Qualified Individual” requirements of FFPSA Part IV and continues to make active efforts through IPC and other means to ensure that we are complying with all relevant statues and regulations related to congregate care placements.

Appendix IV. Descriptive or narrative responses for "Other", in response to Question 12, part h, regarding major points of stress in BH for children and youth.

Alameda County

- Decreased number of clinicians and staff to serve youth.
- High numbers of staff turnover and numerous staff vacancies across the system.

Fresno County

- At the beginning of the pandemic, access to behavioral health services decreased, but soon after increased.

Glenn County

- Adults are having a harder time helping children cope with stressors because of COVID and home schooling.
- Parents are feeling helpless.

Imperial County

- Increased utilization of Crisis Care Response Team and Mobile Response Team.
- Increased number of cases of youth presenting with substance use-related extreme behaviors.

Kern County

- Transportation, family stress, basic needs, unemployment.
- And due to many school systems being shut down, there was decreased ability to monitor child and youth well-being.
- One problem was a lack of BH inpatient bed availability for COVID positive youth.

Kings County

- With respect to children's Full-Service Partnerships (FSPs), we have seen an increase in anxiety expression, suicidal ideations, and reported self-harm.
- Many of the symptoms were linked to social isolation and social restriction.

Orange County

- #1 Point of Stress: Decreased workforce due to fewer qualified behavioral health professionals seeking employment with OC HCA and OC contract agencies.
- #2: Increased numbers of staff out sick with COVID and requiring quarantine.
- #3: Recruitment challenges due to highly competitive salaries offered by other organizations and contiguous county Mental Health Plans.

Placer County

- We don't have access to ED data, but we know opioid-related deaths increased.
- While mobile crisis calls decreased, 5150s increased.
- The pandemic impacted our access to youth, and we had to change approaches to reach them.

San Luis Obispo

- Increased requests for eating disorder treatment.

Santa Barbara County

- Increase in eating disorders.

Santa Cruz County

- Increase in eating disorder treatment needs in all levels: intensive outpatient, partial hospitalization, and residential treatment.

Shasta County

- While “Increased ED visits related to misuse of alcohol and drugs among youth” was not selected in our top choices, it is still an issue and major concern for members of the board in Shasta County.
- There simply was not a large increase in numbers seen over the course of the pandemic.
- However, any number of visits for this reason, large or small, is still problematic and not something we want to see affecting the youth in Shasta County.

Sonoma County

- Severe staffing shortage.

Stanislaus County

- As a department, we did not track data for options a-g specifically.
- However, anecdotally, children’s leadership staff received information that children, youth and caregivers were experiencing more anxiety during the pandemic and increased feelings of isolation.
- BHRS also observed a decrease in children’s crisis referrals in the first 3 months of the pandemic, followed by an increased number, but no specific trends over time.
- BHRS saw a decrease in the referrals coming from schools during the pandemic since children and youth were engaging in school remotely for a period of time.
- Our local Child Welfare referrals were decreased, which in turn also impacted referrals coming to Behavioral Health from Child Welfare.

- Service providers reported “higher acuity” as far as symptoms of youth who have been presenting to services during the pandemic and currently. However, we do not have specific numerical data to support these reported observations.

Tri-City MHB (in a region of L.A. County)

- Based on diagnosis data for anxiety and depressive disorders, there was a slight increase in both anxiety and depression during the pandemic.
- Emergency Room data from our local hospital revealed there was a decrease in ER visits.
- However, this may be due to people's fear of going to the hospital rather than a lack of need for ER services.
- Conversations with the clinical department indicate that most of these were points of stress during the pandemic.

Tulare County

- While general admission for SMHS was lower than expected, those youth that did engage in services had high risk factors associated with crisis states.

Tuolumne County

- #1 Point of Stress - An increasing incidence of youth considering suicide.
- #3 Point of Stress - Increased use of alcohol and drugs by youth,
- Includes a wave of overdoses and fentanyl use.

Ventura County

- Staff shortage.
- Emergency department data are unavailable.
- Data sharing agreements and systems are under development.

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

Alameda County

- Serving children and youth during the Covid-19 pandemic has been a challenge.
- With school closures, youth became less accessible, so relying on telehealth and/or virtual platforms for clinical services presented challenges.
- Engagement for younger children during the pandemic has been hard as they don't always have access to electronic devices for clinical services. Also, many children and youth did not have private settings to engage in therapy during the initial isolation periods and school closures.
- During the pandemic, our system lost many staff at many levels from administration to direct services and many of those vacancies remain open as recruitment has been a significant challenge.
- In relation to clinical services, our system both internal and external providers have been doing all they can to meet the growing service needs that we've experienced during the pandemic as well as the increase to service access as ushered in by the changes in Medi-Cal regulations.
- We continue to work hard to meet the need and keep up with all the new regulatory requirements that impact child and youth services within specialty mental health.
- We are hopeful that we can strengthen our infrastructure to meet the demands.
- We continue our system wide recruitment efforts to increase the number of available clinicians to provide services.

Amador County

- There were difficulties initially with telehealth due to lack of equipment.
- There was also resistance from youth to utilize telehealth.
- Youth were attending school virtually and they didn't seem to want to do therapy this way as well. This changed how clinicians interacted and provided treatment.
- There were also issues of privacy and confidentiality, as clients were not in the office with the clinician but in their homes and often had other family members nearby when they were trying to engage in their sessions.

Butte County

- Ongoing recruitment and retention challenges with behavioral health and health care workforce.
- Ongoing stress, burn out, and management of services in a complex time continues to increase the need for mental health and substance use disorder services.
- These conditions prevail concurrently with decreased provider capacity and less network access to meet needs and demands.

Calaveras

- Our county found it helpful to have a contracted provider (Sierra Child and Family) present on campus' as a student resource.

Colusa County

- Has expanded staff to meet the needs of youth.

Contra Costa County

- Several factors impacted access to mental health services during COVID, including school closures, access to telehealth-capable devices, and limited privacy for telehealth sessions.
- Due to diminished visibility of youth at schools or clinics, many with mental health were not identified or referred for services.

Del Norte County

- Our Children's Service provider has had significant staffing shortages which have impacted access to mental health services.

El Dorado County

- Expanding access to telehealth was valuable during the pandemic and helped to get services to children.
- The Wellness Centers were expanded quickly to respond to the need of children and youth when they came back to school in person.
- Suggestions include discussions between school and Behavioral Health to provide a strong foundation to create a resilient model to quickly deliver services to help children and youth, and their families, to get the services they need to respond during the next crisis.
- This would include a Rapid Response Model to coordinate with EDCOE to expand services across the county.

Fresno County

- Access to services was impaired due to technological difficulties and insufficient internet access for our community. These were concerns during the COVID-19 pandemic.

Glenn County

- We continue to make suicide prevention trainings more accessible for teachers, school staff, and partner agencies.
- With the recent Mental Health Services School Grant, we are identifying more office space for staff on school campuses to improve access for children, youth, and families.

- Mental health staff continue to support parents in the community to ensure they are part of the treatment team and have skills to support children at home.
- Behavioral Health continues to expand activities to promote Suicide Prevention information and training. This includes social media, information tables in the schools, and through local radio and television advertising, including Spanish networks.
- We are identifying opportunities to partner with other counties to promote the use of the new 9-8-8 Suicide Crisis line. The 9-8-8 line will be forwarded to the Glenn County crisis line to help link callers to local resources.
- GCBH will also collaborate with 2-1-1 information line to obtain data on the number of requests for mental health and/or substance use services each year.

