Overview Report
2024 Data Notebook Project on California Behavioral Health: Homelessness in the Public Behavioral Health System

California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

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The California Behavioral Health Planning Council (CBHPC) is under federal and state mandate to advocate on behalf of the population of CA, including both children and adults, with mental health and/or substance use disorders. The Council is also statutorily required to advise the California Legislature on behavioral health issues, polices and priorities pertinent to both mental health and substance use disorders 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 and/or substance use disorders.

Acknowledgements

We appreciate the assistance of the California Association of Local Behavioral Health Boards and Commissions. We want to thank everyone who participated in preparing the information and discussion for responses to the data and questions in the 2024 Data Notebook. These include local Behavioral Health Boards and Commissions and their respective county and local[1, 2] Departments of Behavioral Health/Mental Health, listed below:

Alameda, Alpine, Amador, Berkeley (City of), Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Kern, Kings, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Plumas, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, ,San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter-Yuba, Tri-City, Trinity, Tulare, Tuolumne. Ventura, and Yolo.

In summary, we received 52 Data Notebook reports from 51 counties and 2 non-county local agencies and their respective Behavioral Health or Mental Health Boards and Commissions. Two counties, Sutter and Yuba, collaborate in a single Department of Behavioral Health and Mental Health Plan to provide services. Seven counties did not submit data[3].

[1] These include the City of Berkeley in Alameda County and The Tri-Cities within eastern Los Angeles County.
[2] For more than 60 years, Tri-City Mental Health Authority has served as the mental health authority for the cities of Pomona, La Verne, and Claremont, are adjacent to the San Gabriel Valley, and lie within the boundaries of L.A. County.
[3] Contra Costa, Inyo, Lake, Mono, Riverside, Solano, and Tehama Counties.

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2024 Data Notebook Project Introduction

Purpose and Goals

This document is the annual report on the 2024 Data Notebook Project prepared by staff and members of the California Behavioral Health Planning Council (CBHPC). This report is a compilation and analysis of information from the local behavioral health boards/commissions that completed their Data Notebooks. The CBHPC uses this information in its advocacy to the legislature and to provide input on the State Mental Health Block Grant Application to the Substance Abuse and Mental Health Services Administration (SAMHSA)[4].

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, as the overall system is large and complex. 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[5] to the CBHPC. To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for the boards/commissions to complete and submit to the CBHPC. Discussion questions seek input from the county behavioral health departments and boards/commissions. CBHPC staff analyze these responses to create annual reports to inform legislators, policy makers, and the public.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The CBHPC 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 behavioral health boards/commissions and their county behavioral health departments to work together to identify critical issues in their community and inform the county Board of

[4] 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.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

Supervisors and state leadership about their local behavioral health programs, needs, and services.

What Was New This Year?

The 2024 Data Notebook is divided into two sections. The first section addresses **Homelessness in the Public Behavioral Health System.** The CBHPC recognizes that this complex issue is the subject of much discussion, advocacy, and policy across the state. Our goal is to gather information about how counties address the issue of homelessness and housing among people served in their behavioral health systems and identify what data counties collect on this topic.

The second section provides several questions asking for input from the local behavioral health boards/commissions regarding what topics and performance outcomes indicators they would like to see addressed in future years.

In addition, Part I questions that were included in Data Notebooks from 2019 through 2023 are no longer included. An analysis of the data collected over that five-year period was completed in 2025 and some of the data regarding housing and homelessness are discussed in this document. The report, **California Behavioral Health Planning Council: Data Notebook Part I: 5 Year Analysis,** will be available to the public this year. At the end of this overview, we have included the recommendations addressing the significant issues identified in the report.

What are Performance Outcomes?

While local behavioral health boards/commissions are required to review performance outcomes data for their counties, there is some ambiguity about what constitutes a "performance outcome measure." Outcome measures are one of several kinds of measures used to evaluate the quality of health care organizations and services. According to the Agency for Healthcare Research and Quality, a common classification of quality measures[6] includes:

- **Structural Measures** provide data on the capacity, systems, and infrastructure of a health care provider to gauge their ability to provide care. Examples of structural measures would be the ratio of providers to patients, or whether the organization uses electronic medical records.
- **Process Measures** indicate that a provider is using evidence-based best practices and processes to achieve a positive impact on people's health or reduce harmful outcomes. Examples of process measures include the number of patients

[6] Types of Health Care Quality Measures, by the Agency for Healthcare Research and Quality.

who receive recommended health screenings, appointment wait times, and the frequency of follow-up appointments.

- **Outcome Measures** evaluate the impact a service or intervention has on an individual's health status and recovery, whether positive or negative. Examples of outcome measures include evaluations of symptom severity, hospital readmission rates, and quality of life.

Of these three kinds of quality measures, outcome measures may be the most valuable for assessing the effectiveness of a health care service or intervention. However, these are also the hardest to evaluate, as many factors influence health outcomes besides the treatment or services that an individual receives. It is beneficial to evaluate outcome measures in the context of structural and process measures, as they are closely related. Improving processes and system capacity within a health care organization can result in improved outcomes.

Patient-reported outcomes are important for assessing the quality of care that patients receive. These are outcome measures of an individual's health, quality of life, and their experiences regarding the care they receive, using information gathered directly from the patient and/or their caregivers. Examples include patient reports of how well they feel their provider listens to them during appointments, or how effective they feel their treatment has been over the past 6 months.

A performance indicator is a specific measure, whether quantitative or qualitative, that is used to determine if a service or program is achieving their desired outcomes. During the evaluation process, the organization reviews their indicators to assess the effectiveness of their processes, policies, and services. It is important to also review the indicators themselves at regular intervals to determine if those indicators are working as intended, or whether the indicators need to be modified to better serve the evaluation plan. Note that it may be difficult to draw sound conclusions from qualitative indicators.

In behavioral health care, there are many potential outcome indicators that can be used to evaluate the impact of programs and services. The California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) published an issue brief[7] on the topic of performance outcome data that includes suggested data points for county behavioral health departments. The Agency for Healthcare Research and Quality also

[7] Performance Outcome Data Issue Brief, published by the California Association of Local Behavioral Health Boards and Commissions.

has publicly available resources on how to choose healthcare quality measures.[8] We recommend that local behavioral health boards/commissions and behavioral health departments use these resources when considering what data to collect or use.

2024 Data Notebook: Homelessness in the Public Behavioral Health System

Homelessness is a multifaceted and longstanding phenomenon in the United States, and California in particular. The state of California is home to the largest number of individuals experiencing homelessness in the nation. Our state accounts for approximately 12% of the total population of the United States, yet it makes up 31% of the nation's homeless population and 49% of the unsheltered population as of 2023. The combination of low income and a lack of affordable housing continue to be the largest contributing factor to homelessness. However, there are many other factors that play a role, including incarceration, racial disparities, physical and mental health, and domestic violence.

The intersection of homelessness and behavioral health is a complex topic and has been the subject of increasing public discussion, political debate, and legislation. Rates of homelessness have continued to increase at alarming rates, exacerbated by the effects of the COVID-19 pandemic. As public concerns about homelessness have grown, so have statewide efforts to reform behavioral health services in California. While the Council does not share or endorse the view that mental illness is the primary cause of homelessness, the public behavioral health system does play a vital role in serving individuals experiencing homelessness.

Defining Homelessness

The federal government finalized the official definition of homelessness in 2011[9] for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. This definition states that a person or family is homeless if they fall into one of four categories:

- **Currently homeless** (those who do not have a fixed, regular, night-time residence, which includes living in a car or temporary shelter program).

[8] Key Questions When Choosing Health Care Quality Measures, by the Agency for Healthcare Research and Quality.

[9] The final ruling on the definition of homelessness for the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, on the HUD Exchange website.

- **Imminent risk of homelessness** (those who will lose their nighttime residence within 14 days).
- **Homeless under other federal statutes or programs (**those who have not had permanent residence in the last 60 days).
- **Fleeing or attempting to flee domestic violence**, dating violence, or other threatening situations.

Additionally, the definition of "chronic homelessness" was clarified in 2015[10]. This definition includes individuals or families who have been homeless for at least 12 months, or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months.

Since these definitions are used by the Department of Housing and Urban Development, they are used for the purposes of the 2024 Data Notebook. However, we understand that many organizations and programs have different working definitions for these terms and are interested to learn how the county behavioral health agency defines homelessness in practice.

Housing and Homelessness Data Presented in the 2019-2023 Data Notebook Overview Reports

Every year, the states, counties, and many cities perform a Point-in-Time (PIT) Count[11] of the individuals experiencing homelessness, usually on a specific date in January. This data is key to state and federal policy and funding decisions. **Table 1** provides data from the 2023 PIT Count. This data is publicly available from the United States Department of Housing and Urban Development (HUD).

[10] Federal definition of chronic homelessness, on the HUD Exchange website.
[11] 2023 Point-in-Time Homeless Populations and Subpopulations Reports are available on the HUD Exchange website.

