California Behavioral Health Planning Council

2022-2023 Mental Health Block Grant Plan Review

Wednesday, October 13, 2021
9:00 am to 10:00 am

Zoom Meeting Link:

https://us02web.zoom.us/j/86111996285?pwd=VURvN3ZHWEMxRC9kdXoyNDJpWkRrQT09

Join by Phone:
(669) 900-6833

Meeting ID: 861 1199 6285 **Password:** 386246

9:00 am	**Welcome and Introductions** *Naomi Ramirez, CBHPC Staff*	
9:05 am	**Council Member Input on MHBG Plan** *Naomi Ramirez, CBHPC Staff and All Council Members*	**Tab 1**
9:55 am	**Public Comment**	
10:00 am	**Adjourn**	

The scheduled times on the agenda are estimates and subject to change.

Officers: Noel O'Neill, Chairperson Deborah Starkey, Chair-Elect
Committee Members: Arden Tucker, Angelina Woodberry, Barbara Mitchell, Brendan McCarthy, Catherine Moore, Celeste Hunter, Cheryl Treadwell, Christine Costa, Christine Frey, Dale Mueller, Daniel Lee, Daphne Shaw, Darlene Prettyman, Deborah Pitts, Elena Gomez, Elizabeth Oseguera, Gerald White, Hector Ramirez, Iris Mojica de Tatum, Jim Kooler, Joanna Rodriguez, John Black, Karen Baylor, Karen Hart, Kim McCoy Wade, Lorraine Flores, Marina Rangel, Mike Phillips, Monica Caffey, Sokhear Sous, Steve Leoni, Susan Wilson, Tim Lawless, Tony Vartan, Uma Zykofsky, Vera Calloway, Veronica Kelley, Walter Shwe

If reasonable accommodations are needed, please contact the CBHPC at (916) 701-8211 no less than 5 working days prior to the meeting date.

TAB 1

California Behavioral Health Planning Council
2022-2023 Mental Health Block Grant Plan Review
Wednesday, October 13, 2021

Agenda Item: Council Member Input on MHBG Plan

Enclosures: Criterion 1: Comprehensive Community-Based MH Service Systems

Criterion 2: Mental Health System Data Epidemiology

Criterion 3: Children's Services

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Criterion 5: Management Systems

C1. The Health Care System, Parity and Integration

C4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)-10 percent set aside

C5. Person Centered Planning (PCP)

C6. Program Integrity

C13. – Criminal and Juvenile Justice

C15 – Crisis Services

C16. Recovery

C18. Children and Adolescents Behavioral Health Services

C19. Suicide Prevention

Background/Description:

A key role of the Council is to review and comment on the Department of Health Care Services' (DHCS) bi-annual MHBG Plan. The MHBG Plan contains specific questions to which there is a narrative response. We have attached each of the sections that DHCS has prepared a response. Members should review the enclosed 2022-2023 MHBG Plan sections prior to the meeting and be prepared to provide any comment, input, suggestions, etc., during this agenda item. All input will be compiled and submitted to the DHCS by October 21, 2021.

C9. Statutory Criterion for MHBG (Required MHBG) - Criterion 1: Comprehensive Community-Based Mental Health Service Systems

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Department of Health Care Services (DHCS) is responsible for the administration and oversight of a variety of public mental health programs and services provided at the local level by county Mental Health Plans (MHP), Medi-Cal managed care plans (MCP), individual or group Medi-Cal fee-for-service providers, the Mental Health Services Act (MHSA) and Medi-Cal Specialty Mental Health Services (SMHS). These responsibilities include but are not limited to: policy development, guidance, and implementation, program monitoring, technical assistance, compliance oversight, and auditing. DHCS does not provide direct services. California's public mental health system is primarily provided through the following three delivery systems.

Medi-Cal Managed Care Plan and Medi-Cal Fee-for-Service Mental Health Services

- Effective January 1, 2014, mental health services included in the essential health benefits package per the Affordable Care Act became covered Medi-Cal benefits.
- As a result, the following mental health services are covered by Medi-Cal MCP and in the fee-for-service Medi-Cal program for beneficiaries with a mental health disorder as defined by the current Diagnostic and Statistical Manual (DSM) that do not meet SMHS medical necessity criteria:
    - Individual and group mental health evaluation and treatment (psychotherapy);
    - Psychological testing, when clinically indicated, to evaluate a mental health condition;
    - Outpatient services for the purposes of monitoring drug therapy;
    - Psychiatric consultation; and
    - Outpatient laboratory, drugs, supplies and supplements (excluding certain medications.
- MCP primary care providers also continue to provide mental health services within their scopes of practice.

Mental Health Services Act (MHSA)

- MHSA was passed by California voters in 2004.
- MHSA is funded by a one percent income tax on personal income in excess of $1 million per year.
- MHSA is designed to expand and transform California's mental health systems and better serve individuals with and at risk of serious mental health issues, and their families.
- MHSA addresses a broad continuum of prevention, early intervention, and service needs, and the necessary infrastructure, technology and training elements that effectively support the system.
- MHSA funds are distributed to counties on a monthly basis. Counties expend the funds for these components consistent with a local plan, which is subject to a community planning process that includes stakeholders and is approved by the County Board of Supervisors.
- In addition to local programs, the MHSA includes up to 5 percent of revenues for state administration.
- It also funds evaluation of the MHSA by the MHSOAC, which was established by the MHSA.

Medi-Cal SMHS

- DHCS administers California's Medicaid (Medi-Cal) program.
- The Medi-Cal SMHS program is "carved-out" of the broader Medi-Cal program and operates under the authority of a waiver approved by CMS under section 1915(b) of the Social Security Act.
- As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county MHP.
- DHCS contracts with each of the county MHP.
- The MHP are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as

documented in the beneficiaries' client plans. SMHS provided by MHP include a broad array of rehabilitative outpatient mental health services as well as acute inpatient psychiatric hospital services.

MHP provide, or arrange for the provision of SMHS for Medi-Cal beneficiaries that meet medical necessity criteria to receive SMHS. SMHS are delivered consistent with beneficiaries' mental health needs and goals, as identified and documented in the beneficiary's client plan. The following is a description of each SMHS:

MENTAL HEALTH SERVICES

Individual or group therapies and interventions are designed to provide a reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency. These services are separate from those provided as components of adult residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include, but are not limited to:

- Assessment - A service activity designed to evaluate the current status of mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the clinical history, analysis of relevant cultural issues and history; diagnosis; and the use of mental health testing procedures.

- Plan Development - A service activity that consists of development of client plans, approval of client plans, and/or monitoring and recording of progress.

- Therapy - A service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to reduce functional impairments. Therapy may be delivered to an individual or group and may include family therapy at which the client is present.

- Rehabilitation - A service activity that includes, but is not limited to, assistance, improving, maintaining or restoring functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills; obtaining support resources; and/or obtaining medication education.

- Collateral - A service activity involving a significant support person in the beneficiary's life for the purpose of addressing the mental health needs of the beneficiary in terms of achieving goals of the beneficiary's client plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better utilization of mental health services by the client, consultation and training of the significant support person(s) to assist in better

understanding of mental illness, and family counseling with the significant support person(s) in achieving the goals of the client plan. The client may or may not be present for this service activity.

CRISIS INTERVENTION SERVICES

Crisis intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.

CRISIS STABILIZATION SERVICES

Crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

DAY TREATMENT INTENSIVE SERVICES (HALF-DAY & FULL-DAY)

Day treatment intensive services are a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

DAY REHABILITATION (HALF-DAY & FULL-DAY)

Day rehabilitation services are a structured program of rehabilitation and therapy with services to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development and which provides services to a distinct group of beneficiaries who receive services for a minimum of three hours per day (half-day) or more than four hours per day (full-day). Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

ADULT RESIDENTIAL TREATMENT SERVICES

Adult Residential Treatment Services are rehabilitative services provided in a non-institutional, residential setting for beneficiaries [ages 18 and older] who would be at risk of hospitalization or other institutional placement if they were not receiving residential treatment services. The services include a wide range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Service activities may include assessment, plan development, therapy, rehabilitation, and collateral. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

CRISIS RESIDENTIAL SERVICES

Crisis residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

MEDICATION SUPPORT SERVICES

Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of, and alternatives for, medication; collateral and plan development related to the delivery of service and/or assessment for the client; prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals; and medication education.

PSYCHIATRIC HEALTH FACILITY (PHF) SERVICES

A Psychiatric Health Facility is a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations. “Psychiatric Health Facility Services” are therapeutic and/or rehabilitative services provided in a psychiatric health facility on an inpatient basis to beneficiaries who need acute care, which meets the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings. These services are separate from those categorized as “Psychiatric Inpatient Hospital”.

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Psychiatric inpatient hospital services include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services

are provided to beneficiaries for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to beneficiaries who were admitted to the hospital for an acute psychiatric inpatient hospital service and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. MHP claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. MHP are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals, the daily rate includes the cost of any needed professional services. The FFS/MC hospital daily rate does not include professional services, which are billed separately from the FFS/MC inpatient hospital services via the SD/MC claiming system.

TARGETED CASE MANAGEMENT (TCM)

Targeted case management is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Therapeutic behavioral services are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.

INTENSIVE CARE COORDINATION (ICC)

Intensive Care Coordination is a targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age

21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Core Practice Model (CPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
- Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
- Supports the parent/caregiver in meeting their child/youth's needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community.