Imperial County

- Clinician shortage due to the 'great resignation' produced increased caseloads for those who stayed.
- That caused delays in providing needed services to clients.

Kern County

- Protective factors for children decreased with other child-serving entities doing remote work.
- Schools, community-based programs, and behavior health staff had less face-to-face contact and were often the ones to detect MH risk factors for children.
- Each school district authored their own protocols for student contact, leading to inconsistencies in on-site service delivery.
- This has led to delays in ensuring appropriate linkage for children and youth who need additional support.
- In the last six months, all of these entities have increased face-to-face contact.

Kings County

- Children's FSP (Full Service Partnership) maintained a majority of services (68%) in the field at the height of the pandemic.

Lake County

- Major recruitment of mental health workers is essential.

Lassen County

- Many children/youth could not be admitted to psychiatric hospitals because many psych hospitals closed their youth unit during COVID.

Los Angeles County

- Access to Care – The workforce shortage has had significant impact on timely access to mental health services and community engagement.
- Schools remain a vital space for children and youth to access mental health services.
- However, the workforce shortage and school district restrictions on allowing outside partners on campus has impacted students' access to mental health services.
- Workforce shortage in directly operated clinics, which provided access to youth and families, has had significant impact on providing timely, quality services.
- Work force shortage with LEs, which provide school-based, community, and home-based services had significant impact on services.
- Many programs moved to telework services; however, this impacted those who were unable to secure stable internet services and/or computer devices.
- Data Collection – There is a need to improve data collection to better understand youth mental health needs, such information can enhance service delivery.
- Low research on high-risk populations creates barriers to engaging funders.
- HIPAA and FERPA laws may create barriers to gathering data to evaluate effectiveness of services.
- Sustainable Funding – Although there is a large push for increasing funding, there is concern how to sustain funding after time-limited funding expires.
- Need for flexible funding – Some funding sources specify what types of services and activities can be billed which may create barriers for personalized treatment.
- Improve collaboration between private and public partners to enhance access to mental health services.
- Recommend that all schools participate in the Healthy Kids Survey yearly; this will provide more information on youth mental health and the needs of students for MH services.
- Recommend screening for mental health in ER, hospitals; need better communication between hospitals and schools for re-entry plan.
- Recommend mapping of resources and services within County to increase collaboration and prevention services, and intervention programming.
- Increase arts programming in mental health services within prevention and intervention services.
- Identify and increase more non-traditional interventions and programming to communities (spiritual healers, arts and culture, animal therapy, sports).

Madera County

- During this time our department worked to ensure that clients had access to necessary services in all clinically appropriate settings which included In-Person, Telephonic, and Tele-Health.
- Our department worked in collaboration with partner agencies in the effort to ensure that community members were aware and had access to our services.

- Our department did have challenges securing placement in psychiatric facilities and residential placement during the initial start of Covid-19 Pandemic with limitations of availability of facilities.

Mariposa County

- During Covid-19, one concern was limited access to children in need of mental health services when school campuses were closed, and classes were 'virtual.'
- Teachers were not able to see students in-person and more accurately assess their needs, and the number of referrals for MH services decreased.
- Also, existing connections between child clients and behavioral health staff were lost. In these conditions, we feel that staff need to monitor client connections and raise concerns if not being contacted.

Marin County

- During COVID, utilization of mental health services for youth decreased initially for a variety of reasons.
- There appears to be a delayed impact of pandemic effects on youth and we are now seeing a return to robust referrals for youth in distress.

Merced County

- During the pandemic, prevention and early intervention services were increased county-wide to ensure reduction of stressors and a focus on 'help first.'

Mono County

- A local school administrator reported having "seen a number of young adults – ages18-21 – with anxiety and depression. Some in this age group have voiced that they are reluctant to go to MCBH because they see people they know and are afraid of confidentiality issues."

Napa County

- The Napa County Mental Health Division moved from telehealth to more in-person meetings with youth during the 2nd year of the pandemic.
- Youth had wearied of Zoom meetings for school and for therapeutic services during the previous year.
- Families and youth began asking for masked visits in their backyards, porches and schools.
- When positive test results required, Napa MHD pivoted to telehealth when the youth was well enough.
- Comments from educators, parents and providers also reflected the negative impact of "Zoom fatigue" across age groups, from primary school to college age, attributing to it an increase in child/youth stress, disengagement from education and interruption in essential developmental skills.

- "Distance learning" made it difficult to identify and engage with students in distress.
- Professional and community comments include specific concerns that negative educational and developmental impacts will outlast currently planned pandemic remediation efforts and funding.

Nevada County

- During the height of the pandemic, we really struggled with finding and connecting with youth. The schools are typically our largest referral source, and because they were not seeing youth in-person, they were not making referrals for MH services.
- Recently, that has changed, and our numbers are now increasing again.

Orange County

- Greater awareness of services is needed.
- An understanding of the needs and gaps analysis combined with sharing outcomes across the continuum of care continues to be a challenge for the community.

Placer County

- Youth are struggling due to lack of socialization during the pandemic, and lack of emotional coping strategy development.
- Funding is coming from many different locations for services to youth, but there is such a severe shortage of mental health professionals that it is going to take much time and effort to curtail this downward trajectory.
- County service providers are leaving to pursue careers in schools for fewer days worked (summers off) and in hospitals (offering large hiring bonuses).
- It is a severe strain on county services as we are the safety net provider.
- All community non-profit organizations with whom we contract for services are also suffering from this disappearing workforce.

Sacramento County

- We are having a workforce crisis. Our Mental Health Plan providers and the County are having significant staffing shortages, even though BHS has increased contract maximums to require increased salaries and incentives to attract and retain staff.
- We meet with providers every month to discuss hiring, retention, and recruitment strategies. Our provider network is trying very hard to address this workforce crisis, but we are not gaining ground.

- Our system is losing the most qualified staff, most of whom have a behavioral health license, to Managed Care Plans, schools, private practice, or leaving the workforce altogether.
- Managed Care Plans can offer salaries and often telehealth options that we cannot match.
- Schools require a mental health license, but pay significantly more and offer summer vacation, plus paid time off benefits.
- Private practice allows professionals to work at their kitchen table as they provide telehealth services. Online platforms are managing all the "back office" components, so all the professional has to do is open Zoom and do therapy.
- As a result of these attractive non-public behavioral health job options, we are losing our most seasoned and qualified staff and having to hire staff newly out of graduate school.
- Our BHS programming is set up to provide services to clients with moderate to severe intensity needs, while our partners are responsible for the milder needs.
- This means that our most acutely impaired clients are being served by less experienced staff and our clients with milder needs are served by the most qualified.
- Additionally, the exodus of staff from our system leaves those remaining to carry the large caseloads, which creates burnout and another reason to leave our mental health plan. Meanwhile, the referrals keep coming.
- Now that children are back to school, we are experiencing fewer suicide attempts than the prior year, but we also have an increasingly large referral flow for our short-staffed mental health plan.
- Additionally, COVID illnesses take the short-staffed programs down to skeleton crews as staff take time to recover and to isolate.
- These variables create longer times to get first appointments and higher caseloads that cut back the frequency and length of services necessary to address the acute needs of our population.
- Our providers have also lost staff that they have trained in evidence-based practices, so that expertise leaves with those staff, leaving a gap in service offerings.
- Recent increases to our FIT contracts have helped our public mental health sector a little bit with attractive salaries and signing bonuses, but that was only for MHSA-funded programs.
- 'CalAIM' is something our provider network hopes will result in less documentation burden, which has been a historical "turn off" for prospective and current staff.
- Our providers appreciate the ability to address homelessness with flex funds.
- While we have experienced a few positives, the workforce crisis overshadows our system and is a constant threat that keep our providers and County staff up at night, per their reports.