Table 1. 2023 State of California Estimates of Homeless Individuals Point in Time[12] Count

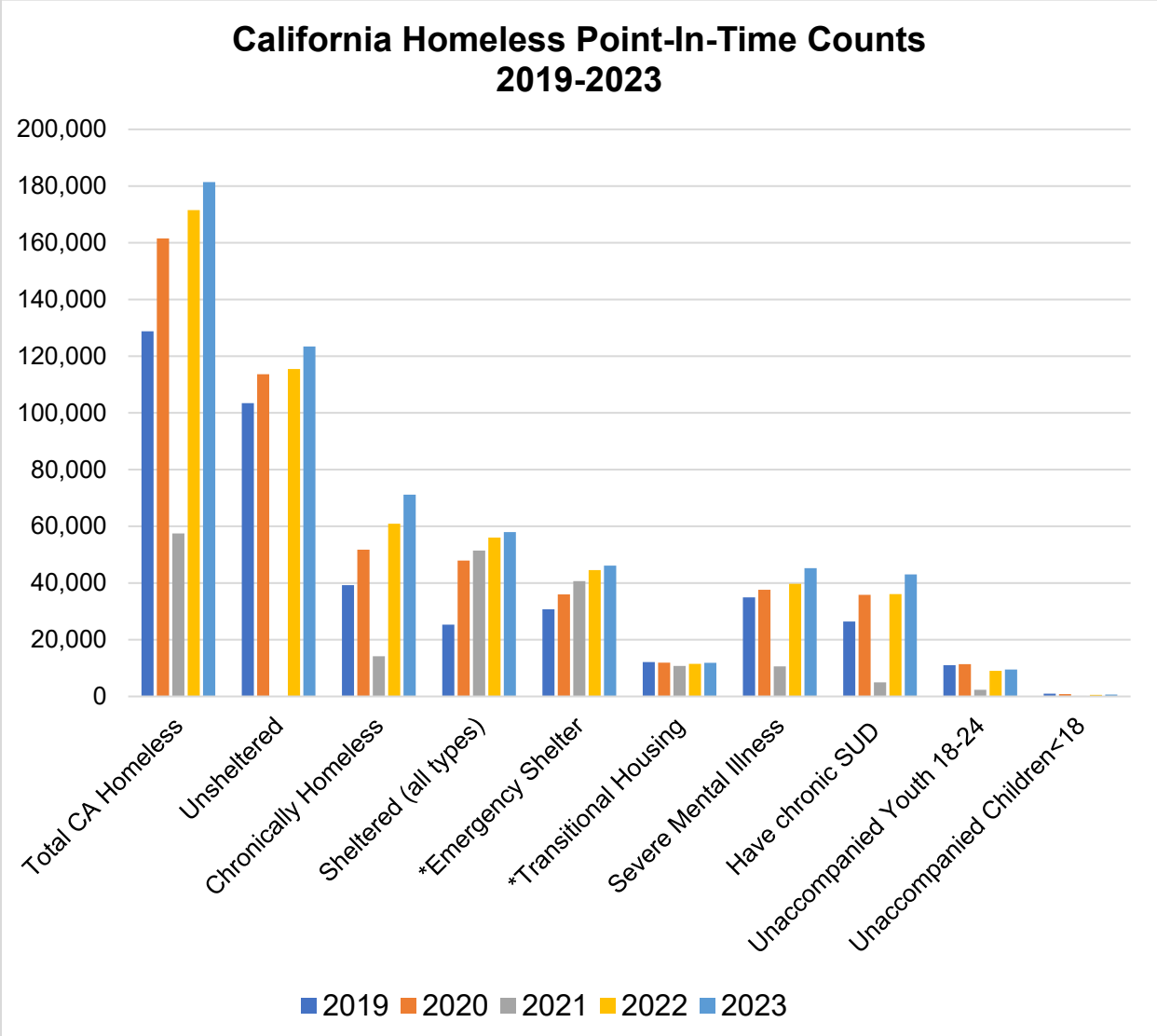
Summary of Homeless Individuals	SHELTERED	UNSHELTERED	2023 TOTAL	Percent Change from 2022
Persons in households without children	38,230	117,020	155,028	+ 6.6%
Persons in households with children	19,484	5,999	25,483	- 0.2%
Unaccompanied homeless youth	3,239	6,934	10,173	+ 6.1%
Veterans	3,153	7,436	10,589	+ 1.9%
Chronically homeless individuals	16,621	54,529	71,150	+ 16.8%
Total (2023) Homeless Persons in CA	57,976	123,423	181,399	+ 5.8%
Total (2023) Homeless Persons, USA	396,494	256,610	653,104	+ 12.1%

We presented California data from the federal Housing and Urban Development (HUD) Point-in-Time (PIT) Count in each data notebook to inform the local behavioral health boards/commissions and to provide a foundation for their discussion and responses.

The data from the past 5 years, displayed below in **Figure 1**, show increasing trends during this time span for nearly all the groups selected, which include total homeless persons, those unsheltered, the chronically homeless, those served by emergency shelters, those persons with severe mental illness, and those who experienced chronic substance abuse. The groups that did not show any major increases during this time include those served in transitional housing, unaccompanied youth aged 18-24, and unaccompanied children under 18. We do not know the reason numbers for those specific groups did not exhibit significant changes over this 5-year time span.

[12] 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 distinct types of transitional or emergency housing.

Figure 1. California Homeless Point-in-Time Counts for Several Vulnerable Populations, 2019-2023.



Note the data gaps for January 2021, when COVID-19 health protocols prohibited counting unsheltered individuals, which impacted any data that normally would have included those numbers in aggregated totals. Table 2 contains the numerical data used to construct Figure 1 and includes an asterisk for the 2021 data for the number of unsheltered homeless persons, indicating that those data were not available due to pandemic protocols. Table 2 provides a clearer depiction of the data for the small numbers of unaccompanied youth aged 18-24 and the even fewer numbers of unaccompanied children under 18 years of age, compared to their negligible representation in Figure 1, due to issues of relative scale for numerically small groups compared to larger groups.

Table 2. CA Homeless Data from Annual Point-in-Time Counts, 2019 – 2023

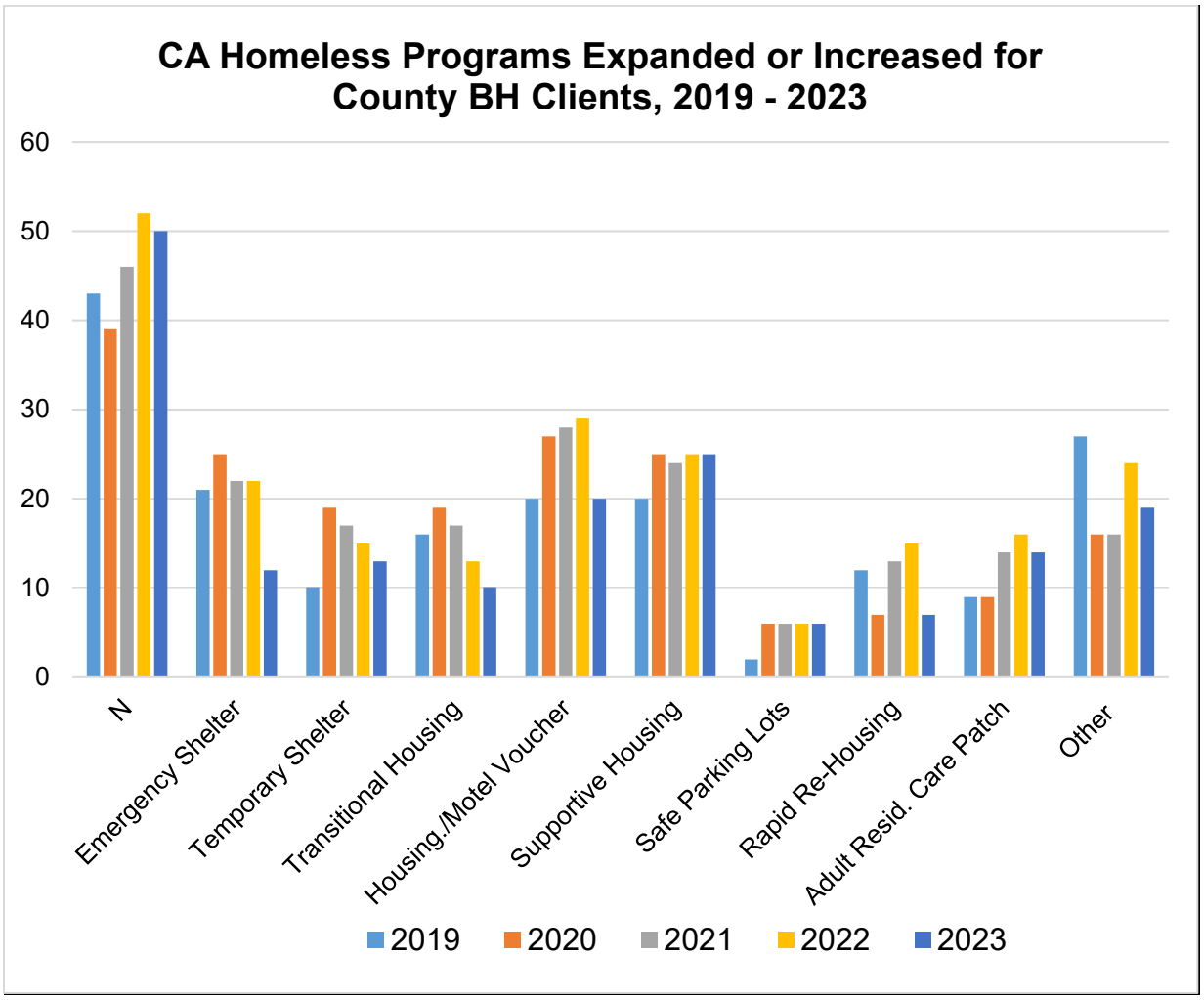
Category	2019	2020	2021	2022	2023
Total CA Homeless	128,777	161,548	57,468	171,521	181,399
Unsheltered	103,454	113,660	*	115,491	123,423
Chronically Homeless	39,275	51,785	14,168	60,905	71,150
Sheltered (all types)	25,323	47,918	51,429	56,030	57,976
***Emergency Shelter**	30,723	35,996	40,662	44,553	46,111
***Transitional Housing**	12,123	11,922	10,767	11,477	11,865
Severe Mental Illness	34,942	37,599	10,607	39,721	45,222
Have chronic SUD	26,410	35,821	4,970	36,096	43,047
Unaccompanied Youth 18-24	11,002	11,370	2,354	9,046	9,519
Unaccompanied Children<18	991	802	172	544	654

In addition to the Housing and Urban Development (HUD) Point-in-Time (PIT) data, previous Data Notebooks included the following survey question:

“During the most recent fiscal year, what new programs were implemented, or what existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?”