INTENSIVE HOME BASED SERVICES (IHBS)

Intensive Home Based Services are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the Core Practice Model (CPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

THERAPEUTIC FOSTER CARE (TFC) SERVICES

The (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized SMHS activities (plan development, rehabilitation and collateral) to children and youth up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma informed interventions that are medically necessary for the child or youth. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high-level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) **Physical health** *(**Yes** or No)*
b) **Mental Health** *(**Yes** or No)*
c) **Rehabilitation services** *(**Yes** or No)*
d) **Employment services** *(**Yes** or No)*
e) **Housing services** *(**Yes** or No)*
f) **Educational services** *(**Yes** or No)*
g) **Substance misuse prevention and SUD treatment services** *(**Yes** or No)*
h) **Medical and dental services** *(Yes or **No**)*
i) **Support services** *(**Yes** or No)*
j) **Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)** *(**Yes** or No)*
k) **Services for persons with co-occurring M/SUDs** *(**Yes** or No)*

Please describe as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

The following two case management services are SMHS available to children and adults.

Targeted case management (TCM)

A service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and

referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

Intensive Care Coordination (ICC)

A targeted case management service that facilitates assessment of, care planning for and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a youth, his/her family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child/youth and family in attaining their goals. ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child/youth;
- Facilitates a collaborative relationship among the child/youth, his/her family and systems involved in providing services to the child/youth;
- Supports the parent/caregiver in meeting their child/youth's needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child/youth to be served in his/her community.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The Investment in Mental Health Wellness Act of 2013, established a competitive grant program to disburse funds to California counties or to their nonprofit or public agency designees for the purpose of developing mental health crisis support

programs. Grants from the California Health Facilities Financing Authority were purposed to develop programs to award funds for the intent of increasing community-based mental health treatment options, such as expanding access to mental health crisis intervention services, reduce unnecessary hospitalizations and inpatient days, reduce recidivism and mitigate law enforcement expenditures on mental health crises. In 2016, Senate Bill 833 (Section 20) expanded the Investment in Mental Health Wellness Act Children and Youth (CY) Grant Program to address a continuum of crisis services for children and youth, 21 years of age and under and allocated approximately $27 million to specifically fund four mental health programs - crisis residential treatment, crisis stabilization, mobile crisis support teams and family respite care. In May 2019, Program regulations were approved to establish an appropriate management framework for the Investment in Mental Health Wellness CY Grant Program. Additional information about the Investment in Mental Health Wellness CY Grants are found in this link: https://www.treasurer.ca.gov/chffa/imhwa/

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)[a]	Statewide Incidence (C)[b]
1. Adults with SMI	1,612,884	436,632
2. Children with SED	503,917	241,393

[a] Center for Behavioral Health Statistics and Quality, NASMHPD Research Institute, SAMHSA, 2015
[b] Client and Service Information data system, DHCS, SFY2016-17

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

- The prevalence figures above are from the Center for Behavioral Health Statistics and Quality, NASMHPD Research Institute, SAMHSA.

- County MHP submit service data to the Client and Service Information data system. An unduplicated count of clients receiving specialty mental health services is created to calculate incidence. Prevalence and incidence rates captured in these systems helps California understand where to focus resources to further improve quality of care.

C10. Statutory Criterion for MHBG (Required MHBG) - Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a) **Social Services** *(**Yes** or No)*
b) **Educational services, including services provided under IDE** *(**Yes** or No)*
c) **Juvenile justice services** *(**Yes** or No)*
d) **Substance misuse prevention and SUD treatment services** *(**Yes** or No)*
e) **Health and mental health services** *(**Yes** or No)*
f) **Establishes defined geographic area for the provision of the services of such system** *(**Yes** or No)*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community- based services to individuals in rural areas; and community-based services to older adults.

a. Describe your state's targeted services to rural populations.

According to the Western Interstate Commission for Higher Education (WICHE), more than 60% of rural Americans live in mental health professional shortage areas, and more than 90% of all psychologists and psychiatrists work exclusively in urban, metropolitan areas. Although serious mental illness prevalence between rural and urban communities is about the same, there are several barriers to mental health care access and utilization in rural communities:[1]

- Accessibility: rural individuals have to travel farther to receive services, are less likely to have mental health insurance benefits, and are less likely to recognize mental illnesses and appropriate treatment options.
- Availability: chronic shortages of mental health professionals in rural areas, and comprehensive services are often unavailable.
- Acceptability: few programs train professionals to work competently in rural areas (e.g. urban programs are assumed to work in rural areas), and stigma associated with seeking mental health care.

As of April 2019, there were 277 Rural Health Clinics (RHCs) in California.[2] RHCs are facilities that meet federal criteria for being able to provide adequate primary and mental health care to elderly and low-income populations in designated rural areas. RHCs receive enhanced reimbursement for Medicare and Medicaid services, making them a primary safety net for both older adults and rural populations who may not have private insurance. In fact, nearly 75 percent of RHC visits are made by patients enrolled in public insurance programs.

Telepsychiatry, where an emergency department, acute facility, or outpatient facility can access a psychiatrist via phone or video call for assessments, is also in use in rural counties. When the psychiatrist makes a diagnosis, medications can be prescribed, further treatment can be sought, and psychiatric holds can be discontinued. Telepsychiatry helps to defray costs involved with having an on-site psychiatrist as well as ameliorate the effects of mental health professional shortages in rural areas. Furthermore, Medi-Cal will reimburse this service.

Federally Qualified Health Centers (FQHCs) are community-based organizations that provide both preventive health care and treatment to people of all ages regardless of their ability to pay or whether they carry health insurance. These facilities are important in rural populations that may not otherwise have private insurance. Programs offered by FQHCs include community health centers that

[1] http://govinfo.library.unt.edu/mentalhealthcommission/presentations/rural.ppt

[2] https://www.ruralhealthinfo.org/states/california

serve medically underserved areas, migrant health centers that provide health services to migrant and/or seasonal agricultural workers, and Health Care for the Homeless which outreaches and provides health services to homeless individuals and their families. As of April 2019, there were 244 FQHC sites located outside of urban areas.[3]

The Mental Health Services Act (MHSA) also funds some rural mental health programs in California. For example, in Fresno County, six mental health clinics provide outpatient based mental health and psychiatric services to children, adolescents, adults, older adults, and seriously mentally ill clients in rural areas.

b. Describe your state's targeted services to the homeless population.

California is home to 24 percent of the population of individuals and families experiencing homelessness in the United States – by far the largest percentage in the country. According to the latest 2018 Point-in-Time count (an annual count of homeless persons conducted on a single night in January), 129,972 people are experiencing homelessness in California at any given time. In addition:[4]

- 69 percent of individuals experiencing homelessness in California are without shelter – the highest rate in the nation.
- California accounts for 12 percent of the nation's homeless families.
- California accounts for 34 percent of the nation's homeless unaccompanied youth.
- California accounts for 29 percent of the nation's homeless veterans.
- California accounts for 37 percent of the nation's population with chronic patterns of homelessness.
- A full 9 percent of the country's homeless individuals reside in Los Angeles County alone.

California has several funding streams for programs that provide services to people experiencing homelessness who also have a serious mental illness. The following are the major mental health-related funding streams in California that target services to the homeless population.

MHSA or Proposition 63)

The MHSA Housing Program made permanent financing and capitalized operating subsidies available for the purpose of developing permanent supportive housing, including both rental housing and shared housing, to serve persons with serious mental illness who are homeless or at risk of homelessness.

Between May 2008 and May 2016, over $391 million of MHSA funds was allocated to housing proposals financed by MHSA capital development loans and long-term

[3] https://data.hrsa.gov/tools/data-explorer

[4] https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

capitalized operating subsidy reserves. MHSA units are typically located within larger affordable rental housing developments and restrict occupancy to MHSA clients that include individuals, families, seniors, and Transitional Aged Youth leaving the foster care system. Some MHSA units also allow for occupancy preferences for veterans. Local mental health agencies commit to provide MHSA residents with an individualized array of supportive services to assist with their recovery and increase the likelihood of them becoming fully functioning community members.

Once the MHSA Housing Program ended, the California Housing Finance Agency (CalHFA) established a voluntary loan program for local governments, called the Local Government Special Needs Housing Program, to continue developing permanent supportive housing for homeless people that also have a serious mental illness.

In addition to housing services, the MHSA provides Outreach and Engagement funding under the Community Services and Supports component. This funding stream enables California counties to provide services that reach, identify, and engage underserved individuals and communities in the mental health system and reduce disparities. Examples of programs utilizing this funding stream include advocacy and increasing awareness of services provided within the county, ethnic outreach programs targeting specific populations that tend to underutilize mental health services, stigma reduction programs, and outreach and engagement to homeless youth, transitional-age youth, adults, and older adults.

No Place Like Home

In 2016, the Governor of California signed legislation dedicating $2 billion in bond proceeds to invest in permanent supportive housing for those with mental health needs and who are experiencing homelessness, chronic homelessness, or are at risk of chronic homelessness. This funding, distributed to counties, provides for permanent supportive housing that must utilize low barrier tenant selection practices, prioritize vulnerable populations, and offer flexible, voluntary, and individualized supportive services. In addition, counties must commit to provide mental health services and help coordinate access to other community-based supportive services.

Substance Abuse and Mental Health Services Administration (SAMHSA) Programs

The State of California, as well as several local governments within, take advantage of several federal funding streams via SAMHSA.

Some Community Mental Health Services Block Grant (MHBG) funding is used specifically to target individuals experiencing homelessness who also have a serious mental illness and who also may have a substance use disorder. Activities include outreach, linkage, intensive case management, crisis residential rehabilitation services, screening/assessment, and coordination of primary and mental health care. For example, Shasta County operates a Homeless Co-Occurring Disorders

Program that seeks to ensure that this population receives the same quality mental health services as other residents of the county and eliminates disparities that exist in accessing treatment.