San Benito County

- The BHB had a discussion about the availability of MH services in the schools.
- It was noted that once students returned to “in-person” classes, there was an increase in the availability of MH services in the schools. This included both the PATH services delivered by SBCBH staff and MHSSA-funded services in the schools.
- There were also discussions about the increase in youth crisis interventions in the high schools.
- There was also concern over youth self-medicating with alcohol and drugs due to anxiety and depression exacerbated by COVID.

San Bernardino County

- The COVID-19 pandemic illustrated how crucial it is to maintain a cohesive network of community-based agencies collaborating to facilitate access to behavioral health care.
- In late March of 2020, providers began to adopt Telehealth services for Assessments and Treatment. Many community-based programs moved to 90-95% telehealth services.
- In the initial stages of the pandemic, ‘Children and Youth Collaborative Services’ (CYCS) put together a weekly “Telehealth Workgroup” with our childrens’ providers regarding the provision of telehealth services via a virtual platform. This allowed the providers to share ideas, tools, and techniques to use to engage children and youth via a virtual format.
- CYCS Staff worked with families, youth, and providers to address the fear and uncertainty and to provide resources to families who lost income or even their jobs.
- Upon the closures of the schools, CYCS met with school-based behavioral health providers [Student Assistance Programs (SAP) and School Aged Treatment services] to design a system where SAP served as an entry point into school-based behavioral health services.
- SAP providers also increased their engagement with their local schools by providing in-service trainings to the teachers, which included but was not limited to, how to identify youth struggling with behavioral health issues via a virtual format.
- The closure of schools during the pandemic led to a significant decrease in Community Crisis Response Team (CCRT) referrals, because at-risk students did not have contact with school personnel who may have been able to identify a need for crisis services.
- With limited/no access to the CCRT mobile response teams, Triage, Engagement and Support Teams (TEST) encounters increased, which could be interpreted to mean that more crisis calls were routed through law enforcement, indicating that the need remained despite the reduction in access.
- Similarly, utilization of other crisis services, such as Crisis Stabilization Units (CSU) and Crisis Walk-In Centers (CWIC) were reduced.

- Law enforcement limitations on welfare checks or calls wherein danger to others was not evident, further reduced linkage to crisis services.
- Additionally, throughout the pandemic, most of the Children's Residential Intensive Services (ChRIS) clinical staff continued with their in-person sessions. One major challenge for ChRIS staff was to address the emotional and behavioral upheaval of the pandemic and the associated quarantine with their youth in the group home.
- All programs experienced some barriers due to limited physical space and technology limitations, which resulted in restricted Telehealth services, especially with Child and Family Team meetings.
- Some providers solved this difficulty by purchasing digital tablets for youth, having the parents use their cell phones to participate, and they explored ways to ensure a confidential, secure space for therapy.
- By December 2021, many of our children's CBOs were providing 25% of their services in-person rather than by Telehealth. The clinical staff of these programs indicated that the clinical impact of Telehealth was mixed, and certainly varied by youth and therapist.
- Some clinicians reported that initially it was novel and successful despite the chaotic nature of the newly-COVID world.
- However, as the months passed, an increasing number of clinicians found that the youth wanted the personal touch of a face-to-face session.

<u>San Diego County</u>

- School support services were not robust.
- Since many kids receive MH services at their school site, and most schools were closed, many children did not get continued services just as they were isolated from their peers.
- The MH fallout from the pandemic exacerbated the mental health needs.
- Lack of clinicians amplified the problems.

<u>San Francisco County</u>

- Covid, the racial tension across the nation, political climate, and poor air quality given wildfires, all impacted staff and families throughout the pandemic.
- Compared to the same time period prior to the pandemic, we saw a 10% increase in suicide risk among our youth clients referred for crisis.
- We also had an increase in referrals to ICM level of care.
- We continue to manage risk as a system very well and intervene with appropriate services and supports to prevent harm, including expansion of 24/7 Mobile Response Team.
- Our providers immediately responded to the need to shift our services to Tele-behavioral health after shelter in place orders.
- Tele-heath therapy went from 30% use at the start of the pandemic to over 70% during the shelter in place within 2 weeks.

- We maintained face to face services to youth that were at risk or high acuity or for youth/ families not able to effectively engage in telehealth Services.
- We monitored access and engagement of clients in our services through Tableau © dashboards.
- There were also some trends of shorter sessions, but for more frequent contact, in that youth /families had Zoom fatigue given being on Zoom all day for school.

San Luis Obispo County

- A number of clinical staff have left to work for schools or private practice.
- Teletherapy has been effective but needs to be balanced with in-person care for our populations.
- The number of Medi-Cal eligibles has increased in our county.
- Mental health service requests also continue to increase.

Santa Barbara County

- 'Wait lists' with CBOs related to staffing impacts.
- Telehealth didn't work as well for kids with virtual school.
- No in-person groups were held.

Santa Clara County

- The penetration rates for youth services have been very positive for youth services, and we continue to develop programs that address the specific needs of various populations.
- We are intentionally designing programs that allow for flexibility and continuity of care for our target populations.

Santa Cruz County

- Increase in request for services, at the same time that we experienced staffing challenges across our system of care with severe issues for recruitment, hiring, and staff retention.

Shasta County

- COVID-19 created staffing challenges both in Children's Services and across organizational providers.
- There were high turnover rates reported in many of our 'Org' providers, and difficulty recruiting new staff.
- Referral times may have been longer, and there were increased caseloads.

Sierra County

- In-person, face-to-face interactions with counselors and other partners of care were dramatically restricted during the Covid-19 pandemic.
- As a result, the challenges of receiving services remotely were keenly felt by children and youth.

Siskiyou County

- The use of telehealth services for youth during the initial months of than pandemic resulted in a significant drop-off of service participation rates despite the observed increase in mental health issues among youth.
- Youth continued to decline (refuse) in-person services and we've found telehealth to be ineffective with many youth clients.

Solano County

- During Covid our county implemented two types of mobile crisis services: community-based and school-based. For the school-based team specific to children/youth, our Solano County office on Education oversees the staff, and our data show that both the utilization and acuity is high, and there is still a need for 'early intervention and diversion' from EDs.
- A critical area is the need for parent education, support and follow up- 'what to do, who to call.' Family-specific interventions and peer-support represent critical gaps in service.

Sonoma County

- Since the pandemic began, we have experienced an on-going and severe staffing shortage which decreases the quantity of services available and impacts our clients' ability to access adequate services in a timely manner.
- This has also had a significant negative impact on staff morale.
- The cumulative impact of repeated wildfires in this county along with the pandemic, has resulted in a significant increase in requests for services for children and youth, and in the acuity of youth requesting MH services.

Stanislaus County

- In the Children's System of Care, when the pandemic began, we quickly shifted to allow options for telehealth and telephone services to ensure continuity of care and continued access to services.
- We also operated an in-person clinic.
- The pandemic had a significant impact on staffing, creating workforce shortages that required management on a daily basis to ensure services continued across the system of care.

- This required a great deal of collaboration and flexibility, emergency planning meetings, cross-system communication, monitoring, and a willingness to operate very differently than was typical.

Sutter-Yuba Counties

- As with all agencies, at the beginning of the pandemic, we lacked the resources to provide consistent supportive services to both existing and new clients.
- However, the county quickly responded and provided the equipment required to deliver telehealth services.
- Staff worked diligently to develop clinical skills in delivering effective telehealth treatment.
- For many clients and their families, that required more intensive services. Telehealth services alone were found to be a marginal or poor substitute to in-person services.