Figure 2 shows a summary of the responses to this question from the past five years. The data group labeled ‘N’ shows the number of counties that submitted responses to this question in that year’s Data Notebook. The category of ‘Other’ includes some programs that were developed with special funding (such as Project Home Key, etc.) in response to the COVID-19 pandemic and the economic dislocation experienced by many individuals.

Figure 2. California Homeless Programs Added or Expanded for County Behavioral Health Clients, 2019-2023



Summary of Responses to the 2024 Data Notebook Survey Questions

Methods

The California Behavioral Health Planning Council's (CBHPC) Performance Outcomes Committee and staff, in consultation with members of the public and invited experts on public behavioral health data, developed a series of questions pertinent to the selected topics. There were also ongoing discussions about the issues and questions to prioritize. The 'SurveyMonkey'™ version of the final questions was released to California county behavioral health departments, their designated staff liaisons, and to the behavioral health boards/commissions. We asked the local behavioral health boards/commissions to respond via the SurveyMonkey link provided in the emailed Data Notebook.

We received a total of 52 reports from local behavioral health boards/commissions, and their behavioral health departments. Two reports were submitted by non-county agencies (City of Berkeley in Alameda County and The Tri-Cities in L.A. County). Fifty reports, representing 51 counties) were submitted by behavioral health boards/commissions and their county behavioral health departments. Note that the counties of Sutter and Yuba operate with a single Behavioral Health Department and Mental Health Plan.

To make the response data easier to understand, most answer selections are presented in order of most frequent responses first, rather than in the order in which the answer options were presented in the Data Notebook. For questions with multiple options, we present the percentage of reporting counties/agencies that selected each response, and in parentheses, the number of counties that selected each option.

Section 1: Homelessness in the Public Behavioral Health System

1. **We asked: Please identify your County/ Local Board or Commission.** *(use dropdown menu).*

   We received a total of 52 Data Notebook Reports, comprised of 50 reports representing 51 counties and two reports from non-county agencies. The list of responding county and non-county departments of behavioral health appears at the beginning of this report on page 3.

   Out of 58 total counties in CA, the seven non-reporting counties included Contra Costa, Riverside, Solano, Tehama, Lake, Inyo, and Mono counties.

2. **We asked: Which of the following definitions of homelessness does your county use to identify individuals experiencing homelessness within your behavioral health system?** *(Select all that apply.)*

   We received 52 responses from the reporting counties/agencies. Below are the percentages of responses, and inside parentheses are the number of responses received for that definition of homelessness.

   - 89% (45) The U.S. Housing and Urban Development (HUD) definition of *homelessness*, as used in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.
   - 37% (19) Substance Abuse and Mental Health Services Administration (SAMHSA) definition of those who are *experiencing homelessness*.
   - 27% (14) The U.S. Department of Education definition of *homeless children and youths* as defined in the McKinney-Vento Homeless Assistance Act.
   - 21% (11) Other (written response, see below)
   - 17% (9) The Social Security Administration (SSA) definition of *homelessness*
   - 12% (6) The U.S. Department of Health and Human Services definition of *homeless youth* established by the Runaway and Homeless Youth Act (RHYA).

   Other variations on definitions of homelessness and explanations provided (11 responses):

   - We use whichever definition our funding source requires.
   - While it sometimes depends on the funding stream, Yolo County generally uses HUD's definition of homelessness, as that is what our local Homelessness Continuum of Care (CoC) uses as a standard.
   - Mental Health Services Act (MHSA) definition of homelessness
   - No Place like Home and Mental Health Services Act (MHSA) definitions.
   - If there is more than one funding source, then the most restrictive definition is used.
   - Our Department of Mental Health uses a broader definition than Housing and Urban Development (HUD) for housing resources that we fund. "An individual unaccompanied youth, or family (with or without minor children in their custody) who lacks a fixed, regular, and adequate nighttime residence, which includes those living in a homeless shelter, car or RV, hotel, on the street, or in a street encampment."
   - San Joaquin County Behavioral Health Services Children-Youth Services used the Department of Health Care Services definition.
   - Health Management Information Systems (HMIS).
   - The California Outcomes Measurement System (CalOMS) definition is used in data for substance use disorder services.
   - California Advancing and Innovating Medi-Cal (CalAIM) definition of homelessness.

- Enhanced Care Management through the Department of Health Care Services.
- Behavioral Health Bridge Housing Program uses the Enhanced Care Management definition of homelessness, which is largely the same as the HUD HEARTH Act definition, with some additional flexibilities.

3. **We asked: Does your county enter data on homelessness and housing services into a Homeless (or Health) Management Information System (HMIS)?**
   We received responses from all 52 reporting counties/agencies.
   - 91% (47) Yes.
   - 10% (5) No.

4. **We asked: Concerning individuals currently receiving services in your county behavioral health system, is your county actively collecting data on the housing status of any of the groups listed?** *(Select all that apply).*

   Note: Many individuals fall into more than one category, because these data groups include not only demographics by age, but also categories of eligibility by major services received, and those populations housed under the continuum of care for behavioral health.

   We received responses from all 52 reporting counties/agencies.
   - 92% (48) Consumers receiving mental health services.
   - 83% (43) Consumers receiving substance use treatment.
   - 83% (43) Adults 66 years of age or older.
   - 83% (43) Adults ages 25-65.
   - 81% (42) Youth ages 19-24.
   - 79% (41) Youth 18 years of age or younger.
   - 75% (39) Veterans.
   - 69% (36) Foster youth.
   - 65% (34) Individuals in Institutions of Mental Disease (IMDs).
   - 62% (32) Individuals in psychiatric hospitals.
   - 58% (30) Individuals exiting incarceration from county jail.
   - 40% (21) Individuals exiting incarceration from prison.
   - 19% (10) Other (See below).
   - 2% (1) None/Not Applicable

   <u>'Other' Responses about the data collected:</u>
   - All of the response options listed above.
   - Psychiatric Health Facility/'Our County psychiatric health facility.
   - LGBTQ+.
   - Families, Mental Health Student Services Act (MHSSA) Grant, Day Crisis Program, Mobile Crisis.
   - Department of Mental Health actively collects housing status data on individuals currently receiving services in intensive mental health programs

like Full-Service Partnerships, and for defined categories and age groups that differ slightly from those defined above.
- Full-Service Partnership clients, unhoused school youth (high school up to age 21).
- Housing status data is collected for all populations by our call center. We are working to implement housing status collection at all treatment entry and exit points.
- Housing status is assessed during the initial assessment into behavioral health services for all clients of all ages and special population status (foster youth, veterans, all FSP clients) and for which referral is generated to an MCP[13] for ECM[14] & CS[15] support if housing support is needed.
- The information is noted within the initial paperwork packets that clients complete early upon intake, re-assessment, or yearly paperwork updates.

5. **We asked: What supports are necessary to provide housing to individuals served in your county behavioral health system for more than 6 months?** *(Select all that apply.)*

We received responses from all 52 reporting counties/agencies.
- 90% (47) Case management services.
- 90% (47) Housing vouchers.
- 90% (47) Full-Service Partnerships (FSPs).
- 88% (46) Transitional and temporary housing.
- 88% (46) Intensive case management services.
- 87% (45) Rental subsidies.
- 83% (43) Health or social services access/navigation services.
- 75% (39) Peer support.
- 73% (38) Wellness centers.
- 67% (35) Medication-Assisted Treatment.
- 65% (34) Enhanced Care Management (ECM) and Community Supports.
- 65% (34) Supported employment services.
- 58% (30) Community health worker.
- 31% (16) Other (see written responses below).

<u>"Other"</u>
A substantial number of individual behavioral health departments identified the need for other additional supports to provide successful housing for clients, as follows:
- Employment assistance
- Interim housing and specialty mental health services
- Offered but not required: Health or social services access/navigation services, medication-assisted treatment, enhanced care management

[13] Managed Care Partner
[14] Enhanced Care Management
[15] Community Services

(ECM), Community Supports, Rental subsidies, Housing vouchers, Transitional and temporary housing, Peer Support, Community Health Worker, Supported employment services.
- Community-Based Fair Housing Mediation, Transportation to receive SUD services, Money Management, Financial Wellness, Volunteerism.
- Housing Navigation Services, Medication support services.
- County of Orange also assists clients with benefits acquisition and coordination/advocacy with landlord/property managers.
- Payee services (because many clients do not have access to banking and checking accounts).
- CAD[16], Bridge Housing, housing support (hygiene, bedding, kitchen supplies, landlord relationship building, housing retention and education, conflict management.)
- More affordable housing options, including more Board and Care facilities.
- Connection to Legal Aid.
- Referral to ATCAA[17], a community-based org. that provides community-based housing services.
- Permanent Housing.
- Available low-income housing is needed.
- Affordable housing units. Note that all the items in the 'Options selection list' are necessary, and our community has all of these included in our behavioral health services. However, the items checked are those where we have both the highest need and the largest gap in resources.
- All the services can and often are offered per individual consumer.

6. We asked: Does your county behavioral health system participate in a county-wide interagency continuum of care that meets regularly to address housing for your county residents?

We received answers from all 52 reporting counties/agencies.
- 96% (50) Yes.
- 4% (2) No.

7. We asked: For people currently receiving services from your county behavioral health system, are you actively collecting any data on whether they are homeless/unsheltered at every point of service? For example, do you check for homeless status every time you provide individuals with any service?

We received the following responses from 52 reporting counties/agencies.
- 40% (21) Yes.