California receives Projects for Assistance in Transition from Homelessness (PATH) funding that is distributed to counties to provide services to homeless adults with a serious mental illness. The basis of the program is to provide community outreach and case management services to link and refer this population to existing mainstream programs, including substance abuse treatment, community mental health care, housing, and vocational and rehabilitation services. In addition, several counties have dedicated staff who work to connect this population with entitlement benefits. The SAMHSA SSI/SSDI Outreach, Access, and Recovery (SOAR) program is the typical model.

Several organizations within California receive or did receive SAMHSA Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH) funds. The purpose of the grant is to support the development and/or expansion of local implementation and community infrastructures that integrate treatment and services for substance use, co-occurring substance use and mental disorders, permanent housing, and other critical services for veterans who experience homelessness or chronic homelessness, and other individuals (non-veterans) who experience chronic homelessness.

Some counties and non-governmental organizations (including Yolo County and various organizations in Los Angeles County) receive funding through SAMHSA's Cooperative Agreements for the Benefit of Homeless Individuals (CABHI) program. This program increases capacity to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services; permanent supportive housing; peer supports; and other critical services for individuals, veterans, families, and youth who experience homelessness or chronic homelessness and have a serious mental illness or severe emotional disturbance.

c. Describe your state's targeted services to the older adult population.

Over the next two decades, California's over-65 population will nearly double, clearly indicating an increased demand for health and support services.[5] The State of California and counties within provide services targeted towards older adults to treat their unique mental health issues and to delay or prevent inappropriate or undesirable institutionalization. Below are specific services provided in California that target the older adult population.

Full Service Partnerships (FSP)

The California Department of Health Care Services (DHCS) distributes funding to

[5] http://www.ppic.org/publication/planning-for-californias-growing-senior-population/

counties to provide FSP services to older adults with a serious and persistent mental illness. To be eligible for the FSP program, older adults must have an SMI that results in substantial functional impairments or symptoms, are likely to become so disabled as to require public assistance, services, or entitlements, and are at risk of becoming homeless, institutionalized, becoming frequent users of hospital/emergency rooms, or being placed into a nursing home or out-of-home care. FSP are defined in the California Code of Regulations as "the collaborative relationship between the county and the client, and when appropriate the client's family, through which the county plans for and provides the full spectrum of community services so that the client can achieve the identified goals."

In effect, the FSP program follows a "whatever it takes" model to ensure that the client can access services that are beneficial to him or her. Services can include, but are not limited to:

- Outreach and engagement;
- Counseling, psychotherapy, and case management;
- Peer support;
- Self-help and family support groups;
- Employment linkage;
- Transportation assistance;
- Housing assistance;
- Physical health care;
- Benefits and entitlements acquisition;
- Representative payee services; and
- Substance abuse services.

Field Capable Clinical Services (FCCS)

The MHSA provides funding for FCCS for older adults who may be reluctant to access or avail themselves of behavioral health care in a traditional setting due to limited mobility, geographic limitations, or stigma. The FCCS team is multidisciplinary and is able to provide a wide range of services to these clients in preferable locations such as homes, senior centers, and assisted living facilities.

California Mental Health Older Adult System of Care Project

The California Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with the UCLA Center for Health Policy Research to assess the state's progress in setting up a statewide system of mental health care for older adults.

The project offered recommendations and guidance to improve mental health

services for older adults by:[6]

- Establishing a System of Care at the state level and within local governments by creating administrative structures with dedicated leaderships positions;
- Requiring mandatory standardized needs assessments and data reporting;
- Creating standardized trainings for mental health professionals that are sensitive to the needs of older adults; and
- Increasing outreach and expanding service integration between medical disciplines.

The project also identified several promising programs offered by counties that are targeted towards older adults with behavioral health issues. These programs range from intensive wraparound services to peer counseling.[7]

The information acquired in the course of the project is available to counties to use when conducting their MHSA planning activities and is located at: http://healthpolicy.ucla.edu/programs/health-disparities/elder-health/Pages/Older-Adult-Mental-Health-Care.aspx.

[6] http://healthpolicy.ucla.edu/programs/health-disparities/elder-health/Documents/MHSAAddendum_KeyFindings.pdf

[7] http://healthpolicy.ucla.edu/publications/Documents/PDF/2018/PromisingPrograms-compendium-jan2018.pdf

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Describe your state's management systems.

The California Department of Health Care Services (DHCS) is the Single State Agency (SSA) responsible for the administration of the federal Medicaid program, called Medi-Cal through two areas: Health Care Delivery Systems, which oversees contracts with managed care plans (MCP) and Mental Health and Substance Use Disorder Services. DHCS recently implemented the integration of behavioral health with the rest of the health care system and reorganized to create a structure in efforts to increase efficiencies department-wide, increase program administration accountability, improve service delivery, decrease processing times, and increase communication and engagement for stakeholders and employees. The reorganization created a total of four Divisions (Behavioral Health Financing Division, Behavioral Health Licensing & Certification Division, Community Services Division and the Medi-Cal Behavioral Health Division).

California funds behavioral health services through multiple dedicated revenue sources. These sources include 1991 Realignment,[1] 2011 Realignment,[2] Federal Financial Participation,[3] Mental Health Services Act (MHSA),[4] SAMHSA Grants (Mental Health Block Grant (MHBG), Projects for Assistance in Transition from Homelessness (PATH) Formula Grant and the Substance Abuse Prevention and Treatment (SAPT) Block Grant) and locally-generated revenue (i.e., Maintenance of Effort (MOE)[5]).

California has a decentralized public mental health and substance use disorders delivery system with most direct services provided through county systems. County Mental Health Plans (MHP) have primary funding and programmatic responsibilities for the majority of Medi-Cal mental health programs, and Drug Medi-Cal (DMC) covers

[1] 1991 Realignment was a legislatively-driven effort initiated in 1991 that approved a half-cent increase in state sales tax and dedicated a portion of vehicle license fees fund local community mental health services.

[2] 2011 Realignment codified the Behavioral Health Services Subaccount that currently funds SMHS, DMC, residential perinatal drug services and treatment, drug court operations, and other non-DMC programs. See AB 109 (Chapter 15, Statutes of 2011) and SB 1020 (Statutes of 2012) for more information.

[3] Counties receive federal funding for public mental health care for services provided to Medi-Cal beneficiaries. Federal payments match state spending based on the federal Medicaid assistance percentage, which in California is set at 50% for most expenditures.

[4] MHSA revenues, established by Proposition 63, which passed in 2004 and is generated through a 1% surtax on personal income over $1 million, are allocated directly to counties and have helped to significantly fund rehabilitative and preventive mental health services to underserved populations.

[5] A portion of local revenue generated from property taxes, patient fees, and some payments from private insurance companies is used to fund mental health services, referred to as a Maintenance of Effort (MOE).

most Medi-Cal substance use service programs.

California's public mental health system has suffered from a shortage of public mental health workers, misdistribution of certain public mental health occupational classifications, a recognized lack of diversity in the mental health workforce, and under-representation of mental health professionals with consumer and family member experience or experience in racially, ethnically, or culturally diverse communities.

To address the public mental health workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. The California Office of Statewide Health Planning and Development (OSHPD), with advice from stakeholders and approval by the California Behavioral Health Planning Council, completed the development of the new MHSA WET Five-Year Plan which covers the period from Fiscal Year (FY) 2020-2021 to FY 2025-2026 and includes the elements outlined in Welfare and Institutions Code Section 5822, providing a framework of strategies that state, local government, community partners, education and training institutions, and other stakeholders can enact to further public mental health workforce, education, and training efforts.

As the State's designated recipient of the MHBG, DHCS will continue to allocate the funding to County Mental Health/Behavioral Health Departments to provide comprehensive community mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). DHCS uses an allocation methodology that ensures that each county receives a base allocation calculated using a formula prescribed in statute, and that some counties receive allocations for special programs. One of those special programs, established and operationalized through departmental policy, is an integrated system of care for children who have a SED. Seven counties receive a fixed allocation for this program that is set at the level they received from the 1994 MHBG. Another special program is an integrated system of care for adults who have SMI. Two counties receive a fixed allocation for this program. Participating counties also receive a fixed allocation for other special programs such as those with co-occurring disorders and for individuals with early serious mental illness and/or experiencing first episode psychosis.

C1. The Health Care System, Parity and Integration – (Required MHBG)

1. **Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.**

The California Department of Health Care Services (DHCS) is the single state agency responsible for the administration of the State's Medicaid program, called Medi-Cal. DHCS administers programs to support the vital health care needs of nearly 14 million Californians, about one-third of the State's population.

California provides beneficiaries access to a mental health and substance use disorder (SUD) benefit that includes a full continuum of substance use and mental health services, establishing non specialty mental health and substance use screening services that are made available through managed care plans in primary care settings, administering the performance of county operated local mental health plans (MHP) that provide specialty mental health services (SMHS) through a CMS approved waiver, as a carve-out, and administering SUD treatment services made available, as a carve-out, through a county organized delivery system waiver and state administered Drug Medi-Cal (DMC) program. The continuum of services are provided, based upon medical necessity criteria and level of care, in inpatient, outpatient, and community-based settings.

California continues to ensure the integration, coordination and provision of mental health and SUD treatment benefits and the services available across all delivery systems by collaborating with local health plans, MHP, and substance use providers; monitoring the provision of and referrals for mental health and substance use services by health plans, MHP, and SUD treatment providers, and ensuring there are linkages in places for effective referrals between health plans providing non specialty mental health services and SUD screening and the specialty or more intensive mental health and SUD services provided by local MHP and SUD treatment providers. The following describes how these services are provided.

Managed Care Plans

DHCS administers health care services through two delivery systems – Managed Care Plans (MCP) and fee-for-service (FFS). MCP are required to provide services in an amount no less than what is offered to beneficiaries under Medi-Cal FFS. MCP provide State Plan services in accordance with State statutes and regulations, DHCS contract with MCP and All Plan Letters (APL). MCP cover most acute, primary and specialty care, pharmacy, and some long-term care services. Approximately 80 percent of full-scope Medi-Cal beneficiaries receive health care services through a MCP.