Tri-City MHB

- Adapting to the changes and the increased need for various services was challenging.
- Trying to meet the needs of children and families with limited staff was difficult.

Tulare County

- With less face-to-face engagement of youth in the schools and outside of the home, there were also fewer referrals for MH services.
- Then, youth often were only being connected when they were significantly struggling or in crisis.

Tuolumne County

- The source of referrals during the pandemic dropped (from schools).
- Initially, youth were accepting of the telehealth modality. According to staff, youth enjoyed it. However, a drop in interest occurred as youth became tired of telehealth.

Ventura County

- The Youth & Family Division has sought to be responsive, nimble and creative in continuing to create access for youth and their families during the COVID-19 pandemic.
- All programs and staff have been available in-person throughout the last fiscal year.
- Telehealth therapy, case management and psychiatry remain options, as clinically appropriate, for youth and family members that have transportation challenges, other barriers, or are not comfortable with in-person services.

- During the pandemic there has been a significant increase in youth served in our clinics and programs. Likely factors include expansion of Medical Necessity, increased outreach efforts and the ongoing stressors of the COVID-19 pandemic.
- The Division continues to receive trauma-informed and evidence-based training to meet the complex clinical needs of the client population.
- Staffing of our programs and clinics is a current concern. There is a shortage of mental health workers nationwide; the County of Ventura is impacted as well.

Yolo County

- A major concern since the beginning of the Covid-19 pandemic has been the challenge in hiring and retaining mental health staff to serve the needs of our community.
- All of our E.P.S.D.T. contracted providers have shared that it is has been difficult to hire mental health staff, including clinician and MHRS positions.
- Due to the lack of therapists, there have been occasions where providers have been unable to take on referrals because they didn't have a therapist available to complete the assessment and to provide services.

Appendix VI. Descriptive comments submitted under "other" for Question 15 regarding major points of stress on the system for Adult BH needs and services.

Calaveras County

- We have seen a larger than usual number of non-Medi-Cal beneficiaries seeking services.

El Dorado County

- Individuals who were already receiving mental health services did not experience a decrease in services.
- However, for new clients to the system of care, it was more difficult to access services because the majority of services were through telehealth. Some clients initially did not have the capacity to participate in telehealth because of limited broadband and limited access to computers.

Glenn County

- Persons without housing and living in the community experience additional stress. It is difficult to obtain benefits without an address, and to secure basic living necessities (e.g., phone; medications; refrigeration; food; hygiene).
- GCBH continues to identify housing opportunities for these individuals to support their health and wellness.

Fresno County

- The number of individuals utilizing DBH services increased following the onset of the pandemic and has remained stable in the time since.
- However, we do not have an ongoing mechanism for tracking individuals receiving services by diagnosis (e.g., anxiety, depression as noted above).
- Due to the manner of which diagnosis is tracked in our EHR, our data on ED admissions is based on follow-up appointments with DBH post ED admission.

Humboldt County

- Lack of crisis triage, limited space in treatment facilities, and lack of housing.

Imperial County

- There was a considerable decrease in utilization of services.
- ICBHS made telehealth services available for clients but still some of them did not feel comfortable receiving services via telephone/ zoom.
- An increased number of individuals presented with substance use problems.

Kern County

- Inpatient bed availability for COVID-positive adults.
- Placement availability for long-term clients needing locked facilities.
- Increased acuity in clients accessing BH services.

Kings County

- Staff shortages with possible explanations such as budget decreases/position cuts, employee attrition due to burnout for personal reasons.
- Inability to fill open positions due to increased recruitment competition.
- Caseload size limits the quantity and frequency of services.

Lake County

- Increased stress due to multiple exposures (to covid and trauma) of patients using emergency services.

Napa County

- Responses from community members included increased social isolation and depression, and increased anxiety.
- Increased self-medication with drugs and alcohol, especially among older adults.

Nevada County

- Increased drug overdose deaths.

Orange County

- Recruitment and retention challenges due to highly competitive salaries offered to candidates and longer response times to find and secure talent.

Santa Barbara County

- Increase in aggressive behaviors observed.

Santa Clara County

To identify stress points, we examined intake information and diagnostic codes related to admissions in BHSD programs and emergency rooms. And we examined causes of death from the County morgue. These data indicate that the County of Santa Clara experienced several stresses on the system for Adult Behavioral Health, as follows.

- The first is decreased access/utilization in SUTS programs. The County experienced declines in enrollments in almost all modalities of SUTS programs due to distancing requirements and the use of telehealth.
- Second, the County also experienced an increase in the number of people presenting with anxiety related diagnoses as the pandemic proceeded. The numbers averaged around 400 patients per quarter prior to the COVID outbreak.

They stayed stable throughout 2020, but since the beginning of 2021 cases have increase to about 600 cases per quarter.

- Third, there was a spike in self-harm related admissions to the ER that began in November of 2020 and abated in the spring of 2021. During the same time there was also a spike in admissions to Emergency Psychiatric Services.
- In contrast, self-harm related calls to the Call Center did not increase nor did the incidence of suicides. For the other points of stress referenced in the question, the County did not experience significant increases in visits or calls for help.

Shasta County

- While only two categories were identified as having increases great enough to create additional stress on Shasta County's services, all these issues remain problems, and were already at concerning levels in our county, and deserve attention.

Stanislaus County

- Data reviewed indicate an increase in client access but a decrease in client utilization of Mental Health Services.

Sutter-Yuba Counties

- Being a rural community, our population has limited to no access to technology to offer or facilitate telemedicine.

Tri-City MHB

- Based on diagnosis data for anxiety and depressive disorders, there was a slight increase in both anxiety and depression during the pandemic.
- Emergency Room data from our local hospital revealed there was a decrease in ER visits; however, this may be due to people's fear of going to the hospital rather than a change in need for ER services.
- Conversations with the clinical department indicated that most of these were points of stress during the pandemic.

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Appendix VII. Descriptive information under "other Comments or concerns" about Adult Behavioral Health services and needs, in response to Question 17.

Alameda County

- The pandemic put a great deal of strain on both beneficiaries and providers. Individuals are seeking more therapy services.
- The workforce capacity issue is so significant now that we are having difficulty getting beneficiaries timely appointments to services at all levels of the system.
- In turn, this resulted in slower access to care and lower performance by providers.
- 'Burn out' is a significant issue due to low staffing and the effects of the pandemic on providers themselves who have concerns for their own health and that of their families.

Amador County

- Initially, there was an adjustment to telehealth services for both clients and clinicians.
- Due to lack of telehealth equipment, sessions were initially being conducted by phone only, so it was difficult to get an accurate assessment as we could not see the clients and much of an assessment is what is observed during a session.
- Privacy and confidentiality were concerns, as clients were not always in a private place to engage in their telehealth services.

Butte County

- Ongoing recruitment and retention challenges with behavioral health and health care workforce.
- Ongoing stress, burn out, and management of services in a complex time continues to increase the needs for mental health and substance use disorder services, concurrently with less provider capacity and limited network access to meet these service needs.

Calaveras County

- It is becoming increasingly more difficult to hire qualified staff.

Colusa County

- Crisis team was created to address the increased need for crisis services.

Del Norte County

- We continue to evaluate the impacts of COVID-19.
- However, the pandemic continues to be on-going at this time [editor: 2022-early 2023].

El Dorado County

- It is important to have access to BH services at the ED 24/7 to respond to all BH crisis situations.
- This includes having the capacity to call the Access Line during a crisis; having a mobile crisis team to respond to the crisis in the community; staff on-site in both Hospital Emergency Departments to respond to any BH crisis.