[16] CAD = Computer-Aided Dispatch (for services or service providers). (CAD may also refer to Child and Adolescent Department or Development stages).
[17] ATCAA: Amador-Tuolumne Community Action Agency, which also has provided services to Calaveras County. [Note, do not confuse with ATCAA = Air Traffic Controlled Assigned Airspace].

- 60% (31) No.

8. **We asked: Please list the organizations/agencies you work with to provide housing support and services for individuals served by your county behavioral health system.** *(Responses: please use bullet points for this list).*

   All 52 counties/agencies and their boards provided responses to this question in the 2024 Data Notebook.

   Here is a summary of some of the types of responses we received:

   - Local affordable housing developers.
   - City/County jurisdictions that collaborate with each other.
   - Local housing authority in each county or HUD[18]-related CoC's, Continuum of Care.
   - Local non-profit agencies.
   - Faith-based groups; for example, Catholic charities have homelessness-related services in multiple counties.
   - U.S. government HUD-supported services via grants to state and local entities.
   - Some local health plans.
   - Services through county-to-county collaborations, for example, the Kings-Tulare Alliance.
   - Another county collaboration is the ATCAA: Amador-Tuolumne Community Action Agency, which also has provided some services to Calaveras County.
   - Some of the largest population counties each list around 100 or more different specific housing-service related entities with which the county either collaborates, subcontracts, or otherwise interacts with to meet the challenge of having a built structure, whether it is an overnight homeless shelter or a more formalized type of subsidized housing (e.g. "Tiny Houses" or low-income apartment buildings).
   - These designated housing units do not include the numerous vouchers for temporary motel rooms or 'Section 8' vouchers for apartments.
   - All the housing units or "doors" need to have available a wide range of services to support the behavioral health needs and social services needs of the residents eligible to live there. These essential supports and services are part of the reason it is enormously expensive for both state and local departments or agencies tasked with providing services for the homeless population.

   Note: For a detailed listing of the responses, please see Appendix I at the end of this report. This listing may be useful as a community resource to help locate resources for newly homeless as well as those who are chronically homeless.

[18] HUD = U.S. Department of Urban Housing and Development, www.HUD.gov.

9. **We asked: Is your county behavioral health system able to use local data when making program decisions and financial investments in existing or new homelessness/housing programs?**

   We received 52 responses from the reporting counties/agencies**.**
   - 87% (45) Yes.
   - 13 % (7) No.

   These results are significant, as 87% of the reporting counties/agencies can use local data to inform decisions about programming and financial investments.

10. **If you answered "Yes" to the previous question, can you give an example of a program your county initiated based on data you collect or track?** *(Written response)*

    Answers were received from 44 county and non-county departments of behavioral health and their local behavioral health boards and commissions. We received hundreds of examples, some of which overlap or are identical to some of those received for Question 8.

    The major conclusion we draw from the large number of service providers and the very large population of homeless persons in California is that most of these services use data from both the departments of behavioral health and the local housing authority that provides or coordinates services for individuals among all the agencies. There is no way to address the size and complexity of the homeless problem without using a substantial application of data technology and information systems. Without data and information systems, there is no way to provide for the services, keep track of the providers and contractors, track the individuals who are receiving services, and track funds and payments. These issues about data and information handling contribute to the impetus for the ongoing discussions of Performance Outcomes Indicators, and the need for better data, and perhaps some newly defined performance metrics informed by recent changes in policy and law.

    Note: For a detailed listing of the responses, please see Appendix II at the end of this report.

11. **We asked: Does your county behavioral health department have a housing services unit or a housing coordinator?**

    We received responses from all 52 reporting behavioral health counties/agencies.
    - 75% (39) Yes.
    - 25% (13) No.

SECTION 2: Performance Outcomes Data

For a detailed listing of the responses, please see Appendix II at the end of this report.

It presents the responses and discussions for Questions 12-16 that request information from the behavioral health board and commissions regarding a discussion of performance indicators.

Summary and Conclusions

A summary of the reporting from the local behavioral boards/commissions in cooperation with their Behavioral Health Department:

1. Are taking on the important task of providing shelter and supportive services to clients with mental health and/or substance use disorders who are homeless or at risk of homelessness.
2. Are using data and information technology to inform both policy and to manage the implementation of service provision in an organized way to large numbers of vulnerable individuals and families.
3. Are taking note of the importance of identifying performance outcomes and indicators to better understand and manage both behavioral health services and services to homeless individuals, and to serve as a basis for measuring quality improvement efforts.
4. Are recognizing the importance of identifying and using performance indicator data in the broader public health system to monitor the needs and services received by clients (beneficiaries of Medi-Cal funded behavioral health services) and to understand client outcomes, so that we have a better idea of what works well and what likely needs improvement or perhaps a different program or therapeutic strategy.
5. Are committed to the ongoing process of improving the use of data and program evaluation tools on a larger scale, and to improving client assessment tools in hopes of leading to better outcomes and quality of life. Part of this process includes recognizing successful evidence-based and community-based practices.

Recommendations

Part 1 of the Data Notebook has attempted to collect consistent year-over-year data on critical topics in California's behavioral health, to allow the California Behavioral Health Planning Council to understand key trends and craft data-informed policy recommendations. While data quality challenges limited some of the planned analysis, the data submitted via Part 1 of the Data Notebook suggests that California can benefit from the following approaches:

1. **Focus on quantifying and reporting unmet needs:**
   While it is important to know how many people are served and how long they remain in services, initiatives to grow California's behavioral health infrastructure and increase access to care may drive changes in these numbers that are not related to increased need for services. As California works towards "right-sizing" its behavioral health system, data collection efforts should focus on understanding the types of services individuals need and whether those needs are met in a timely, culturally responsive fashion in the most community-based setting possible. Additionally, the state and counties should collaborate on a strategy and a mechanism for reporting data on service needs, which is collected at the county level and shared with the state and the public.

2. **Ensure services are provided at the appropriate level of care:**
   California is facing critical workforce and infrastructure shortages that can result in challenges in providing individuals with the right type of service in a timely manner. When this happens, individuals with acute mental health needs may be served at the wrong level of care to ensure they don't face a gap in care. To understand the extent to which this happens, counties should track assessed service need, service placement, and time to placement in the assessed level of care. Additionally, counties should reassess service needs on a regular basis and adjust service placement as necessary. Both initial and reassessments, as well as the time between assessments and the resulting placements should be tracked systematically, and counties should measure the need for each service type, the waiting time for placement in each service type, and the average time to transition or "step down" between levels of care. When individuals need to be placed in a higher level of care due to a lack of service availability at the appropriate level of care, counties should track the time that elapses until the appropriate placement becomes available.

3. **Expand the availability of Institutes of Mental Disease (IMD) services in all regions, especially rural areas:**
   More than half of California counties do not have an IMD, and individuals in small, rural counties who require intensive services often must travel hundreds of miles to access that care. This separates them from their communities, families, and existing social support. Though it is not realistic for all small counties to have IMDs, California should support rural counties to develop and administer these types of facilities in their region, including through multi-county partnerships. This may require funding for the development of physical facilities, incentives to recruit and train providers, and infrastructure to manage shared-county facilities.

4. **Increase service availability and provider skills for serving children and youth in group care:**
   Like Institutions for Mental Disease (IMDs), there is a significant shortage of Short-Term Residential Therapeutic Programs (STRTPs) in smaller, rural counties in

California. Additionally, counties reported a need for more service availability for children and youth ready to “step down” from STRTP care. This includes expanding the availability of therapeutic foster care and resource family foster homes, as well as increasing the provision of wraparound services and training for providers to serve this population. California is in the process of implementing a new tiered rate structure for these services, which may further affect counties’ ability to effectively serve this population.

5. **Prioritize diversion, shelter, and affordable housing for individuals experiencing both behavioral health challenges and risk of homelessness:** Though the behavioral health system is not, and should not be, primarily responsible for addressing homelessness in California, individuals served by the behavioral health system are often at risk of homelessness. Moreover, recovery is extremely difficult without safe, stable housing. Behavioral health providers should provide diversion and supportive services to help people avoid ever becoming homeless. Additionally, they should collaborate with housing service providers to ensure there is sufficient emergency shelter capacity so no one must sleep outside, and to ensure that housing services are focused on helping individuals obtain permanent, affordable housing in integrated community settings. Behavioral health providers should work closely with housing service providers and proactively talk to the people they serve about their housing needs. Additionally, housing service providers should ensure that people who experience homelessness have access to trauma-informed behavioral health services.

6. **Track performance outcome measures to demonstrate the effectiveness of behavioral health programs, with a focus on recovery-oriented outcomes:** California’s behavioral health system is actively working to improve its data collection strategies, both to minimize data collection burden and to increase its ability to show the importance of the services it provides. In addition to the process-based measures like access to care and quality of care, California should implement recovery-oriented outcome measures that demonstrate improvements in the quality of life of the people being served. This can include tracking settings and achievement of treatment goals, stepping down to lower levels of care, and use of designated assessment tools like the Flourishing Scale and Brief Inventory of Thriving. Behavioral health providers should also track and report social indicators like housing, employment, education, supportive relationships, and community involvement. These measures should be implemented for individuals served through Medi-Cal specialty mental health services, but also for individuals served through non-Medi-Cal services, including those in Adult Residential Facilities (ARF) and Institutions for Mental Disease (IMD) settings.

APPENDICES I, II, III:

Appendix I: Detailed Data for Responses to Question #8.