In California, there are six models of managed care within the 58 counties:

- County Organized Health Systems (COHS)
- Two-Plan

- Geographic Managed Care (GMC)
- Regional
- Imperial
- San Benito

California has expanded benefits for Medi-Cal beneficiaries with mental health conditions who do not meet the SMHS medical necessity criteria, thus providing access to a limited scope of primary care-based, non-emergency mental health and SUD services provided by MCP. Pursuant to the State Plan, MCP provide non-SMHS included in the essential health benefits package.[1]

Outpatient non-SMHS include:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purpose of monitoring drug therapy;
- Outpatient laboratory, drugs, supplies and supplements (excluding antipsychotics); and
- Psychiatric consultation.

MCP do not provide SUD services or SMHS, but are responsible for referral and coordination with the local county office for these services. DHCS ensures that all contracts with MCP include a process for screening, referral, and coordination with MHP, as set forth in Welfare and Institutions Code Section 14681[2].

MCP are responsible for providing SUD preventative services, which include Screening, Brief Intervention, and Referral to Treatment (SBIRT) for misuse of alcohol, tobacco cessation services and office visits associated with alcohol and SUD services when provided by a network provider acting within their scope of practice.

SMHS

In California, the SMHS are carved-out of managed care through CMS-approved Medicaid Waivers. California's SMHS are provided under the 1915(b) Freedom of Choice Waiver. Pursuant to the terms of the 1915(b) Medi-Cal SMHS Waiver, SMHS in California are provided to Medi-Cal adult beneficiaries who have a serious mental disorder and children with a serious emotional disturbance. DHCS contracts with county MHP who are responsible for assessing and providing the provision of SMHS to beneficiaries who meet SMHS requirements in Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210 in a manner consistent with the beneficiary's mental health treatment needs and goals as documented in the beneficiary's treatment plan. The county MHP provide SMHS in the least restrictive community-based settings to promote appropriate and timely

[1] Welfare & Institutions Code Sections 14132.03 and 14189.

[2] Welfare & Institutions Code Section 14681: http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-14681.html

access to care for beneficiaries. The SMHS covered under the 1915(b) SMHS Waiver are outlined in the California State Plan and include a range of interventions to assist beneficiaries with serious emotional and behavioral challenges by providing rehabilitative mental health services.

SUD Services

DHCS administers State Plan DMC, the DMC Organized Delivery System (DMC-ODS), and Substance Abuse Prevention and Treatment Block Grant (SABG) programs through a community-based system for SUD services through counties or through direct contracts with service providers.

Beneficiaries enrolled in Medi-Cal receive SUD treatment through DMC, which is a carve-out of the MCPs' benefits. California's State Plan authorizes the DMC program to provide the following five treatment modalities:

- Outpatient Drug Free Treatment (group and/or individual counseling)
- Intensive Outpatient Treatment
- Residential Treatment (limited to pregnant and perinatal clients)
- Medication Assisted Treatment

In 2015, CMS approved the DMC-ODS waiver amendment to the Medi-Cal 2020 Demonstration Waiver. By opting into the DMC-ODS and executing the DMC-ODS Intergovernmental Agreement, participating counties agree to provide or arrange for the provision of DMC-ODS services as a Prepaid Inpatient Health Plan (PIHP). The county makes DMC-ODS services available as a Medi-Cal benefit for all individuals who reside within its county borders, have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for an SUD, and meet the medical necessity to receive that particular service based on American Society of Addiction Medicine (ASAM) criteria for SUD treatment services. DMC-ODS services include:

- Outpatient drug free services;
- Intensive outpatient services;
- Withdrawal management (detoxification) services;
- Narcotic replacement therapy;
- Medication-assisted treatment;
- Residential treatment services; and
- Recovery services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

On July 1, 2019, mental health and SUD services programs were reorganized to

form a comprehensive Behavioral Health program while better integrating behavioral health in the overall health care system. The reorganization will improve service delivery and program outcomes, increase program administration accountability, leverage experience and expertise that exist in other areas of DHCS, and improve communication and engagement for stakeholders and employees.

3. **a./b. Is there a plan for monitoring whether individuals and families have access to MH/SUD services offered through QHPs and Medicaid?** (***Yes*** *or No)*

   DHCS monitors the provision of Medi-Cal benefits and services across all delivery systems. Beneficiary access to mental health and SUD services from health plans, MHP, and substance use providers is monitored and reviewed through routinely established audits and compliance reviews.

4. **Who is responsible for monitoring access to MH/SUD services by the QHPs?**

   DHCS is responsible for monitoring quality, access and costs of medical/surgical, mental health, SUD services and other health services provided by local health, mental health, and SUD plans.

5. **Is the SSA/SMHA involved in any coordinated care initiatives in the state?** *(**Yes** or No)*

   DHCS' Coordinated Care Initiative (CCI) marked an important step toward transforming California's Medi-Cal delivery system to better serve the state's low-income seniors and persons with disabilities. Building upon many years of stakeholder discussions, the CCI begins the process of integrating delivery of medical, behavioral, and long-term care services and also provides a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries.

6. **Do the behavioral health providers screen and refer for:**

   a. **Prevention and wellness education** *(**Yes** or No)*
   b. **Health risks such as**

      i. **heart disease** *(Yes or **No**)*
      ii. **hypertension** *(Yes or **No**)*
      iii. **high cholesterol** *(Yes or **No**)*
      iv. **diabetes** *(Yes or **No**)*

   c. **Recovery supports** *(**Yes** or No)*

7. **Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance**

coordination of care? *(Yes or **No**)*

8. **Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?** *(**Yes** or No)*

9. **What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?**

   DHCS conducted a mandatory assessment of Medicaid benefits across the delivery systems to ensure the State's compliance with the Parity Rule. DHCS adhered to the Parity Toolkit that outlined key steps to conducting the parity analysis and examined benefits across the delivery systems for parity compliance, which included: Medi-Cal MCP, county MHP, DMC, DMC Organized Delivery System (DMC-ODS), Waivers, and Fee-for-Service (FFS).

   To gain perspectives on current practices and identify parity concerns, DHCS administered surveys to the MCP, county MHP, and counties providing SUD services through DMC and DMC-ODS to gain perspectives on policies operationalized at the local levels. The surveys were focused in the following areas: authorizations and referral processes, pharmacy and drug formulary, provider network, credentialing and contracting, case management and care coordination, treatment restriction and/or exclusions, and financial requirements. This included collection and analysis of plan/county policies and procedures.

   In addition, DHCS convened an internal workgroup comprised of program, clinical, legal, and executive staff to ensure a multidisciplinary approach to evaluating State-level policies. The workgroup reviewed State guidance within the Medicaid State Plan, waiver programs, State and Federal statutes and regulations, APL and County Information Notices, DHCS contracts with the MCP and MHP, Medi-Cal Provider Manual, and the DMC and SMHS Billing Manual for potential FR, QTL, and NQTL.

   DHCS submitted its Compliance Plan to the CMS and is posted on DHCS' public website.

   To comply with Parity requirements, DHCS implemented several new statewide policies pertaining to the delivery of SMHS provided by county MHP and SUD services provided by DMC-ODS pilot counties. The new policies, including policies related to authorization of SMHS and continuity of care arrangements, were complex in nature and required significant changes to local operations.

   DHCS monitors Parity compliance on an ongoing basis through its compliance reviews and audits of the MCP, MHP, and DMC-ODS plans.

10. Does the state have any activities related to this section that you would like to highlight?

The California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year DHCS initiative to implement overarching policy changes across all Medi-Cal delivery systems, with the objectives of:

1. Reducing variation and complexity across the delivery systems;
2. Identifying and managing member risk and need through population health management strategies; and,
3. Improving quality outcomes and driving delivery system transformation through value-based initiatives and payment reform.

These objectives will be further explored through the development of workgroups in efforts to examine the possibilities of Population Health Management, an Annual Health Plan Open Enrollment option, NCQA accreditation requirements, an enhanced care management benefit, flexible wrap-around services and continued research examining the challenges and effectiveness of behavioral health integration and a planned pilot project to assess the effectiveness of the integration of physical health, behavioral health, and oral health.

C4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)-10 percent set aside - Required for MHBG

1. **Does the state have policies for addressing early serious mental illness (ESMI)?** *(**Yes** or No)*

2. **Has the state implemented any evidence-based practices (EBPs) for those with ESMI?** *(**Yes** or No)*

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI

   DHCS is partnering with the University of California, Davis to expand and enhance First Episode Psychosis (FEP) programming. Specifically, DHCS is launching a series of Learning Collaboratives designed as part of the Early Psychosis Intervention Plus Program, and is intended to ensure a standard of care exists across California for all individuals experiencing an FEP or other ESMI. The training will focus on the evidence-based practice of coordinated specialty care (CSC) as the leading treatment modality for FEP, and will benefit programs in all stages of implementation.

3. **How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?**

   DHCS requires participating subrecipient counties to provide EBP for individuals with ESMI and provides training and technical assistance on EBP for ESMI. Additionally, counties must provide comprehensive individualized treatment or integrated mental and physical health services per their annual agreements with DHCS.

4. **Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?** *(**Yes** or No)*

5. **Does the state collect data specifically related to ESMI?** *(**Yes** or No)*

6. **Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?** *(**Yes** or No)*

7. **Please provide an updated description of the State's chosen EBPs for the 10 percent set-aside for ESMI.**

   California continues to award counties the MHBG 10% Set-aside to promote the development of an integrated CSC program for individuals with an ESMI and/or experiencing an FEP. Several programs within the state operate utilizing EBP to

promote intensive community-based services and supports that work with individuals to successfully manage their mental health issues while promoting hope, wellness, and recovery. The table below provides a full listing of EBP implemented within county programs using the 10 percent set aside.