Fresno County

- Yes, to question 16 above.
- 1st priority points of stress: Staffing issues, inability to hire, quarantine and remote services.
- 2nd: Facility limitations (spatial) so no walk-ins, also no transportation (bus).
- 3rd: Technology challenges (not yet fluent in Teams, Zoom etc.

Glenn County

- There is concern for ensuring adequate nutrition and housing for the unhoused community.
- In addition, as funding and services are expanded, there is a need for additional office space for BH staff and partner agencies to deliver services.

Imperial County

- Increased number of clients reporting being homeless.
- Lack of beds or places to be able to house (temporarily) clients.
- Clients were referred to Home Energy Assistance Program and Homeless Task Force during pandemic, which assisted clients with temporary placement.
- Workforce challenges related to staff leaving then resulted in clinicians having high caseloads and delays in providing needed services.

Kern County

- Needing services for adults decreased with the transition to remote work.
- Social service agencies, community-based programs and behavioral health staff had less face-to-face contact, and therefore adults with needs that would have otherwise been identified may have been missed.
- In addition, sober living environments, room and boards, adult residential facilities and skilled nursing facilities implemented different levels of restrictions at different times which made it difficult to deliver face-to-face services in client's homes.
- Inpatient psychiatric beds and other enhanced placements were also a challenge due to facility shutdowns as a result of client and staff outbreaks of COVID.
- Also, facilities not being able to accommodate COVID positive clients in need of inpatient psychiatric care.

Kings County

- Staff shortages impacted our adult providers in many ways, specifically staff shortage, resulting in an influx of consumers seeking services and not having staff to be able to serve in a timely manner caused long wait times.
- Based on staff shortages, this contributed to burnout of the remaining staff, resulting in further staff attrition.

Lake County

- Continued lack of assistance for family and volunteer caregivers who support individuals suffering from aging-related mental health issues.
- The county needs do a better job at allowing patients access to care. It is hard for anyone in Lake County to get seen for mental health. There are not enough providers or facilities.
- Behavioral Health Department was near impossible to reach for Mental Health Services and Crisis teams would not provide MH services.
- We do not have enough services in this county to meet the acute need of the community.
- Crisis and drug and alcohol services are dangerously lacking in their ability to meet the need of the community.
- We need 100 community health/peer support workers in Lake County.

Lassen County

- Many could not be admitted to psychiatric hospitals because many psych hospitals would not accept a person if they tested positive for COVID even though they had no signs or symptoms of illness.

Los Angeles County

- As a result of the Covid-19 pandemic, DMH experienced challenges in terms of recruiting and retaining mental health professionals.
- This challenge was in part due to staff leaving the profession or deciding to exit the public mental health system. This shift made the corresponding increase for mental health services difficult to address.
- Currently, the department is leveraging recruitment and retention strategies to ensure that the workforce is adequate to meet the expanding needs within Los Angeles County.

Madera County

- Covid-19 triggered the ‘great resignation’ which later resulted in staff shortages state-wide; Madera County is not the exception to these challenges.
- Additional resources and approaches to reach potential candidates have been implemented to create interest in current vacancies.

- Some of these efforts include sending communications to all potential clinical candidates state-wide, distribution of a hiring flyer, leveraging of social media platforms, spreading the word in the agency and community.
- Retention strategies have also been implemented in the form of incentives for hard-to-fill direct service vacancies, bilingual pay opportunities, and internal lateral transfer opportunities.
- Our department did have challenges securing placement in psychiatric facilities and residential placement in the initial start of Covid-19 pandemic with limitations in the availability of facilities.

Marin County

- The pandemic increased the number of Medi-Cal beneficiaries, and the increased numbers both eligible for MH treatment and seeking services meant that more people qualified for services in our system of care than previously.
- This has had ripple effects into the system of clients with high needs with diagnostic pictures that were different than pre-pandemic in terms of trauma, depression, anxiety, and personality disorders.

Mariposa County

- In some areas of the county, older adults needing treatment were fearful of in-person services due to underlying medical conditions, but they also had difficulty using telehealth due to poor internet connectivity.
- Another issue was that engaging new clients proved difficult during transition from in-person to telehealth.

Merced County

- Each behavioral health program created a plan for increasing adult engagement and serving them to strengthen protective factors and function as a buffer.

Mono County

- A local school administrator provided this extended observation, having *"seen many young people become discouraged with school (post high school) and want to take one or more gap years, or drag out their completion by dropping courses, or drop out. I'm not at all sure that gap years are a bad thing. That may be very healthy for these students. However, the students that were at home for a chunk of high school, often seem disorientated with the world. They perhaps did not get the support and socialization both with peers and supportive adults during high school, and now really need both even though they might not even realize it! I believe MCBH has done an incredible job of reaching out with a variety of programs, as we came out of the pandemic and could start being more active again. Sometimes it is very difficult to get those who need it the most to become involved!"*

Napa County

- Comments from community members reflect that the pandemic increased stress and anxiety for parents and caregivers who did not work remotely, due to the lack of access to daycare and child-care resources.

Nevada County

- The rise in fentanyl-related drug overdoses and deaths has been horrifying over the past three years.

Orange County

- Greater awareness of services.
- An understanding analysis of the needs and gaps analysis combined with sharing outcomes across the continuum of care continues to be a challenge for the community.

Placer County

- We need increased access to Substance Use residential, MH beds, and shelter space (although project Room Key helped).
- Covid reduced our number of "beds" available and increased wait times to needed care, in particular SUD.
- We had to space people out to isolate with Covid cases.

Sacramento County

- The adult outpatient mental health system did not experience a significant decrease or increase in services during FY 2019-20.
- The data show a slight decrease of 2.8% in overall utilization, Anxiety diagnosis increased from 14% to 16%, and Depression diagnosis increased from 21% to 23% during this period.
- The system was able to implement a flexible delivery approach offering services in person, or via phone as well as through telehealth.
- The crisis continuum was impacted during this period, for example the Crisis Residential Programs and the Mental Health Urgent Care Clinic capacity and hours of operation were impacted by COVID outbreaks and staffing coverage issues. All of these factors resulted in limiting access to these resources.

San Benito County

- BHB members discussed the concern about an increase in anxiety and depression for adults during and after the COVID-19 pandemic.
- It was also noted that adults coped with the increase in anxiety and depression by an increased use of alcohol and drugs.

San Bernardino County

- The COVID-19 pandemic illustrated how crucial it is to maintain a cohesive network of community agencies collaborating to facilitate access to behavioral healthcare.
- With limited/no access to the CCRT mobile response teams, TEST[32] encounters increased, which could be interpreted to mean that more crisis calls were routed through law enforcement, indicating that the need remained despite the reduction in access.
- Similarly, with fewer referring community agencies in contact with potential adult consumers, linkage to and utilization of Crisis Stabilization Units (CSU) and Crisis Walk-In Centers (CWIC) were reduced for three out of four facilities.
- Additionally, law enforcement limitations on welfare checks or calls wherein danger to others was not evident, further reduced linkage to crisis services.
- Finally, increased placement barriers to stepdown facilities following inpatient psychiatric treatment led to an increase in inpatient lengths of stay when an alternative level of care may have been more appropriate for consumers' needs.

San Diego County

- No. Clearly, the same problems caused by the pandemic exists for all adults, but specifically the lack of wraparound services for the unhoused.
- Programs need to become more accessible for children in group care especially since they do not use private insurance and many services are restricted because of this.
- More behavioral health programs also need to be available and adequately staffed.

Santa Barbara County

- 3rd priority concern above indicated as "Other" is: Increase in Aggression.