Alameda

- BOSS – Building Opportunities for Self-Sufficiency
- EOCP – East Oakland Community Project
- St. Mary's
- Abode Services
- BACS – Bay Area Community Services
- SAHA – Satellite Affordable Housing Associates

Alpine

- Social Services

Amador

- ATCAA - Amador Tuolumne Community Action Agency
- Social Services
- Central Sierra Continuum of Care
- St. Vincent DePaul

Berkeley (City of)

- None

Butte

- Northern Valley Catholic Social Services
- True North Housing Alliance
- Jesus Center
- Chico Housing Action Team
- Department of Employment and Social Services
- Housing Authority
- Oroville Rescue Mission

- ‘Caminar’
- John Stewart Company
- Community Housing Improvement Program
- Youth For Change
- Safe Space
- Veteran's Administration
- Department of Rehabilitation
- Catalyst
- Community Action Agency
- ‘Pneumacare’

Calaveras

- Housing Department
- HHSA
- Sierra Hope
- Mother Lode Job Training
- Amador Tuolumne Calaveras Community (ATCAA)

Colusa

- Health and Human Services
- TCCAP (serves Tri-County Community Action Partnership [of] Colusa, Glenn & Trinity)

Del Norte

- Mission Possible
- Veterans Administration
- HUD
- Del Norte Department of Health and Human Services (DHHS)
- Oxford House
- Del Norte County School District
- Tribal Organizations
- City of Crescent City
- Harrington House.

El Dorado

- El Dorado County HHSA Community Services Division
    - Housing and Homelessness Services

Fresno

- ‘Upholdings’
- Fresno Housing Authority
- GSF Properties Inc.
- RH Community Builders
- Community Management Services
- Exodus Recovery Housing Supportive Services

Glenn

- Community Action Department
- Tri-Counties Community Action Partnership (TCCAP)
- Habitat for Humanity
- Westside Domestic Violence Shelter
- Unity and Recovery
- Johnson's House
- Visions of the Cross
- True North Housing Alliance
- Good News Rescue Mission
- Mission in Orville

Humboldt

- HOME
- CoC (Continuum of Care)
- Redwood Community Action Agency
- Arcata House Partnership
- SSB, multiple City provider

Imperial

- Catholic Charities
- Dept. of Social Services,
- ‘Womanhaven’
- Neighborhood House
- Our Lady of Guadalupe Shelter
- Imperial Valley Food Bank
- Casa of Imperial County
- Volunteers of America
- New Creations Men's Home
- Imperial Valley Housing Authority

Kern

- A Friend's House R&B
- Abundant House Room and Board
- Action Family Counseling SLE
- Alma D Best R & B #1
- Alma D Best R & B #2
- Alma D Best R & B #3
- Alma D Best R & B #4
- Alma D Best R & B #5
- Alma The Light House R&B
- ‘Altaville’ ARF
- Bakersfield Links to Change SLE
- Bakersfield Links to Change dba Maggie's Place SLE
- Bakersfield Recovery Services DBA Capistrano Community for Women SLE
- Bakersfield Recovery Services DBA Jason's Retreat SLE
- Benton Park, No Place Like Home Facility
- Brenda Jeans SLE
- Brown Family Home SLE
- Brundage Lane Navigation Center
- Center Street Board and Care
- College Heights, ‘No place like Home’ facility
- Cottages of Hope & Gratitude SLE
- Crossroads Christian Men's Home SLE
- Daily Reprieve, Inc. (Nick's Place SLE)
- Devilla ARF
- Dobbs House Transitional SLE
- FHJ Room and Board
- Flood Ministries
- Freedom House DBA Terra Lynn's House of Hope
- Freedom House SLE
- Freedom House Transitional SLE
- Gifted Heart Residential, LLC
- Glendale Street Apartments, ‘No place like home’ facility
- Green Gardens
- Haven Cottages
- Heritage Living Inc.
- Housing Authority with the County of Kern
- Isaiah's Sober Living Home

- KC's Home, Oliver Wyman Properties, LLC
- Leap of Faith
- M Street Navigation Center Manila Inn R & B
- Minnie Marvels
- New Direction R&B
- New Life Recovery & Training Center
- Open Door Network
- Pioneer Cottages, No Place like Home facility
- Redwood Senior Living
- Ridgecrest Restoration Ministries-Men's
- Ridgecrest Restoration Ministries-Women's Right at Home R&B, Kristen Arterberry
- S.H.A.R.E Recovery SLE
- 'Safe Haven' Recovery SLE
- Serene House "Andrews House" SLE
- Serene House "Women Recover" SLE
- Serene House Room and Board
- Sycamore Board and Care
- The Mission Homeless Shelter
- Third Traditions SLE Union Villa ARF
- Vernon Gardens Adult Residential Care Center
- Way Maker ARF
- 6th Street Apartments
- Good Samaritan Hospital
- Clinical Sierra Vista (Street Medicine)
- The Dream Center Akido Medical
- Managed Care Plans: Kaiser, Anthem and Kern Health Systems
- Department of Human Services
- St. Vincent of D'Paul
- Community Action Partnership of Kern (CAPK)
- M St. Navigation Center, Kern Medical
- Mercy House, Brundage Lane Navigation Center

Kings

- Local Managed Care Plan (Anthem, CalVIVA, Kaiser)
- ECM and CS providers such as Champions and Kings View

- Local Community and faith-based organizations such as Kings United Way which also operates the HMIS and Coordinated Entry System
- Kings Community Action Organization, Self-Help Enterprises, and Kings Gospel Mission
- Local Housing Developers such as 'Upholdings'
- Local and statewide Board & Cares such as 'Plumlees' and 'Psynergy'
- Local Continuum of Care (Kings/Tulare Homeless Alliance)
- Kings County Human Services Agency and Housing Authority

Lassen

- Lassen County Health and Social Services
- Housing and Grants Program

Los Angeles

- All DMH Legal Entity Contractors and directly operated programs that provide services to a client that is unhoused are expected to provide housing support to that client, including helping them to access housing resources and housing retention services.
- DMH has a Housing and Supportive Services Program (HSSP) and the HSSP legal entities provide specialty mental health services to individuals that were homeless and are now living in Permanent Supportive Housing.
- DMH works with other homeless services funders such as Chief Executive Office – Homeless Initiative, Department of Health Services – Housing for Health, Los Angeles Homeless Services Authority, and Department of Public Health Substance Abuse Prevention and Control.
- Intensive Case Management Services providers funded through Department of Health Services-Housing for Health.
- Through a fiscal intermediary, DMH funds Interim Housing, licensed residential care and permanent supportive housing.

Madera

- Community Action partnership of Madera County (CAPMC)
- Madera County Department of Social Services
- Madera Rescue Mission
- Madera County Housing Authority
- Fresno Madera Continuum of Care (FMCOC)
- Madera County Department of Public Health
- Homebase (Technical Assistance for strategic plan)
- RH Community Builders (contracted homeless service provider)

- Camarena Health (Outreach, Engagement Partnership Sub-Committee co-lead)

Marin

- Housing Authority of Marin County
- Homeward Bound
- Episcopal Community Services (ECS)
- Legal Aid of Marin
- Buckelew
- Eden
- Shelter Inc.
- St. Vincent's
- Ritter Center
- SLE providers (Marin Services for Men, Center Point, Cornerstone, Summit, Buckelew)
- Progress Foundation
- Community Action Marin (CAM) CARE Team

Mariposa

- The Alliance of Community Transformations
- Always with integrity
- Self Help Enterprise

Mendocino

- Redwood Community Services
- Mendocino Coast Hospitality House
- Mendocino County Youth Project
- Rural Communities Housing Development Corporation
- Individual motels for voucher based interim housing
- Establishing sober living environment short term housing support relationships.

Merced

- Continuum of Care
- Collaborative Applicant
- New Direction
- Merced County Human Services Agency
- Merced County Community Action Agency

- Mission Merced
- Sierra Saving Grace

Modoc

- Teach (T.E.A.C.H.)
- Apartment management
- Social services
- Probation
- Residential treatment facilities (out of county)

Monterey

- Interim, Inc.
- Sun Street Centers
- Housing Authority

Napa

- Progress Foundation
- Buckelew
- Mentis
- Abode

Nevada

- AMI Housing
- Hospitality House
- Turning Point
- FREED

Orange

- Telecare Home First
- Mercy House
- OASIS
- Life Steps
- Hope Through Housing
- Western Community Housing
- Jamboree
- Friendship Shelter

- A Community of Friends (ACOF)
- EngAge
- The Salvation Army
- American Family Housing
- VA

Placer

- Unity Care
- AMIH
- Whole Person Learning
- TGI
- VOA
- Turning Point
- County Behavioral Health
- Housing Authority
- Community Planning Department
- Facilities services
- Animal Services
- Public Health
- Probation

Plumas

- Plumas Crisis Intervention & Resource Center (PCIRC)
- Plumas-Sierra Continuum of Care
- Environmental Alternatives

Sacramento

- SHRA
- Sacramento Steps Forward
- Every homeless continuum of care provider
- Housing developers
- Residential tenant service providers
- Room and Board/Board and Care operators
- BHS system of care

San Benito

- SBC Health & Human Services Agency (including Community Services & Workforce Development)

- Community Homeless Solutions
- H.O.M.E. Resource Center
- Community Food Bank of San Benito
- Sun Street Centers
- My Father's House
- Emmaus House

San Bernardino

- San Bernardino County Office of Homeless Services
- San Bernardino County Probation Department
- San Bernardino County Sheriff's Department
- U.S. Department of Veterans Affairs
- Local Faith Based Organizations
- Contracted Community Based Organizations
- San Bernardino County Department of Aging and Adult Services
- Interagency Council on Homelessness
- San Bernardino County Public Health
- San Bernardino County Transitional Assistance Department
- San Bernardino County Community Housing and Development
- Housing Authority of the County of San Bernardino
- San Bernardino County Department of Behavioral Health, Substance Use Disorder, and Recovery Services

San Diego

- Regional Task Force on Homelessness
- City jurisdictions
- Housing Authorities
- Full-Service Partnership providers (contractors)
- Treatment providers (contactors)
- Independent living home operators
- Recovery residence operators
- Board and care operators

San Francisco

- We partner with the Homeless Supportive Housing Department to manage and place persons in our permanent supportive housing units.
- They put clients in units based on our Coordinated Entry Systems.