Evidence-Based Practices Used with the 10 percent set-aside

Assertive Community Treatment	Cognitive Behavioral Therapy for Psychosis CBTp	Family Psychoeducation
Motivational Interviewing	Trauma-Focused Cognitive Behavioral Therapy (TF CBT)	Medication Algorithms
Supported Employment	Supported Education	Supported Housing
Coordinated Specialty Care	Transition to Independence (TIP)	Functional Family Therapy (FFT)

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

For FFY 2022 and FFY 2023, California will continue to award the MHBG FEP Set Aside funding to participating counties as they further their efforts to maintain and strengthen their existing early intervention programs that are consistent with the CSC model to serve more people. California will also continue to allocate MHBG FEP set-aside funding to those counties that continue to leverage the clinical and administrative resources within a full-service partnership program to further the development of their CSC programs for those with an ESMI and/or a FEP.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

California requires counties to collect and report data demonstrating the effect of FEP services. California revised its existing data collection tool to report on FEP outcome data required in the Uniform Reporting System (URS) Tables. This revised data collection tool will collect certain demographic data on individuals served demonstrating impact of the 10 percent set-aside, as well as report on EBP that have been implemented. Counties are required to submit to the State, data on the number of individuals served and EBP implemented on an annual basis.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Below are the diagnostic categories which are covered for the ESMI programs. In order for services to be covered, the beneficiary must exhibit behaviors/symptoms which support an included diagnosis.

- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders

- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor-Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders
- Feeding and Eating Disorders
- Elimination Disorders
- Personality Disorders
- Disruptive, Impulse-Control, and Conduct Disorders
- Paraphilic Disorders

C5. Person Centered Planning (PCP) –Required (MHBG)

1. **Does your state have policies related to person centered planning?** (***Yes*** *or No)*

2. **If no, describe any action steps planned by the state in developing PCP initiatives in the future.**

3. **Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.**

   Engagement of mental health clients, their caregivers, family members, and others is part of the Person-Centered Planning (PCP) process. Staff from various state agencies, such as options counselors, support brokers, social workers, peer support workers, and others assist clients and others included in the client's PCP process. This assistance includes helping identify available paid and unpaid services, guiding selection of the range and types of services for the client, and supporting and guiding access to services.

   The Department of Health Care Services (DHCS) uses PCP to engage individuals and their support systems in the process of coordinating and delivering mental health services, as applicable, with the goal of enhancing quality of care to improve an individual's health and well-being through more efficient and effective use of resources. The process is focused on recovery-oriented and culturally appropriate/competent services and is family-centered, youth-guided, and developmentally appropriate, specific to target populations.

4. **Describe the person-centered planning process in your state.**

   PCP is a process by which individuals develop their plans of service. The purpose of PCP is to enable and assist people with identifying and accessing a unique mix of services to meet their needs and provide support during this process. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

   The PCP process may include a representative the person freely choses, and/or who is authorized to make personal or health decisions for the person. Another step in PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP process should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcomes.

   DHCS administers various mental health services that utilize the PCP approach. Specifically, the PCP approach is used in the delivery of rehabilitative mental health services related to client plan development, the client and family team process, and full service partnerships, as described below.

Rehabilitative Mental Health Services

Rehabilitative mental health services are provided to Medi-Cal (California's Medicaid program) beneficiaries that meet medical necessity criteria for specialty mental health services established by DHCS, based on the beneficiary's need for rehabilitative mental health services established by an assessment and documented in the client plan. The purpose of rehabilitative mental health services is to provide services in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

A client plan for services is developed to support and address the beneficiary's needs, consistent with his/her diagnosis or diagnoses. A patient-centered approach is used in developing the client plan, to collaborate and engage individuals in goal setting and decision-making. The beneficiary's participation and feedback in this process helps to identify specific observable and/or quantifiable goals and treatment objectives, proposed type(s) of intervention, and the proposed duration of the intervention(s) to achieve their desired outcomes. In addition, the beneficiary is encouraged to include any support person(s) that they desire or need to participate in the treatment planning process.

Child and Family Team

The Child and Family Team (CFT) is a team of people comprised of a child or youth and all ancillary individuals working with them to achieve their mental health goals. The CFT composition for children and families involved with both child welfare and mental health must include at least the child welfare worker and mental health worker and the child and family. Youth and family engage in discussions about support systems and who they might want to be on their CFT. Successful CFTs include persons with natural supportive relationships with the family, so that the family's support system will continue after formal services are completed. The CFT model is most effective because its dynamic process is child/youth and family-centered. Using a team-based approach, CFTs combine the structure of professional interdisciplinary teams with the strength-based and inclusive principles of family-centered care to make informed decisions.

CFT members work together to ensure access to needed services, and monitor the child, youth and family's progress, making individualized adaptations as necessary so that the family's goals and team-identified outcomes can be achieved. As the CFT works together to identify strengths and needs and develop action plans that connect the two, team commitment and cohesion are greatly strengthened. Team members assume responsibility for contributing to the family's success, as they observe achievements in the areas of safety, permanence, and well-being. Teaming embraces family empowerment and inclusion, respects family culture and values, and honors diversity of perspectives and culture among all team members. Working with children, youth, and families as partner's results in plans that are developed

collaboratively and in a shared decision-making process. The family members hold significant power of choice when strategies are defined.

CFTs evolve over time, as effective strategies are put in place and goals are achieved. Some members may fulfill their purpose on the team and decide to leave. Over time, new members with the skills and strengths to address emerging needs will join the process. As these strengths and needs are identified, the original team expands to include other members as necessary and appropriate. Each individual team member has a unique role and responsibilities, but always works as a part of the team. The CFT process is used for every child/youth and family receiving services through child welfare and mental health as a best practice, in addition to other children/youth that need that level of support.

Full Service Partnerships

A Full Service Partnerships (FSP) is a collaborative relationship between the County and the individual, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve their identified goals. FSPs provide wrap-around or "whatever it takes" services to clients. Wraparound is a strengths-based planning process that occurs in a team setting to engage with individuals and their families. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve well-being.

FSP are provided through the Mental Health Services Act, as part of the Community Services and Supports component. The FSP is designed to serve Californians with the most severe mental health challenges; children and adolescents identified as seriously emotionally disturbed and adults and older adults identified as having serious mental illness. FSP focus on recovery and resilience while providing clients and families an integrated service experience. FSP provide substantial opportunity and flexibility in services for a population that has been historically underserved and greatly benefits from improved access and participation in quality mental health treatment and support services

C6. Program Integrity – Required MHBG

Please respond to the following:

1. **Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?** *(**Yes** or No)*

2. **Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?** (**Yes** or No)

3. **Does the state have any activities related to this section that you would like to highlight?**

   California's budget process and DHCS' internal controls associated with the budget process ensures that DHCS does not expend more than five percent to administer the MHBG. The Budget Act, as enacted by the Legislature and signed by the Governor, must appropriate funding to DHCS in order for DHCS to expend MHBG funds.

   DHCS allocates the MHBG award among 57 counties based upon a formula established in State statute. In order to ensure compliance with State and federal requirements, each participating county department must submit to DHCS an annual renewal application and expenditure plan for the MHBG. The application and expenditure plan must be reviewed and approved by DHCS prior to the county receiving payments from their MHBG allocation. DHCS implements processes and procedures that include quarterly expenditure reports, year-end cost reports, site reviews, and audits to ensure that counties are spending their MHBG funding consistent with their applications and budgets and complying with the certifications and agreements.

   Counties are required to submit quarterly expenditure reports for the MHBG for the duration of the fiscal year. Counties must incur expenditures before receiving payments from their MHBG allocation. Payments are based on actual expenditures documented on quarterly expenditure reports, which are due to DHCS 20 days after the end of each quarter. The quarterly expenditure reports serve as a control mechanism to ensure that the county does not spend beyond their allocation and that DHCS does not reimburse beyond the county's allocation.

   Counties are required to submit Year End Cost Reports to DHCS by December 31st of each year. The Year End Cost Reports are used to reconcile program costs throughout the grant year and undergo analyst and supervisory levels of review and approval.

Federal regulations require that the State conduct peer reviews of not less than 5% of the entities providing mental health services in the State on an annual basis. DHCS performs peer reviews in accordance with federal regulations to decrease the risk of federal dollars being utilized for unallowable costs and to ensure program quality, appropriateness, and efficacy of treatment service standards of the state.

Program performance reviews are integrated with peer reviews to maintain standards of program integrity, monitoring and compliance efforts. Counties that receive MHBG funding are required to comply with 45 Code of Federal Regulations (CFR) Part 75 requirements, including Single Audit requirements. Counties are required to file their Single Audit with the State Controller's Office. DHCS' Community Services Division and Audit and Investigations Division continue to work collaboratively to refine the DHCS' audit processes.

In accordance with 45 CFR Part 75, DHCS has implemented a pre-award risk assessment process. Additionally, this requirement is conveyed to county mental health/behavioral health departments through the release of policy letters in that those counties who subcontract for MHBG services must perform pre-award risk assessments of potential providers prior to disbursing MHBG funds.

C13. – Criminal and Juvenile Justice

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?

Yes, the Department of Health Care Services (DHCS), as the Single State Agency (SSA) for substance use disorder (SUD) services and the State Mental Health Authority (SMHA) for mental health disorder (MH) services, has a plan for coordination with the criminal and juvenile justice systems on diversion for individuals with MH and/or SUD from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community. DHCS has developed linkages with the California Department of Corrections and Rehabilitation (CDCR) via county- and provider-level treatment and recovery services made available through various funding streams.