Santa Clara County

- BHSD saw a decrease in the number of adult and older adults accessing services in-person during the pandemic based on fear of contracting the virus.
- As public health restrictions were reduced, there was a rebound effect in clients accessing BHSD services, far exceeding the previous year during lockdown.
- See our county's response to Question 23 for more information about staffing.

Santa Cruz County

- COVID outbreaks in MH facilities limited the capacity for new admissions.

[32] Need definition of TEST acronym, maybe with a supporting reference.

- Shifting to Telehealth or Telephonic services was challenging for adults experiencing homelessness.

Shasta County

- Lack of adequate staffing was, and continues to be, a major problem, although the board recognizes this is not limited just to adult behavioral health programs.
- An additional concern for the board is that telehealth services are not always the most appropriate or effective, especially for individuals with psychotic disorders.
- While it was understandable, particularly in the early stages of the pandemic, that in-person services were not always available, they are sometimes the best or only way to ensure adequate levels of care and emotional support for many consumers.

Sierra County

- Sierra County Behavioral Health maintained both clinical sites and all services throughout the Covid-19 pandemic.
- We successfully implemented telehealth services with support access in the office and out in the field. Transportation services were demised due to safety protocols but have since been fully reinstated.

Siskiyou County

- We have had a significant rise in the number of people living unhoused since the beginning of the pandemic, and a significant influx of fentanyl.
- Our system is inundated with people seeking housing services, which has impacted our ability to provide timely access for those seeking behavioral health services.

Solano County

- During Covid our county implemented mobile crisis services, 2 types: community-based and school-based.
- For the community-based mobile crisis used by adults, the prevalence of drug use and mental health symptoms are high, and law enforcement training needs to be expanded (we will be implementing CIT soon).
- Expansion of crisis/peer respite funding would be ideal.

Sonoma County

- Staff burn-out increased, which created shortages and capacity issues.

Stanislaus County

- Due to the limitations and challenges presented by COVID-19, several services were provided via telehealth in accordance with local safety guidelines.
- In-person services were provided when clinically indicated.

Sutter-Yuba Counties

- During the Covid-19 pandemic and the transition to telehealth services, our more rural and isolated partners faced the most challenges.
- Those with a larger socioeconomic barrier or rural location had an easier time with a telephone only appointment versus using an online video conference appointment.

Tri-City MHB

- Our agency was very adaptive to the needs of the community.
- However staffing and reduced services from other agencies presented challenges.

Tulare County

- Adults increased their access of SMHS.
- Additionally, the MHP opened services to more adults due to significant risk factors and potential deterioration.
- This was in parallel to more adults presenting in crisis, many with no previous MH services.

Tuolumne County

- During the COVID-19 pandemic, it was necessary to close the department's Enrichment Center (for clients), and the Lambert Center (for the homeless).
- There was a loss of volunteers to work with the adult programs.
- It was helpful for staff to become familiar with other organizations and partners to assist adult behavioral health clients.
- During the pandemic, State and Federal funding were "thrown" at various programs/services. What was needed was a master plan, a ‘needs assessment’ process, and determination of which areas had the highest need for services.

Ventura County

- Ventura County Behavioral Health continued to provide direct mental health services and treatment throughout the pandemic, including in-person contacts when the circumstances warranted (i.e., crises/5150, administration of injectable medication, and administration of benefits.

Appendix VIII. Descriptive responses or comments to Question 21, regarding availability of certain laboratory services associated with MAT and SU treatment and whether those services were useful in assisting clients' recovery. The following responses dressed the follow-up questions: "If yes, how has this been useful in promoting successful outcomes? If no, do you have alternatives to help clients succeed?

Alameda County

- Yes, we coordinate with clinics to the extent that testing is available.
- While we have not formally completed an analysis of this manner, anecdotal evidence would suggest a positive correlation with success.

Alpine County

- Ability to find out levels of medications that client is on.
- Also, to find out whether clients are staying on the course of treatment.

Amador County

- At the start of the pandemic our offices were closed to the public and services were not provided in-person, which resulted in lack of routine drug testing, and which seemed to negatively impact the success of clients.
- Later, counselors were then able to schedule in-person drug testing which seemed to result in clients taking responsibility for their recovery with more accountability to treatment.

Butte County

- Yes, this has promoted successful outcomes because having clinic near the client opens an opportunity to have access to resources.
- Having a clinic near the client reduces the barrier to accessibility for clients that may lack transportation.

Contra Costa County

- Yes, it has facilitated access and decreased barriers.

Del Norte County

- MAT is provided outside of the county through a contracted provider.
- Suboxone is the only medication available in the county through the FQHC and clients are referred when appropriate.

Fresno County

- In regard to testing at five clinics in Fresno: MedMart, ART E. Street and Aegis- the testing is performed on-site.
- ART Cartwright and Van Ness - Not able to coordinate services with other clinics.

- However, our County would be able to provide testing through Quest, available UA tests for patients in online MAT services.
- Alternative to help clients succeed (response from BayMark = MedMark and the 3 ART clinics): Many of our clients are more successful when they are able to access medical transportation services. All of our counselors are trained on how to assist or walk our patients through utilizing transportation services to one of our locations.
- We encourage new clients to schedule the intake appointment and transportation in advance. Intakes can be lengthy, which is a barrier to treatment for patients who are employed or have other responsibilities like caring for children. We reduce the time a new patient has to spend during the initial visit when appointments are scheduled in advance.

Glenn County

- Our county utilizes in-house drug testing with clients for therapeutic purposes.
- We do not provide drug testing for use in courts, with Probation, or with primary care.

Humboldt County

- Unknown for our county.

Imperial County

- ICBHS conducts routine drug testing onsite using oral swab tests.
- Additionally, we conduct testing as part of MAT services for adherence to medication and monitoring clients taking buprenorphine as prescribed.

Kern County

- Not for drug testing.
- Clients participating in MAT programs are required to present in person for dosing and counseling.
- Drug testing is completed according to Title 9 requirements.

Kings County

- MAT programs are all out of county.
- If providers do not refer out due to refusal of client, they are referred to a local clinic.

Lassen County

- LCBH does not provide MAT.
- However, the local Federally Qualified Health Clinic does provide MAT and already provides drug testing.

Los Angeles County

- Urine drug screening has been helpful for the clients to achieve success and is an opportunity for contingency management.
- However, obtaining urine drug screens was challenging for some clients during the pandemic (shelter lockdowns, limited in-person staff, and patients' reluctance to come to clinic).

Madera County

- The SUD program does not require routine testing.
- However, BHS is committed to the successful recovery of all our clients and to assist in coordination of various services as needed.
- It is important to note that the majority of our clients are referred by the legal system such as probation who do conduct testing functions.
- The SUD Program does contract with MAT providers in neighboring counties for our clients. Local MAT provider is 'in process.'

Marin County

- We have clients in the clinic at least one or more time a month and obtain monthly urinalysis testing from them.
- Emergency regulations due to COVID PHE allows only 8 urine tests a year per patient; usually, (pre-pandemic) we almost always got 12 or more.
- Urine tests are generally helpful in guiding patients towards recovery as they are a basis for who gets how many 'take-homes'. Under COVID that linkage is no longer in place and urine testing is of more limited value.

Mariposa County

- We utilize supportive case management services, community partners such as the Heritage House, and support individuals with Substance Use Navigator.
- We have contracted with Aegis to provide MAT services (they test as needed) and other contracted providers can test if needed.

Merced County

- Our county has a collaboration with Aegis Treatment Centers.

Mono County

- MCBH refers all MAT clients to an outside agency.