San Joaquin

- Central Valley Low Income Housing Corporation (CVLIHC)
- Housing Authority of San Joaquin
- God's Love Outreach Ministries (G.L.O.M)
- University of the Pacific
- Recovery Residences
- San Joaquin County Human Services Agency
- Veterans Services
- San Joaquin County Public Health and the Board and Care Continuum.

San Luis Obispo

- Transitions Mental Health Association
- People's Self Help Housing Corporation
- Sober Living Environment contracted providers
- Housing Authority
- Community Action Partnership SLO
- Five Cities Homeless Coalition
- ECHO Shelter
- Department of Social Services

San Mateo

- County Department of Housing
- Housing Authority of San Mateo County
- Mental Health Association
- Mid-Pen Housing
- Caminar
- Human Services Agency Center on Homelessness County Coordinated Entry and Assessment Process
- Eden Housing
- Alta Housing
- FSP Housing
- Health Plan of San Mateo.

Santa Barbara

- Santa Barbara County Housing and Community Development (HCD)
- Housing Authority County of Santa Barbara (HASBARCO)
- Housing Authority City of Santa Barbara (HACSB)
- Santa Barbara Community Housing Corporation (CHCSB)

- Sanctuary Centers of Santa Barbara
- Mental Wellness Center
- Good Samaritan
- Telecare Corp.
- Transitions Mental Health Association (T-MHA)17
- PATH
- Santa Barbara Rescue Mission
- Salvation Army
- 'PathPoint'
- 'CityNet'
- New Beginnings
- SB ACT
- City of Santa Barbara
- City of Santa Barbara Police Dept.
- City of Goleta
- Santa Barbara County Sheriff's Office
- Crestwood
- Cottage Hospital
- Legal Aid Foundation
- United Way
- Veterans Administration
- Father Virgil Cordano Center
- CA Dept of Social Services
- CA Dept of Social Services, Community Care Licensing Division.
- 'CenCal'
- Santa Barbara County Public Health Dept.
- Aegis
- 'AmeriCorp'
- Champion Center
- Stalwart Recovery
- Jenny's Board and Care
- Bitfocus/Clarity

Santa Clara

- County of Santa Clara Office of Supportive Housing
- Abode Services
- Community Solutions
- Pathways Society
- CADS
- Solace
- Crossroads

- TURN – BHS
- SCC Homelessness Prevention System

Santa Cruz

- Front Street
- Encompass Community Services
- Community Connection
- Housing Matters
- County Housing for Health Division of the Human Services Department
- HPHP
- Volunteer Center
- Housing for Health

Shasta

- Victor Community Support Services
- Northern Valley Catholic Social Services
- Health Human Services Agency Housing

Sierra

- PCIRC (Plumas Crisis Intervention & Resource Center)

Siskiyou

- NorCal Continuum of Care
- Youth Empowerment Siskiyou
- Northern Valley Catholic Social Services
- Rural Communities Housing Development Corporation
- Family Resource Centers
- County Office of Education
- The unhoused community
- Nation's Finest
- Disability Rights
- Partnership Health Plan, and
- We are a super agency, so we work closely with the Social Services and Public Health Divisions to ensure services are available and accessible.

Sonoma

- Catholic Charities
- COTS
- Buckelew
- Burbank Housing
- Felton Institute
- TLC
- AFS
- Victor
- WPC ECM
- WPC Community Supports
- Interfaith Shelter Network
- Telecare
- Progress Foundation
- Psynergy
- Greenacre
- County of Sonoma HSD STRTP
- Valley of the Moon Children's Center
- St. Vincent De Paul
- Lifeworks
- Seneca
- Board and Care Facilities: CSN A&A HealthCare
- Davis Guest Homes
- Hope House
- Le Ellen
- McHugh
- Palm View Retreat
- Parker Hill Place
- Place of Grace
- 'Psynergy' Programs
- St Michael's

Stanislaus

- Local affordable housing developers
- City/County jurisdictions
- Local Housing Authority
- Local non-profit agencies
- Local Health Plans

Sutter-Yuba

- Regional Housing Authority
- Homeless Consortium

- Sutter County Public Health
- FREED
- Telecare
- Salvation Army
- Habitat for Humanity
- Adventist Health
- Ampla Health

Tri-City

- Tri-City housing collaborations to include but not limited to Homeless & Housing Resource Network
- Jamboree Housing Corp.
- LA County Department of Public Social Services, et. al per attached.

Trinity

- Health and Human Services Housing Division
- Human Response Network
- Sheriff's Office
- Board of Supervisors
- Community Stakeholders
- County CAO, Planning and Economic Development.

Tulare

- Kings Tulare Homeless Alliance
- KingsView
- Salt+Light
- Self Help Enterprises
- CSET
- Turning Point
- Tulare County Housing Authority
- Local Navigation Center
- RH Community Builders
- 'UpHoldings'

Tuolumne

- Tuolumne County Health & Human Services Agency
- Stanislaus Housing Authority
- City of Sonora
- Anthem Blue Cross
- HealthNet

- Center for Non-Violent Communities
- ATCAA
- Second Chance
- Resiliency Village

Ventura

- Spirit of Santa Paula – shelter
- Turning Point Foundation – shelter
- Khepera House - recovery residence
- Housing Authority of San Buenaventura/Valentine Road - Rental assistance
- Casa Pacifica - under age 23
- HHAP - TAY Grant
- HUD - CoC Grant
- BHBH - Behavioral Health Bridge Housing Grant
- Seneca - under 21
- Mesa - TAY - Tiny House facilities

Yolo

- Hope Cooperative
- Shores of Hope
- Fourth and Hope
- City of W. Sacramento
- North Valley Behavioral Health
- Canyon Manor
- Psynergy
- Vista Pacific
- Sierra Vista
- Heritage Oaks
- Granite Wellness
- Generations Health Care
- Dignity Health
- Davis Community Meals
- Crestwood
- Willow Glenn
- Ridgeview (Cascade Management)
- The Grove
- Individual room and board providers
- Pine Tree Gardens ARF /North Valley BH

- Individual board and care providers
- Friends of the Mission
- Mercy Housing Coalition
- Yolo County Housing
- New Hope

Appendix II: Detailed Data for Responses to Question #10

Alameda

- Medical respite
- Fairmont Housing Nav
- Casa Maria

Butte

- Resiliency Empowerment Support Team
- Community Outreach and Peer Engagement Team
- Target Team Liaison in Partnership with Chico Police Department Completed

Del Norte

- Behavioral Health Bridge Housing (BHBH) grant and
- Encampment Resolution Funds.

El Dorado

- El Dorado County BH division implemented the Behavioral Health Bridge Housing project in 2024.
- During the development of this project, the Point in Time count (PIT) from the El Dorado Continuum of Care was utilized to inform decisions about the utilization of the BHBH funding.

Fresno

- The INN Plan project Handle with Care Plus was driven based on data demonstrating the need for prompt response to life-changing events which may include trauma often resulting from emergencies, crisis, etc.

- This program was developed based on data for INN-funded pilot program and subsequently sunset by our Department of Behavioral Health largely due to lack of data to demonstrate the effectiveness of the model.
- While INN funding is intended to test new ideas and models, this program did not demonstrate effectiveness.

Glenn

- Bridge Housing grant to develop a residential facility
- MHSA data for parenting program- Triple P Program; Suicide Prevention; SMART Team

Humboldt

- Arcata House Partnerships "The Grove" project

Imperial

- Behavioral Health Bridge Housing and Point-In-Time Count

Kern

- Relational outreach Engagement Model

Kings

- The Kings County Homelessness Collaborative conducted a needs assessment in 2019 wherein it was identified as a priority need to develop the county's first low barrier shelter.
- This needs assessment and subsequent recommendation led to the action by the Collaborative and the Kings Community Action Organization to develop a 150-200 bed low barrier shelter which is slated to begin construction in FY 24/25 and is close to full funding through a blending of multiple funding streams.

Lassen

- Judy House - Peer Run Drop-in Center

Los Angeles

- TBD

Madera

- On August 6, 2024, the County's Board of Supervisors approved a contract with RH Community Builders LP to provide supportive services at Madera County's first Behavioral Health Bridge Housing (BHBH) program.
- BHBH, administered by the Madera County Department of Behavioral Health Services (MCDBHS), will provide temporary, safe housing and comprehensive support services for individuals and families experiencing homelessness.
- This effort came after monitoring and gathering housing specific data from those served by MCDBHS.
- These data were also presented during MCDBHS' collaborative housing meetings with community partners to better understand additional needs for which MCDBHS and/or partners could provide support to the community we serve.

Marin

- Carmelita House,
- Progress Foundation,
- SLE houses

Mariposa

- No Place like Home (11 units at the new Creekside Apartments),
- Behavioral Health Bridge Housing ($1.4 million),
- PATH 3 ($38.0),
- Central California Alliance for Health ($164.0).

Mendocino

- In developing our Mental Health Services Act Housing Program, we used local data on vacancy rates and application data for other behavioral health housing units to determine need.
- We also used consumer feedback data to determine type of housing unit and location to prioritize.

Merced

- Bridge to home' program through Behavioral Health Bridge Housing Funds.

Modoc

- Bridge housing

Monterey

- US Census
- Homeless Count
- HMIS

Napa

- An example would be Fresh Start, which is a program within the Adult Full-Service Partnership Program that was developed ten years ago which offers transitional supportive housing for up to 13 individuals with a serious mental illness who are unhoused or at risk of being unhoused.
- The premise for the development of the program was a result of meetings that were held with multiple community- based organizations within Napa to determine unmet housing needs.
- All the participants are tracked and monitored through HMIS and entered DCR regularly.