The Community Services Mental Health Block Grant (MHBG) provides an important and flexible funding source to support a broad range of innovative activities specific to the needs of each county. Many counties are using the MHBG to fund MH services that are innovative, recovery based, culturally competent and community based. The MHBG funds are allocated to 57 of California's 58 counties through two methodologies.

1) The first method is a legislated formula that provides a stable, flexible and non-categorical funding base, which the counties can use to develop innovative programs or augment existing programs within their systems of care for adults with serious mental illnesses (SMI) or children with serious emotional disturbances (SED). In order to receive the formula allocation, each county is required to submit an annual application or expenditure plan that includes a narrative detailing its intended use of the funds.

2) The second method of allocating the MHBG funds is a discretionary method that allows DHCS, in consultation with the California Behavioral Health Directors Association (CBHDA), to fund specific projects that are innovative and based on best practices. In the past, the funds have been used to support numerous successful projects including the development of an Older Adult System of Care, Dual Diagnosis, At-Risk Assessment and Intervention, Youth Development and Crime Prevention, Criminal Justice Reintegration, Juvenile Justice Reintegration, Transitional Supportive Housing, Crisis Management to Reduce Recidivism, and veteran programs within the community.

Public Safety Realignment

Public Safety Realignment was enacted through Assembly Bill (AB) 109 in 2011 (Chapter 15, Statutes of 2011). Public Safety Realignment mandates that individuals sentenced to non-serious, non-violent, or non-sex offenses serve their sentences in county jails instead of State prisons. Along with Public Safety Realignment, the

Post-Release Community Supervision (PRCS) Act of 2011 established the PRCS program. Under PRCS, on and after October 1, 2011, certain individuals released from State prison are subject to community supervision by county probation departments. PRCS is not available for some individuals, such as those who committed a serious or violent felony, high-risk sex offenders, or individuals required to undergo treatment at a State hospital. A key provision of AB 109 is the establishment of a Community Corrections Partnership that includes county-level SUD staff to assist with determining funding levels for each respective county.

Drug Courts

DHCS previously collaborated with drug courts in the effort to divert individuals who need SUD treatment out of the correctional system and into treatment. However, drug court funding was reallocated from the State to the counties through the 2011 Realignment Legislation to address public safety. Drug court funding is allocated directly into each county's Behavioral Health Sub-Accounts. Counties have discretion as to how they use these reallocated funds.

Penal Code 1000 – Drug Diversion Program

As part of the State's Penal Code 1000 Drug Diversion or Deferred Entry of Judgement Programs, screening and services can be provided to individuals with SUD issues who are facing criminal proceedings. In addition, California's Drug Court programs offer screening and services to eligible offenders. Screening services for each program include, but are not limited to, initial assessment of the individual, counseling and outpatient, or residential SUD treatment (depending on the level of treatment needed), and, specifically in Drug Court programs, court supervision of the individual.

Assembly Bill 900 – Reentry Program

In 2007, California passed AB 900 refocusing correctional efforts to use innovative and evidence-based programs both in prison and post-release. This included a renewed commitment to reentry programming through which many county and local level SUD programs became actively involved, thus, establishing linkages to treatment and recovery services for offenders pre- and post-release from prison.

CDCR Reentry Programs

CDCR, through extensive community partnerships, innovative community supervision, and a commitment to rehabilitation, is helping offenders succeed as they return to their communities. Comprehensive pre- and post-release rehabilitative programs and services delivered through alternative custody, residential, outpatient and drop-in centers are offered in communities throughout California.

Live-in programs provide links to community rehabilitative services and programs focused on skills such as MH/SUD treatment and recovery services, education, housing, family reunification, vocational training and employment services to

offenders serving the last part of their sentence in community programs in lieu of confinement in State prison. Some of the programs provided are:

- Alternative Custody Program (ACP)
- Community Prisoner Mother Program (CPMP)
- Custody to Community Transitional Reentry Program (CCTRP)
- Male Community Reentry Program (MCRP)

Residential programs for parolees are offered throughout the State. All residential programs provide residency and support services to parolees including MH/SUD treatment, Cognitive Behavioral Therapies, life skills, employment, education, and transitional housing. Some of the programs provided are:

- Female Offender Treatment and Employment Program (FOTEP)
- Parolee Service Center (PSC)
- Specialized Treatment for Optimized Programming (STOP)
- Transitional Housing Program (THP)

Outpatient and drop-in programs for parolees provide support in employment assistance and placement, relationships, Cognitive Behavioral Therapies, education, housing, and vocational training. Some of the programs provided are:

- CalTrans Parolee Work Crew Program
- Day Reporting Centers/Community-Based Coalition (CBC)

Medicaid/Medi-Cal

In general, individuals involved in California's adult and juvenile justice systems are able to enroll in Medicaid/Medi-Cal in the same manner as any other citizen of the State, provided criteria for eligibility is met. Specific enrollment processes have been developed for offenders involved in the criminal justice system. These processes have become part of intake and post-release service planning. Most of these processes have been determined by CDCR, not DHCS. Nevertheless, as the SSA/SMHA, DHCS ensures that the population at risk or involved in the criminal and juvenile justice system has access to MH/SUD services.

Affordable Care Act

Effective January 1, 2014, the Affordable Care Act (ACA) authorized states to expand Medicaid to cover many low-income individuals under the age of 65 who were previously ineligible for Medicaid coverage. As a result, many probationers, individuals on PRCS, parolees, and county jail inmates who may not have been eligible for Medi-Cal coverage prior to the ACA, have now become eligible.

Section 1915(b) Waiver - Medi-Cal Specialty Mental Health Services

Specialty Mental Health Services (SMHS) are authorized pursuant to a waiver approved by the Centers for Medicare and Medicaid Services under Section 1915(b)

of the Social Security Act. Under the Medi-Cal SMHS Waiver, each county's Mental Health Plan (MHP) must ensure the provision of Medi-Cal SMHS, as described in California's Medicaid State Plan and Title 9, California Code of Regulations (CCR), Section 1810.247, to all Medi-Cal beneficiaries who meet medical necessity criteria.

The Mental Health Services Act (MHSA)

In 2004, California voters passed MHSA. MHSA is funded by a one percent income tax on personal income in excess of $1 million per year. The MHSA is designed to expand and transform California's MH systems to better serve individuals who have or are at risk of having SMI, and their families. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as the necessary infrastructure, technology, and training elements to support the system.

The State Controller's Office distributes MHSA funds to counties on a monthly basis per *Welfare & Institutions Code (W&I), § 5891(c).* Counties spend the funds on five components: Community Services and Support; Prevention and Early Intervention; Innovation; Capital Facilities and Technological Needs; and, Workforce Education and Training (W&I § 5892(a), (b).). The MHSA requires each county's MH department to prepare and submit a Three-Year Program and Expenditure Plan and annual updates to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) (W&I § 5847). The plans and updates are subject to a community planning process that includes stakeholder involvement and approval by the county's board of supervisors (W&I § 5848).

Per Title 9 CCR § 3610(f), MHSA-funded services are not available for parolees or individuals incarcerated in State or Federal prisons. PRCS program participants are supervised by county probation departments, and thus, are not considered parolees. Since individuals who are on PRCS are no longer incarcerated in a State prison and are not parolees, they are eligible for services funded by the MHSA as long as all other MHSA requirements are met.

As stated above, parolees, probationers, and individuals on PRCS are not inmates. Therefore, Medi-Cal beneficiaries on county probation, parole, or on PRCS are entitled to receive SMHS if they meet medical necessity criteria and SMHS are needed to address the beneficiary's MH needs and goals as documented in the beneficiary's client plan. Additionally, MHBG funding can be used to supplement Medicaid/Medi-Cal by funding those priority treatment and support services that are not covered by Medicaid, Medicare, or private insurance and that demonstrate success in improving outcomes and/or supporting recovery.

In situations where MHSA funds are not allowed to be used to provide services for an individual, counties must ensure that MHSA is not used as the non-federal funding source while still providing SMHS to Medi-Cal eligible beneficiaries.

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g., civil citations, mobile crisis intervention, M/SUD provider ride-along, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

Yes, as indicated in DHCS's response to Question 5, California has implemented efforts to address the MH/SUD service needs of adults and juveniles involved in the criminal justice system that include, but are not limited to, crisis intervention training, screening services, drug courts, diversion programs, reentry/reintegration programs, transitional housing support, comprehensive pre- and post-release rehabilitative programs and services delivered through alternative custody, residential, and outpatient and drop-in centers, as well as live-in programs for offenders serving the last part of their sentence in community programs in lieu of confinement in State prison. These programs and services include linkages to community rehabilitative services and programs focused on skills such as MH/SUD treatment and recovery services, education, housing, family reunification, vocational training and employment services. These programs are coordinated by DHCS through developed linkages with CDCR via county- and provider-level involvement with services made available through various funding streams as stated in DHCS's response to Question 1.

Additionally, as mentioned in our response to Question 4, the California Health and Human Services Behavioral Health Task Force was recently launched to address the urgent MH/SUD needs across California.

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

Yes, enrollment and care coordination efforts for offenders involved in the adult and juvenile justice system are addressed by CDCR. However, DHCS reviews current treatment capacity levels to ensure services needed by future offender populations utilizing Medi-Cal and other state sponsored plans will have access to timely MH/SUD treatment services.