Nevada County

- Yes, the drug testing program helps with honest dialog about ongoing needs and for adjusting the treatment plan.

Orange County

- Yes. Drug testing is performed in clinics where clients are receiving treatment plus clients can have drug testing at other clinic locations if needed.
- This allows clients to complete drug testing whenever and wherever necessary and with no interruption to their treatment.
- Additionally, labs can be done and sent out for confirmation.

Placer County

- Regular testing is a critical part of MAT treatment.

Plumas County

- Working now to start partnering to provide those services.

San Benito County

- Yes, our County contracts with Valley Health Associates to offer MAT services.
- This is helpful to clients who need this level of treatment, so they do not need to drive to another county to receive treatment.

San Bernardino County

- Best practices in providing MAT includes regular testing.
- When testing can be provided on site by point of care testing, results can reliably be obtained.
- When clients are required to go offsite to a laboratory collection center, they typically require assistance from a case manager to successfully complete labs.

San Diego County

- No, all SUD programs are expected to provide individual treatment plans to address individual barriers.
- Our programs have increasingly been delivering case management services which do help clients succeed.

San Francisco County

- Our Opioid Treatment Programs have on-site drug testing.

San Luis Obispo County

- Testing helps the prescriber determine the effectiveness of the current dosage. For example, if the client indicates that they are still having symptoms, but the testing is negative, then the prescriber can ask more questions to see if dosage needs to be adjusted.
- It also helps to determine negative outcomes, for example, diversion of medications by the client.

- If drug testing is positive (meaning the client is taking the medication appropriately), then positive outcomes can be attributed at least in part to the use of the medication.

Santa Clara County

- We offer drug testing in all our Addiction Medicine Clinics.
- We assign patients to any clinic that is close to their place or work or residence.
- By giving clients choices it has help us to stay in compliance with state and Federal regulations and promoted successful treatment outcomes towards recovery and ensuring to address their needs more in timely manner.

Shasta County

- Shasta County does not offer MAT in our clinic.
- We do offer routine drug screening for many of our other programs.

Solano County

- We are in process of expanding MAT within our MH clinics.
- We do already offer supports and drug testing when needed.
- However, few of our psychiatrists are suboxone-waivered. More advocacy is needed to have MDs take this on.

Stanislaus County

- Narcotic Treatment Programs (NTP), office-based opioid treatment 'spokes', and non-NTP additional medication assisted treatment sites are located within time and distance standards for all Medi-Cal beneficiaries in Stanislaus County.
- In addition, Medi-Cal beneficiaries are entitled to transportation services under the Plan.
- BHRS provides care coordination to ensure clients are able to utilize transportation services to attend medication counseling and other appointments, including routine drug testing.

Sutter-Yuba

- The routine drug testing is helpful for the providers. It helps to determine if the patient needs an increase in medication due to relapse, and to better manage their medications and therapy.

Tulare County

- Each medication has different precautions and significant considerations for medical providers, based on a patient's unique needs and circumstances.
- An important factor in promoting successful outcomes is for the provider to have the routine drug test results for continued monitoring of progress.

Ventura County

- Testing promotes candor. If the client tests positive, clinician may adjust treatment and medication.
- Negative tests provide positive reinforcement to continue recovery.

Yolo County

- Clients are being held accountable due to the results of their routine drug tests.

Appendix IX. **For Question 22: "Have any of the following factors impacted your county's ability to provide crisis intervention services? (Check all that apply)" one of the options was "other". Listed below are various answers received for this option.**

Alameda County

- Recruitment and retention of staff and our very long HR process.
- We lost a few great candidates because our HR process takes months.

Fresno County

- Inability to access 'Care Mobile Unit' grant fund awarded 09/2021 for expanded crisis services (case management and CIT for youth training) in FY 21-22 due to contract delays from DHCS contract grant administrator. Contract was finally scheduled to be presented at 9/2022 BOS meeting.
- Clarification to Rural ED's in 12/2021 of contracted Rural Triage CIT Program's intent to provide mobile CIT services out in the field with law enforcement and other first responders.
- Thus, they discontinued CIT services at hospital facilities.
- Also, Fresno Police Department CIT changed data systems, therefore it has been difficult to gather information and outcomes of FPD CIT encounters after 02/2022.

Glenn County

- There are fewer organizational providers to contract for crisis intervention services.
- Also, there is limited ability to hire trained bilingual staff.

Lake County

- Access to services

Los Angeles County

- Difficulty with ongoing operational funding for crisis services, including urgent care services, crisis residential treatment programs, short term inpatient programming, and
- Funding and staffing for crisis mobile response for shifts that are difficult to fill like nights, weekends and holidays.

Madera County

- In October 2021, MCDBHS received notification that it was awarded $3M in funding to expand its crisis continuum of services through the DHCS 'Crisis Care Mobile Units Program' funding as part of the larger State Behavioral Health Continuum Infrastructure Program.

Napa County

- Difficulty in recruiting and retaining staff.

Orange County

- Long ambulance wait-times resulted in delayed psychiatric hospitalization.
- Delayed access to hospitalization decreased accessibility of lower level of care treatment for clients when discharged from crisis services due to capacity issues.
- In addition, there is an increasing trend with law enforcement of hesitancy to assist mobile crisis staff gaining entry to dwellings to assess individuals in crisis.

San Joaquin County

- Difficulty finding psych placements (hospitals) for detained clients as a result of hospitals that closed units due to COVID-19.

Santa Barbara County

In-person activity never stopped, including going to ERs for evaluations. Answers for #23: Negative effects of staffing issues led to the following:

- 1st Impact: Inpatient and crisis services staffing impact.
- 2nd Impact: Loss of shelter/placement options due to COVID lock downs.
- 3rd Impact: Crisis residential treatment impacted.

Santa Clara County

- Note, the following relates to the selected option above.
- The Department continues to recruit for the open positions.
- Due the 24/7 nature of the work environment it has been a challenge to find candidates.

Santa Cruz County

- Loss in revenues and reduced in-person services.

Shasta County

- An additional issue identified by the Shasta County board is the lack of beds to place people, particularly during the pandemic when moving consumers between counties or facilities was not always possible.
- Emergency Departments and other areas where crisis services are offered were easily backed up for this reason as well, besides just issues with staffing.
- Staffing in turn affected how many additional people could be quickly evaluated.

Siskiyou County

- Challenges due to local hospital not wanting Behavioral Health clients in the ED.

Tri-City MHB (for region in L.A. County)

- At times there was a lack of ambulance resources, and it was difficult to transport people in a timely manner.
- Additionally, during the pandemic, Tri-City continued to provide crisis services both in the community and on-site.

Tulare County

- While one-time funding has been released, we are unable to add staff as needed.
- Sustainable, identified funding streams are needed (beyond Medi-Cal) to support comprehensive community crisis services.
- Also, in collaboration with our ERs and hospitals, tele-health has not been acceptable at some sites (outside of the MHP).

Tuolumne County

- Hospital COVID protocols/safety measures.

Appendix X. Responses supplied to the "Other" option, for Question 24: Has your county used any of the following methods to meet staffing needs during the pandemic?

El Dorado County

- Supplemental Paid Sick Leave for COVID-19

Fresno County

- The Department utilizes various strategies to attract qualified candidates with increased paid marketing, strategies for greater social media presence, promotion of County benefits, and inclusion-focused efforts, which are described in job flyers.
- The HR Dept. participates in general job fairs and collaborates with college universities to attend their job fairs.
- Other efforts include the hiring of new staff, utilization of contracted (non-county) positions for difficult to fill classifications.
- Participation in student work experience-contracted help and CalWORKs work experience in certain positions.
- As government institutions, we are bound by civil service processes and county wide policies, so the department use of retired staff, flexible work hours, or facilitating access to childcare/daycare are not options readily available.
- The Department offers some form of flexible work hours (start/end times, shorter lunch periods within the defined core business operations hours, and while following federal, state and county rules, i.e., MOU with bargaining labor units).