Nevada

- The County recently initiated and expanded an interim housing program using data we had collected on people experiencing homelessness in a specific geographic area.

Orange

- OC BHS housing and outreach and engagement efforts use local data to make programmatic and service delivery decisions about housing needs, outreach locations (hot spots), trends in the population accessing services, identifying needs such as potential partners needed to bring in to collaborate (to fill service gaps), and consulting cases within a care team.

- Data are used from HMIS, advisory committees (including individuals with lived experience), community input, Geo pin drops, Point in Time and other homeless and housing surveys, Coordinated Entry, and the county's integrated data platform, SOCDIS.
- For example, BHS Housing and Supportive Services has developed a Housing FSP program in response to community discussions and re-evaluation of services needed to support previously homeless individuals with a serious mental illness living in permanent housing who are at risk of losing their housing.
- Two community engagement meetings were conducted, extensive research was gathered, needs assessments were conducted, and data and outcomes of individuals living in permanent housing were gathered and evaluated for the creation of this program.
- Another example is OC O&E has created specific encampment data in HMIS and referral linkage logs to track the needs, progress, and outcomes of individuals such as frequency of contacts, needs, referrals/linkages, interest in housing/shelter, linkage to housing and shelter, access/use of entitlements including Medi-Cal, and documents needed for CES prioritization and match.
- These data were monitored and tracked as a case management tool for BHS outreach teams until the encampments no longer had any individuals because they had been linked to shelter, housing, full-service partnership provider, behavioral health bridge program, or transitioned to another option.

Placer

- We used Data to pursue 'Homekey' grant funding, and
- To ask for Grants/ subsidies, and
- To design bridge housing, and
- To add shelter beds.

Sacramento

- HEART (Homeless Engagement and Response Team)
- Infused/embedded MHSA housing funds throughout the outpatient system based on data that showed the % of unhoused individuals being served.
- Youth Help Network
- CORE (Community Outreach Teams) - Outreach workers were included in the program design of our Adult MH Outpatient CORE program based off the % of unhoused individuals being served.

San Benito

- Behavioral Health Bridge Housing,
- CHISPA Project at Buena Vista Apartments

San Bernardino

- Programs that the San Bernardino County Department of Behavioral Health has initiated and implemented include the following:
  - Innovative Remote Onsite Assistance Delivery (InnROADs) is a program that works with community and county agencies to provide services to people who are experiencing homelessness and living in rural and isolated areas. Pacific Village provides housing, specifically with single-family residence, duplexes, and trailers to more than 40 people who experienced homelessness. Pacific Village is made possible through a collaboration with San Bernardino County departments including the Department of Behavioral Health and external partners that work closely to provide support to residents.
  - Adult Residential Facilities

San Diego

- The epidemiology team analyzes emergency department (ED), hospitalization, mortality, and sociodemographic data to inform service planning for behavioral health services.
- For example, through analysis of overdose related data, we were able to identify populations and areas of greatest need for our harm reduction services, including among individuals experiencing homelessness.
- This data-driven approach informed the strategic planning and placement of naloxone vending machines, with Father Joe's Villages, an organization dedicated to preventing and ending homelessness, implementing the first naloxone vending machine in the County.
- By leveraging data and identifying those most impacted by overdose, including within the unhoused population, this ensures life-saving interventions are accessible to those in greatest need.

San Francisco

- We developed culturally congruent services for Black/African American Transitional Age Youth and

- Adult/Older Adults within our civil service clinics.
- We implemented initiatives for pre and postpartum mental health services.

San Joaquin

- BHBH (Behavioral Health Bridge Housing) Round 1 Grant Program, and
- The SJ Cares Program

San Luis Obispo

- Homelessness point-in-time count and housing inventory
- Our county is a local data source used when developing the application for the Behavioral Health Bridge Housing program

San Mateo

- We used county homeless data obtained from the one-day homeless count for the joint application with Eden Housing for No Place Like Home Funding.
- This application was worth $1.74 million.

Santa Barbara

- Behavioral wellness initiated the housing assistance and retention team (HART) based on data collected through the Homeless Information Management System (HMIS) and point in time count information.
- The HART program is a three-prong approach to increase retention within our permanent supportive housing program by assisting clients as they transition into independent living, educating and training Housing Authority and other property management staff on how best to serve this vulnerable population, and creating data collection methods to drive decision making and identify emerging trends.
- The project is designed to assist clients as they transition into housing to ensure a smooth adjustment to their new community, while also gaining independent living skills through a series of classes and onsite supportive services.
- HART will also provide extra support to tenants who are struggling to maintain housing, including a 24-hour “warm line” manned by Peer Recovery Specialists available to support new tenants.
- The Department of Behavioral Wellness (BWell) uses and collects housing and demographic data via the Housing Management Information System (HMIS), SmartSheet’, and ‘Smart Care.’

Santa Clara

- One program we established was a homelessness prevention program using MHSA funds.
- We were able to use homelessness prevention system data.

Santa Cruz

- County Behavioral Health used local data to develop a new FSP team with a population of focus on individuals with SMI who are experiencing homelessness-IHART (Integrated Housing and Recovery Team).
- This FSP works closely with mental health connectors supported by Front Street to provide connection to the Housing CoC and Coordinated Entry system and provide housing navigation services.

Shasta

- Shasta County is part of a 7 county Continuum of Care that uses Homeless Management Information System (HMIS) software.
- The HMIS system is used for coordinated entry into homeless programs for housing. Entities around the community participate in HMIS and the placement of individuals into available housing.

Siskiyou

- HMIS data suggests that Native Americans are over-represented in the local homeless population.
- In response to this, the CoC Advisory Board created a position for a tribal member so that this population is represented and considered when funding decisions are made.

Sonoma

- Community Data was used to identify providers and locations for the ‘No Place Like Home’ Project.

Stanislaus: Behavioral Health and Recovery Services added multiple housing projects utilizing homeless data information, as follows:

- Kestrel Ridge - 8 units: 416 Coolidge Ave., Modesto
- Walker Pointe - 19 units: 6764-6788 Walker Lane, Hughson

- Central Valley Homes - 18 units: 412 Vine St., Modesto and 1143 Park St., Turlock
- 835 California Project - 7 units: 835 California Ave., Modesto

Sutter-Yuba

- Our county uses our point-in-time surveys to help make decisions regarding the needs for homelessness/housing programs.
- The Homeless Consortium provides input and data from a host of agencies and services that work with homeless. Additionally, we collaborate with the Regional Housing Authority to get their input and data on housing needs.
- Our Start to Finish program was initiated when data from our HEART surveys through HMIS showed us that a large percentage of folks who were unhoused were struggling with substance use disorders and were unable to receive treatment as they did not have some type of short-term housing that they could stay in before their admit date to residential treatment. This program allows us to house individuals in our short-term housing program until their admit date.
- Our Health and Human Services Department has a collaborative program between Behavioral Health and Public Health which provides services to the Homeless. The manager of this program is jointly funded by BH and PH.

Tri-City

- Tri-City Apartments
- David & Margaret Permanent Supportive Housing, and
- City of Pomona Hope for Homeless Services Center

Tulare

- Point-In-Time Count

Tuolumne

- Behavioral Health Bridge Housing

Ventura

- Simi Valley Crisis Center

Yolo

- Behavioral Health Bridging Housing.

Appendix III: Responses to Questions 12 – 17 (Section 2) of 2024 DN

Appendix III contains the responses to questions 12 –17, and some related discussion material. This examination of performance outcomes data that are used by county departments of behavioral health is part of a process of ongoing discussion among various stakeholders in the state of California, partly in response to recent major changes in legislation and policy affecting behavioral health in the public mental health system in California. The CBPHC and other agencies are part of this ongoing statewide discussion.

Section 2: Performance Outcomes Data

12. We asked: Does your behavioral health agency currently collect data for the performance indicators listed below for all adult[19] beneficiaries? *(Select all that apply)*

We received responses from 50 of the 52 reporting counties/agencies, below:

- 88% (44) Psychiatric Hospitalizations.
- 86% (43) Housing status.
- 82% (41) Lanterman-Petris-Short (LPS) Conservatorship.
- 76% (38) Overall patient satisfaction.
- 72% (36) Employment status.
- 68% (34) Criminal justice involvement.
- 52% (26) Visits to the emergency room (ER).
- 50% (25) Rates of suicide.
- 42% (21) Self-reported wellness.
- 36% (18) Rates of self-harm.
- 34% (17) Social functioning and community connectedness.
- 22% (11) Other (See below).

Other examples of data or performance indicators:

- Full-Service Partnership (FSP) data.
- Natural support (families) and 'Dimensions of Wellness.'

[19] 'All adults' is taken to include older adults as well, for the purposes of this report.

- Treatment courts participation.
- Imperial County Jail Re-entry program.
- Number and type of 'Crisis Contacts', including mobile crisis, 5150 evaluations, safety plans and visits to emergency room.
- Discharge outcomes (evaluation at completion of treatment).
- The Consumer Perception Survey and Treatment Perception Survey.

In summary, half or fewer than half of the responding counties/agencies collect adult data for rates of suicide, self-reported wellness, rates of self-harm, social functioning, and community connectedness. Adult suicide data and self-harm data, as well as visits to the emergency room, are reported by departments of public health and those agencies that monitor data for hospital utilization (including diagnosis), but these data are collected over a long term, and reporting is not timely for shaping policy, community programming, or interventions. Similarly, we found that 66-88% of reporting county or local behavioral health departments monitor adult data for psychiatric hospitalization, LPS conservatorship, housing status, employment status, and criminal justice involvement. In the category of 'other' adult data that at least some counties collect includes Full-Service Partnership, treatment courts participation, and the number and types of 'Crisis Contacts, including mobile crisis units, 5150 evaluations, safety plans, visits to emergency rooms or psychiatric emergency rooms (or equivalent).