<u>Section 1115 Waiver – Capacity Change in Behavioral Health</u>

The Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver is increasing the SUD treatment system capacity and is expanding the number of available providers certified to offer DMC-reimbursable residential services. Under the waiver, residential services will be available to all Medi-Cal beneficiaries in facilities with no bed limit. Additionally, the waiver's mandate to include evidence based practices (EPBs) requires providers to expand their workforce and workforce training. Workforce increases will allow for greater system capacity and responsiveness to trauma and justice issues with more counselors able to provide treatment and recovery support services. Components of the DMC-ODS portion of the waiver relative to criminal justice and recovery support services contain additional services for this population that may include the following:

- ***Eligibility:*** Counties recognize and educate staff and collaborative partners that an individual's parole and/or probation status is not a barrier to expanded Medi-Cal MH/SUD treatment and recovery support services, as long as the Medi-Cal eligibility requirements are met.
- ***Lengths of Stay:*** Counties understand that additional lengths of stay for withdrawal and residential services for criminal justice offenders are allowable, if assessed for need (e.g., up to six months residential; three months with a one-time 30-day extension, if determined to be medically necessary).
- ***Promising Practices:*** Ensure counties utilize promising practices such as drug court services.

MHSA

As indicated in DHCS's response to Question 1, MHSA funds are distributed to counties on a monthly basis to spend on five components: Community Services and Support; Prevention and Early Intervention; Innovation; Capital Facilities and Technological Needs; and Workforce Education and Training. The MHSA requires each county MH department to prepare and submit a Three-Year Program and Expenditure Plan and annual updates to DHCS and the MHSOAC. The plans and updates are subject to a community planning process that includes stakeholder involvement and approval by the county's board of supervisors.

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

Yes, the State of California recently launched the California Health and Human Services Behavioral Health Task Force to address the urgent MH/SUD needs of Californians. The Behavioral Health Task Force is chaired by the California Health and Human Services Secretary. Task Force members include a broad range of stakeholders, including people living with behavioral health conditions, family members, advocates, providers, health plans, counties, probation departments, the Council on Criminal Justice and Behavioral Health, and State agency leaders. The Task Force will advise the administration's efforts on advancing statewide behavioral health services, prevention, and early intervention to stabilize conditions before they become severe, as well as working toward a behavioral health system that provides timely access to high-quality care for all Californians.

5. Does the state have any activities related to this section that you would like to highlight?

Yes, California has implemented efforts to address the MH/SUD service needs of adults and juveniles involved in the criminal justice system that include, but are not limited to, drug courts, crisis intervention training, and reentry programs to help reduce arrests, imprisonment, and recidivism.

C15 – Crisis Services

Does the State have any activities related to this section that they would like to highlight at this time?

California currently has a robust set of crisis programs aimed at providing the three elements identified by the Substance Abuse and Mental Health Services Administration (SAMHSA): *Someone to talk to, someone to respond, and a place to go*.

These elements are addressed through various funding streams, locations, and providers, supporting a comprehensive continuum of care throughout the state for individuals experiencing behavioral health crises. However, given the exceptionally large and diverse geographic and cultural landscapes within the state, some populations can face challenges accessing care. California must continue to advance its efforts of ensuring all of its services are readily accessible to all of its residents, and it will leverage the newly devised 5 percent Community Mental Health Services Block Grant (MHBG) crisis services set-aside to address current gaps in care.

Current Systems and Efforts

As mentioned above, California already administers multiple crisis programs that address the three core elements of a crisis system. The table below indicates the stages of implementation for each element of the crisis system in California:

Table 1: California Crisis System Implementation Status

	Exploration Planning	Installation	Early implementation Less than 25% of people in state	Middle Implementation About 50% of people in state	Majority Implementation At least 75% of people in state	Program Sustainment
Someone to talk to						X
Someone to respond					X	
Place to go					X	

The geographic and cultural diversity of the state has limited implementation of the elements *Someone to respond* and a *Place to go*, but DHCS' proposed use of the MHBG crisis services set-aside aims to achieve Program Sustainment for those two elements. The discussion of existing crisis system programs and elements below is organized around primary funding streams for clarity sake.

Mental Health Services Act (MHSA)

In 2004, California voters approved Proposition 63, which established MHSA. Unique to California, MHSA is funded by a one percent income tax on personal income in excess of $1 million per year. MHSA is designed to expand and transform California's mental health systems and better serve individuals with and at risk of serious mental health

issues, and their families. MHSA addresses a broad continuum of prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community mental health system.

A component of the MHSA is the California Health Facilities Financing Authority (CHFFA). CHFFA conducted a total of six funding rounds for the SB 82 (2013) Investment in Mental Health Wellness Grant Program: five funding rounds were for mobile crisis support, crisis stabilization and crisis residential treatment, and one funding round was for peer respite care. After the completion of all funding rounds, CHFFA approved 56 grant awards for the benefit of 41 counties. Grant awards totaling $136.5 million utilizing state funds were awarded. Specific to Mobile Crisis Support Teams (MCST), a total of $3 million in state funds was awarded to 15 counties.

Additionally, SB 82 included up to $4 million in MHSA funds for personnel funding in FY 2013-14, of which $3,974,289 was awarded. The $4 million MHSA funding is only available to counties awarded grants for MCSTs in the first and second funding rounds of SB 82 grants. For FYs 2014-15, 2015-16, and 2016-17, $3,998,942 in MHSA funds was awarded each year. The nine counties awarded and receiving personnel funding from MHSA for MCST purposes are Contra Costa, Lake, Los Angeles, Marin, Mendocino, Riverside, Sacramento, San Joaquin, and Santa Barbara.

Finally, DHCS selected Didi Hirsch Psychiatric Service, the largest crisis call center in the state, to provide or arrange for the provision of suicide prevention services to California residents statewide. The contractor accepts calls, or arranges for calls to be accepted, from residents in each of the state's 58 counties, 24/7/365. These services include: Warm Lines, Online Chat Interventions, Survivor Support Groups, Grief Counseling, Mental Health Information and Referral Services, Community Outreach, Follow-Up Services for High Risk Callers, special population dedicated numbers, community training, and research, among other services. Didi Hirsch provides quality mental health and substance use services in communities where stigma or poverty limit access. Accredited by the American Association of Suicidology (AAS), they are a leader in hotline management, with accomplishments like the creation of a data collection system (Crisis Center Common Metrics), being the designated California backup for National Suicide Prevention Lifeline, use of innovative communication techniques (i.e. texting for the hard of hearing), and the longest running program in the state.

Medi-Cal Specialty Mental Health Services (SMHS)

DHCS administers California's Medicaid (Medi-Cal) program. The Medi-Cal SMHS program is "carved-out" of the broader Medi-Cal program, and operates under the authority of a waiver approved by CMS under section 1915(b) of the Social Security Act. As the single state Medicaid agency, DHCS is responsible for administering the Medi-Cal SMHS Waiver Program, which provides SMHS to Medi-Cal beneficiaries through county Mental Health Plans (MHPs). DHCS contracts with each of the 56 MHPs. The MHPs are required to provide or arrange for the provision of SMHS to beneficiaries in their counties that meet SMHS medical necessity criteria, consistent with the beneficiaries' mental health treatment needs and goals as documented in the beneficiaries' client plans. SMHS provided by MHPs include a broad array of

rehabilitative outpatient mental health services as well as acute inpatient psychiatric hospital services. Crisis services include crisis intervention, crisis stabilization, crisis residential, and therapeutic behavioral services.

Crisis Intervention Services

Crisis intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral, and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary's significant support person and may be provided anywhere in the community.

Crisis Stabilization Services

Crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers.

Crisis Residential Services

Crisis residential services provide an alternative to acute psychiatric hospital services for beneficiaries who otherwise would require hospitalization. The services follow a social rehabilitation model that integrates aspects of emergency psychiatric care, psychosocial rehabilitation, milieu therapy, case management and practical social work.

Therapeutic Behavioral Services (TBS)

Therapeutic behavioral services are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish outcomes specified in the written treatment plan.

Federal Fiscal Year 2021 and 2022 MHBG Crisis Activities

Utilizing Coronavirus Response and Relief Supplemental Appropriations (CRRSAA) MHBG funding, DHCS released a competitive funding opportunity in July 2021 to select an organization to develop and manage a centralized Crisis Care Mobile Units (CCMU) program. This centralized CCMU Program Administrator will develop, manage, and/or subcontract CCMUs.

The CCMU program will make funding available to California county or city behavioral health agencies, or joint applications of city or county behavioral health agencies to support and expand behavioral health mobile crisis and non-crisis services. A CCMU program must:

- Provide services to individuals experiencing behavioral health crises, including mental health crises, substance use crises, or co-occurring mental health and substance use crises;
- Prioritize services to individuals 25 and younger, which may include activities such as conducting needs assessments for youth services; placing mobile units near schools and universities, outreach, public education campaigns, and taking measurable steps towards addressing the youth and young adult crisis needs within the community;
- Include appropriate staff, acting within their scope, who can assess the needs of individuals within the region of operation and provide direct treatment services, and a licensed mental health professional to oversee the program, in accordance with Welfare and Institutions Code § 5848.7;
- Develop mobile crisis services available to reach any person in the service area in a home, school, workplace, or any other community-based location in a timely manner; and
- Connect individuals to facility-based, or other follow-up care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

DHCS is offering two separate tracks of funding. Applicants may apply for either Track 1 or Track 2 funding, but not both:

- Track 1 – Planning grants for up to $200,000 to assess the need, and develop an action plan to address the need of mobile crisis and non-crisis programs; and
- Track 2 – Implementation grants for up to $1 million for each new or expanded CCMU team.

The total funding amount available for this project is $205 million. $150 million will be available for Infrastructure development and support from September 15, 2021 through June 30, 2025 (through State General Funds) and $55 million (through CRRSAA funds) will be available for direct services or infrastructure from September 15, 2021 through February 14, 2023.

All eligible applicants will receive a non-competitive Implementation Grant Base Allocation of $500,000 each. All applicants may apply for less than the $500,000 Base allocation.