Imperial County

- ICBHS requested salary increases for Clinicians to offer competitive salaries.

Madera County

- We have worked with human resources to prioritize our recruitments and increased our advertising sites.
- Director worked with Unions to provide incentives for "hard to fill" positions and "hard to fill" locations in the department.

San Diego County

- Use of temp staff.
- Reduction of capacity when adequate staffing wasn't available.

San Luis Obispo County

- Hiring new staff has been challenging depending on the classification.

Santa Barbara County

- Maximize temp workers, traveling nurses, locums tenum (temporary clinicians).

Shasta County

- We asked for other County departments to assist with the COVID effort during the pandemic.
- Most departments in the County either assigned someone to work in the EOC/DOC or had staff in their department with COVID as their priority.

Siskiyou County

- Siskiyou County only allows telework for individuals who are out ill with COVID-19 or at home with children who are ill with COVID.
- We have attempted to hire new staff but have had open recruitments for over one year without any applicants.

Solano County

- Trying to advertise more on social media and other channels.
- We need to redo classifications/salaries to compete with other organizations.
- We barely get any applicants to each round of advertising.

Sonoma County

- Temp agencies.

Tri-City MHB

- Financial incentives: Hiring bonuses, longevity incentives, and an increase in merit pay.
- Also: hazard pay, teleworking reimbursement stipend, and paid administrative leave.

Appendix XI. Responses listed under "Other" for Question 25: Has the pandemic adversely affected your county's ability to reach and serve clients and families from various demographic groups?

Contra Costa County

- It's unclear if any effects on the numbers served in these groups were related to the pandemic.

Fresno County

- For Black/African American Latino/Hispanic populations services increased.
- Note, for Asian Pacific Islander and Native American/Alaska Native populations, there was a small decrease in number of persons served, which has now rebounded to pre-pandemic levels.

Kings County

- Caucasian clients.

Madera County

- The pandemic affected our ability to reach and serve all populations due to lack of information when the pandemic first hit and due to fear of contracting the virus thereafter.
- In 2022 more of the population was open to returning to some level of pre-pandemic normalcy [edit: original answer apparently included a table which was not detected by SurveyMonkey].
- However, the pandemic continues to affect many.
- BHS services are available to all who need them in whichever manner they are most comfortable, from in-person to virtual platform and telephone.

Orange County

- Providers have noted that the pandemic has impacted children and youth in all of these populations.
- At the beginning of the pandemic when many services were being delivered via telehealth, providers expressed challenges in engaging this young population due to lack of access to appropriate devices, no Wi-Fi access, and other technical challenges.
- Providers have also shared that the challenges with engagement and conducting therapy sessions were especially significant with children of younger ages.
- For adults across the board, there were the same challenges related to not having appropriate devices, no Wi-Fi access, inadequate privacy, and other technical challenges.

San Bernardino County

- Based on data for clients pulled on July 28, 2022, for FY 20/21 and comparing it to data for FY 19/20 all racial/ethnic communities were adversely affected by our county's ability to reach and serve those in need of Behavioral Health Services.
- In FY 20/21 we served 5,723 fewer Medi-Cal clients than the previous fiscal year 19/20.
- The following groups were most affected, showing a decline in numbers of clients served for these racial/ethnic groups (total decreases shown in parentheses): Latino/Hispanic (-2,709); Caucasian/White (-2,182); African American/Black (-1,170).

San Francisco County

- There had been some focus on creating culturally congruent BH care (particularly for the African American Community which represents a small proportion of residents in San Francisco but are disproportionately served in community behavioral health, hospital, and jail settings),
- Also there have been effects on community-focused interventions and equity issues related to impacts of Covid and related supports.

Santa Barbara County

- Yes, some families had less access to telehealth and Wi-Fi – especially Latino/Hispanic clients and their family members.

Sierra County

- All Sierra County community members.

Solano County

- We have actually improved access due to telehealth being an accommodating factor.

Sutter-Yuba Counties

- Isolation of rural and low socio-economic status communities due to lack of adequate internet access.

Yolo County

- Multigenerational families under one roof.
- Increased risk of COVID-19 spread across members of the household from different age groups.

Appendix XII. With respect to Question 26: Based on experience in your county, has the pandemic adversely affected your ability to reach and serve several listed vulnerable groups? The following answers were submitted under "other:"

Amador County

- Initially, all populations were adversely impacted as our offices were closed and we did not have telehealth equipment to provide services.

Alpine County

- Couch-surfing individuals.

Fresno County

- Note, services for children and youth and foster children increased.
- However, fewer services were provided in homeless shelters and for seniors 65+

Kings County

- Rural communities or persons with low socioeconomic status.

Lassen County

- People living in the very rural areas of the county.

Madera County

- Although our system is not set up at the moment to pull data by the specific breakdown in this question, we can report age specific data regarding changes in the number of individuals seen by our county BH as shown in table below.
- In FY21-22: 66 fewer in age group 0-21, 866 fewer in age group 22-64 and 31 fewer individuals ages 65+ were seen.
- From FY19-20 to FY20-21 we saw a decrease of 22% in age group 0-21, age group 22-64 decreased by 23%, and ages 65+ decreased by 2%.
- [editor's note: the info provided in the source is somewhat unclear, as the numbers for FY21-22 were given as difference in overall numbers, whereas the data from an earlier time period were listed as overall percent changes].

Sacramento County

- We faced challenges reaching and serving Latino/Hispanic clients, and
- Those who were asylees (refugees seeking asylum).

San Bernardino County

- Clinic-based crisis programs such as CSUs, CWICs, and Crisis Residential Treatment (CRTs) that rely on community partnerships to generate referrals were unable to perform in-person outreach during the height of the pandemic.

- This reduced their ability to raise awareness of their services in key areas wherein they had historically been able to connect with members of vulnerable demographic populations, including all the above groups [as listed in the question].

Sierra County

- All Sierra County Community members.

Sutter-Yuba Counties

- Isolation of rural and low socio-economic status communities due to lack of adequate internet access.

Tri-City MHB

- During the pandemic, Tri-City continued to provide outreach and in-person services.
- Efforts were made to communicate to the community that the agency was open and available to help them.
- Therefore, Tri-City was able to reach the underserved and unserved populations listed above [in the question].

Appendix XIII. Question 27 asked about several categories of potential barriers to accessing BH services during the pandemic. Below, we list the county responses that fell under "Other".

Fresno County

For Children:

- The pandemic limited parents from attending due to COVID protocols,
- Childcare was eliminated during the pandemic,
- Group therapy and family therapy were both affected.

Imperial County

- Clients had limited contact with agencies that generate referrals like Department of Social Services, schools, etc.

Kings County

- Rural communities and those with low socioeconomic status.

Napa County

- For school-age children & youth, "distance learning" hampered identifying and engaging with individuals experiencing behavioral health distress.

Santa Clara County

- Child-care related barriers.
- Finance-related barrier post the 'peaks' of the pandemic.
- Low level of awareness of where to seek help post the 'peaks' of the pandemic.

Tuolumne County

- The challenge for the unsheltered has been access issues due to technology, such as not being able to charge a cell phone.

Ventura County

- Although there were no significant barriers, some populations had difficulty utilizing telehealth services.

Yolo County

- Staff illness due to COVID-19.