It is important to note that our current report counts the number of responding county or local behavioral health departments and their boards as a percentage of the total entities that submitted a report. Thus, the small-rural and small-population counties have the same 'weight' (or vote) as do the counties with medium-sized or large population. A quite different picture would emerge if that spreadsheet data added a column for population linked to each county, or just the Medi-Cal population in that county. Then, statistically "weight" the end results using this alternative strategy. Plus, we are missing data from at least three large population counties.

13. We asked: Does your behavioral health agency currently collect data for the performance indicators listed below for all child and youth beneficiaries? *(Please select all that apply).*

We received responses from 50 of the 52 reporting counties/agencies.

- 88% (44) Psychiatric Hospitalizations.

- 76% (38) Housing status.
- 70% (35) Overall patient satisfaction.
- 62% (31) Criminal justice involvement.
- 56% (28) Visits to the emergency room (ER).
- 54% (27) Rates of suicide.
- 52% (26) Self-reported wellness.
- 48% (24) Social functioning and community connectedness.
- 46% (23) School attendance/absenteeism.
- 40% (20) Academic engagement.
- 40% (20) Rates of self-harm.
- 34% (17) Classroom behavior.
- 20% (10) Other (See below).

Other data or performance indicators that counties are collecting:

- Child and Adolescent Needs and Strengths (CANS) assessment tool (cited by a total of 4 counties/agencies).
- In addition, identification of 'Natural Supports' (families, friends).
- Student Emotional Learning (SEL).
- California Healthy Kids Survey (CHKS).
- Risky Behaviors Survey.
- Caregiver Strengths (PSC-35, cited by 2 counties), which measures attention behaviors, internalizing behaviors, and externalizing behaviors.
- Full-Service Partnership data for children and youth involved in that model of wrap-around services (cited by 2 counties).
- Discharge outcomes (at the completion of services).
- Criminal justice involvement data (cited by 2 counties).
- Crisis contacts, including mobile crisis contacts, emergency room contacts, 5150 evaluations, and safety plans.
- Consumer Perception Survey and Treatment Perception Survey.

In summary, almost three-fifths or more of the counties responded that they collect data on items that have a significant impact on both the individual child/youth, including potentially expensive costs to the public system for visits to the emergency room, criminal justice involvement, psychiatric hospitalizations, and housing status. The housing status of unhoused or unsheltered youth sets the stage for other costly and negative outcomes, such as becoming victims of crime, violence, sexual trafficking, and having increased proximity to users of illicit drugs, which can make the drugs potentially

easier to acquire and use. Being unsheltered or unstably housed often comes with the opportunity costs of poor school attendance and reduced community connectedness.

Only 40% of county respondents said they track rates of self-harm, and only 54% say they track rates of child/youth suicide, but both events are tracked in other public health department data or hospital utilization data. The issue is that these data, while collected, are not reported in a time frame that is useful to county behavioral health, or to local school districts, or to parents of youth. County departments and individual behavioral health service providers are more likely to use diagnostic survey tools (some of which are listed below) to help individuals get the right type of help and treatment, but some of the survey tools have a public health function in terms of helping determine what are the major problems in a community and what type of mental health or substance use treatment services might be needed. None of the county respondents listed anything to do with foster youth behavioral health needs for assessments and/or services, trauma, adverse childhood experiences, or rates of substantiated child abuse or severe neglect, but these have major downstream effects on behavioral health or wellness, needs for behavioral health services or justice system involvement.

County Departments of behavioral health have identified these data listed under 'Other' as useful for initial and ongoing client assessments, notation of significant clinical events, and of client outcomes. Note that all the individual outcomes/events in the community contribute to the aggregate data about the system performance, at least in part, if not the entirety of the public behavioral health system.

14. **We asked: Do you utilize the performance indicators previously identified in any of the following ways?** *(Please select all that apply).*

    We received 51 responses from the 52 reporting counties/agencies.

    - 90% (46) Make changes in program planning.
    - 86% (44) Inform partners and stakeholders.
    - 84% (43) Evaluate the effectiveness of programs.
    - 78% (40) Engage in community outreach.
    - 67% (34) Make changes in spending.
    - 67% (34) Advocate for policy changes.
    - 16 % (8) Other (written response, please specify). See below.

    Other:

    - 'We use other data for decisions on spending, but they are not the performance indicators listed in this Data Notebook."

- When requested, data are used for various program planning and evaluation activities.
- Used to inform treatment. Not yet used to inform policies, stakeholders, or to measure performance due to conversion to a new 'E.H.R.' system[20] for which reports and dashboards are being developed.
- Milestones of Recovery Scale (MORS).
- Expanding culturally diverse workforce and services.
- BHSD[21] consistently strives to evaluate program effectiveness and evolve program design through the continuous improvement and review of performance metrics from the programs through the system. Available data are used to meet state reporting requirements as well as report to partners and stakeholders. In some instances, data and performance metrics can be used to demonstrate a need for changes in policy.

In summary, utilization of data and/or performance indicators appears to vary by county and by the nature of the data and the data tools available in each county. Counties reported that they ***can*** use their performance indicator data to make changes in program planning, inform partners and stakeholders, evaluate the effectiveness of programs, and engage in community outreach for 78 to 90% of the responding counties.

In addition, two-thirds (67%) of the respondents stated that they could utilize their performance indicator data to make adjustments in spending and advocate for policy changes. One large population county noted that their available data are used to meet state reporting requirements as well as report to partners and stakeholders. Another county indicated that data are used to inform treatment, but "due to a recent conversion to a new Electronic Health Records system" their county data systems are not yet able to collect and aggregate data for reports and dashboards but were currently in the process of developing that ability. Yet another county stated that "when requested, data are used for various program planning and evaluation activities." Another response indicated that they use the Milestones of Recovery Scale (MORS), which is a client assessment tool, but the statement did not specify how, or whether, that information is aggregated for use in county data reporting.

[20] "E. H. R." = Electronic Health Records. (Note to editor/reviewer on autocorrect problem: this acronym gets converted to the feminine possessive pronoun, regardless of how I try to format this and especially if I remove the periods and the spaces. Is there an easy fix?
[21] BHSD = Behavioral Health San Diego.

15. We asked: Overall, do you have adequate data to evaluate and comment on performance outcomes in your county behavioral health system?

We received 51 responses from the 52 reporting counties/agencies.

- 55% (28) Yes.
- 45% (23) No.

Note that these responses seem to contradict the overall picture presented by the responses to Question 14, for which 78 to 90% of the responding counties indicated that they *can* use their performance indicator data to make changes in program planning, inform partners and stakeholders, evaluate the effectiveness of programs, and engage in community outreach. In addition, two-thirds (67%) of the respondents stated that they could utilize their performance indicator data to make adjustments in spending and advocate for policy changes. There is some nuance or context that needs further examination to understand this apparent conflict. The nuance lies in the difference between performance indicators and performance outcomes. Further consideration based on various committee and stakeholder discussions suggests the answer may be as simple as "we do the best we can, with whatever data we have, however imperfect or incomplete it may be."

16. We asked: Which of the following topics or areas of interest would your county like to see future Data Notebooks focus on? *(Please select up to 5).*

We received responses from 51 of the 52 reporting counties/agencies.

- 57% (29) School-Based Wellness for Children/Youth.
- 55% (28) Criminal Justice Involvement.
- 53% (27) Psychiatric Hospitalizations.
- 45% (23) Social Functioning and Community Connectedness.
- 43% (22) Visits to the emergency room (ER).
- 41% (21) Rates of Self-Harm and Suicide.
- 39% (20) Housing Status.
- 31% (16) Lanterman-Petris-Short (LPS) Conservatorship.
- 20% (10) Overall Patient Satisfaction.
- 16% (8) Employment Status.
- 12% (6) Self-reported wellness.
- 14% (7) Other (See below).

Other topics suggested in the 2024 Data Notebook responses included the following:

- Parity for mental health and substance use services that are covered by commercial services, private insurances, and Medi-Cal beneficiaries.
- Substance use.
- Substance use as it relates to behavioral health and homelessness.
- Dual diagnoses and age-specific utilization of behavioral health services.
- LGBTQ/Trans housing focus. mobile crisis and emergency department visits.
- While those topics listed in the question (#16) are all relevant and important topics that BHSD will continue to evolve in terms of data collection, review and use, the overlap between BHSD and other systems (Housing and Criminal Justice in particular have been an important focus recently. Ongoing efforts to increase collaboration and improve data collection in these areas exist and could be explored further in future iterations of the Data Notebook. BHB members expressed interest in cultural competency as a future focus and added that stable housing is foundational to mental health.

In summary, the goal of this question for the Performance Outcomes Committee was to seek information that would help select a topic for the 2025 Data Notebook. The top selection was School-Based Wellness for Children/Youth, and a close second was Criminal Justice Involvement.

The Council seeks to select topics relevant to stakeholders and members of BHBs, many of whom are volunteers comprised of clients/consumers, and/or the family members of these beneficiaries. Another goal is to make the project manageable for the board members and those county staff who would assist them in developing the responses needed to complete the next Data Notebook (2025).

For Question 17, we received comments from participants in the Post-Data Notebook Questionnaire. Feedback from the local behavioral health boards and commissions is uniformly positive. There were several comments expressing appreciation for the relative ease of completing the shorter, more focused, and simplified approach of the 2024 Data Notebook.

There were a couple of comments from larger counties indicating that they preferred to see both more data in total and more detailed data. They recognized the importance of the focus on services for homeless individuals (and those at imminent risk of becoming

homeless) and identifying sources and types of data that the counties already collect. They also appreciated the identification of where they are trying to improve the adequacy of data collection to help drive policy and the ability to address quality improvement in the services provided in client outcomes.