DHCS will make additional FFY 2022 MHBG funding available to CCMU grantees to increase funding allocations made during the initial funding round.

General County Crisis Set-Aside

DHCS will directly allocate funding to counties to support evidence-based crisis care programs addressing the needs of individuals with serious mental illness and children with SED.

The following crisis services will be allowable and recommended uses of American Rescue Plan Act (ARPA) MHBG funds:

- Crisis stabilization services at facilities providing short-term (under 24 hours) observation to all referrals in a home-like, non-hospital environment;
- Crisis intervention training and programs for law enforcement and other first responders. Specifically, funding can be used to embed social workers, counselors, case managers, and peer support specialists with local law enforcement during emergency responses;
- Supplemental funding for crisis mobile services;
- Supplemental funding for crisis call centers that provides crisis intervention capabilities through telephone, text, and chat). Such a service will be required to meet National Suicide Prevention Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time;
- Staff administrative and clinical salaries in crisis;
- Screening and diagnosis;
- Peer support;
- Minor remodeling;
- Short-term residential crisis stabilization beds;
- Treatment planning,
- Referral services;
- Case management;
- Care coordination;
- Outreach; and
- Evidence-based protocols for delivering services to individuals with suicide risk.

1) Please indicate if the State's crisis response system provides services to children in crisis, either through the same resources as used for adults, or via a separate system.

Yes, California's crisis response system provides services to children in crisis utilizing a multitude of funding sources, including Medi-Cal, Mental Health Services Act (MHSA), MHBG, private insurance, and others. The Mental Health Services Oversight and Accountability Commission (MHSOAC) and the California Health Facilities Financing Authority (CHFFA) are both authorized to award grants to counties to address a continuum of crisis services for adults and children.

In 2016, Senate Bill 833 (Section 20) expanded the Investment in Mental Health Wellness Act to specifically address a continuum of crisis services for children and youth, 21 years of age and under and allocated funding to develop four mental health programs - crisis residential treatment, crisis stabilization, mobile crisis support teams and family respite care. The grants from CHFFA are disbursed to California counties or to their nonprofit or public agency designees to support capital improvement, expansion and limited start-up costs.

For more information on these programs, please visit the links below:

MHSOAC Triage Program

CHFFA - Investment in Mental Health Wellness Act

2) Please indicate the current state of mobile crisis services.

California's crisis services are primarily administered by its counties. Counties may expend Medi-Cal, MHSA, and MHBG funds on mobile crisis services, but it is not specifically required. MHSA administrative funds are used to provide crisis services, including mobile crisis services, through the Investment in Mental Health Wellness Act (Senate Bills 82/2013 and 833/2016).

Counties are required to develop MHSA Three-Year Program and Expenditure plans through an extensive stakeholder process that includes a community comment period and approval of the plan by the local board of supervisors. As programs are developed based on a county's needs, not all counties will establish a mobile crisis program. DHCS has attached a document titled, "MHSA Mobile Crisis Services" that provides information on MHSA-funded mobile crisis programs, as presented in Three-Year Program and Expenditure plans or annual updates.

Counties utilize MHBG funding to supplement mobile crisis programs. Funded programs include: law enforcement crisis intervention teams; mobile crisis teams that respond and connect individuals to a variety of community supports and treatment services; youth-focused mobile crisis teams; bilingual and bicultural community-based mobile teams; and mobile outreach services for homeless individuals and those in danger of becoming homeless. DHCS' goal through the Crisis Set-Aside is to establish and provide a standardized statewide system of mobile crisis units.

3) Please indicate whether or not the current crisis stabilization services open to anyone, regardless of payer and not limited to Medi-Cal recipients.

California's crisis stabilization services are open to anyone and not limited to Medi-Cal recipients, as various payer sources may be utilized, to include MHSA, MHBG, and private insurance.

4) Please describe, if available, how the state plans on coordinating 988 with its crisis services?

California's 988 planning project is currently in development. The project is funded by

Vibrant Health, is an 8-month project to develop a plan for the implementation of 988 in the state. A state-level leadership team, comprised of DHCS, the California Department of Public Health, MHSOAC, and the Steinberg Institute are providing policy support to Didi Hirsch Psychiatric Services, who is serving as the fiscal agent and implementer of the planning project. All of California's 13 National Suicide Prevention Lifeline centers are participating in the project.

5) Please indicate the following: Does the contractor for crisis calls, Hirsch Psychiatric Services, dispatch mobile crisis staff? This is due by 3/24/2021.

Didi Hirsch Psychiatric Services does not currently dispatch mobile crisis staff.

C16. Recovery - Required

Please respond to the following:

1. **Does the state support recovery through any of the following:**

   a) **Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?** *(**Yes** or No)*
   b) **Required peer accreditation or certification?** *(Yes or **No**)*
   c) **Block grant funding of recovery support services.** *(**Yes** or No)*
   d) **Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system**? *(**Yes** or No)*

2. **Does the state measure the impact of your consumer and recovery community outreach activity?** *(Yes or **No**)*

3. **Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.**

   The California Department of Health Care Services (DHCS) is committed to our mission to ensure the overall health and well-being of all Californians. Through the combined and coordinated efforts of health care providers, health plans, county and federal officials, other state agencies, community groups and all the other stakeholders concerned with Californians' health, we work to attain a system that promotes effective, efficient and integrated care. All mental health programs within California utilize recovery as a core principle. SAMHSA's working definition of recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

   This recovery principle is woven into California's State Plan for Medicaid, which covers rehabilitative behavioral health services for beneficiaries as part of a comprehensive behavioral health program. These services are available to all beneficiaries who meet medical necessity criteria established by the State. As specified in the State Plan, services are to be provided consistent with wellness, recovery, and resiliency principles, which align with the concept of person-centered care.

   Under the Mental Health Services Act (MHSA), all programs developed with MHSA funds must include provisions consistent with the recovery model. The MHSA includes six general standards: 1) community collaboration; 2) cultural competence; 3) client driven; 4) family driven; 5) wellness, recovery, and resilience focused; and, 6) integrated service experience for clients and their families. Each client is required to have an Individual Services and Supports Plan (ISSP) which is developed collaboratively with the client, and when appropriate the client's family. Client supports include "whatever it takes" services to help individuals on their path

to recovery and wellness. These services may include housing, employment, education and peer support services. In support of SAMHSA's working definition of recovery, California will continue to utilize state and federal funding in the development of our program design efforts to advance recovery and improve overall consumer health and well-being.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Through statewide prevention and treatment programs utilizing State Plan Drug Medi-Cal, the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program, the Substance Abuse Block Grant, the California Medication Assisted Treatment (MAT) Expansion Project and the integration of Prepaid Inpatient Health Plans (PIHP), certified DMC providers, community resources, and additional county, state, and federal agencies DHCS works to promote the overall health and well-being of all Californians throughout the substance use disorder treatment process. Treatment is designed to emphasize the beneficiary's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management.

Drug Medi-Cal SUD treatment services include: Early Intervention, Outpatient Services, Intensive Outpatient Services, Residential Treatment Services, Perinatal Treatment Services, Withdrawal Management Services, Narcotic Treatment Program Services and other Medication Assisted Treatment Services, Physician Consultation, Case Management, and Recovery Services. All SUD treatment services are based on an individual assessment and medical necessity determination. The beneficiary's individualized treatment plans may include: individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.

The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery.

Further support is provided to beneficiaries after completing their course of treatment through recovery services, a required benefit in counties that participate in DMC-ODS. The components of recovery services are:

- **Outpatient Counseling Services** in the form of individual or group counseling to stabilize the beneficiary and reassess if further care is needed;
- **Recovery Monitoring**, including recovery coaching and monitoring via telephone/telehealth;
- **Substance Abuse Assistance**, including peer-to-peer services and relapse prevention;
- **Support for Education and Job Skills**, such as linkages to life skills, employment services, job training, and education services;
- **Family Support**, such as linkages to childcare, parent education, child development support services, and family/marriage education;
- **Support Groups**, including linkages to self-help and faith-based support; and
- **Ancillary Services**, such as linkages to housing assistance, transportation, case management, and individual services coordination.

5. Does the state have any activities that it would like to highlight?

In an effort to address the opioid epidemic throughout the state, DHCS is implementing the California MAT Expansion Project which aims to increase access to medications for addiction treatment, reduce unmet treatment need, and reduce opioid overdose related deaths through the provision of prevention, treatment, and recovery activities. The California MAT Expansion Project focuses on populations with limited MAT access, including rural areas and American Indian & Alaska Native tribal communities.

Recovery Housing

The MAT Expansion Project has funded the development of supportive housing projects, which provide recovery support services in a residential setting to individuals seeking treatment for opioid use disorder.

In San Francisco, Health Right 360 is providing access to recovery residence transitional housing and peer support for homeless individuals with OUD to facilitate continued engagement in SUD treatment and related recovery support services. In the next iteration of the project, the program will also be available to individuals with stimulant use disorders (i.e., addiction to substances like cocaine and methamphetamine).

Riverside County is also implementing a recovery housing project, with a focus on recovery residences, supportive housing, and treatment services for individuals with an opioid or stimulant use disorder.

New recovery housing programs based in the Northern and Central parts of California are beginning in late summer 2021.

Young People in Recovery

Young People in Recovery (YPR) is a recovery support services organization focused on creating recovery-ready communities throughout the nation for young people in, or seeking, recovery. YPR has partnered with DHCS to launch YPR chapters and life-skills curriculum programs to individuals in recovery from opioid use and substance use disorders.

To Date, YPR has served 2,800 Californians across its programs and chapters in the state, and has held over 215 events. We look forward to continuing to serve more Californians and to making all California communities recovery-ready.

To learn more about implementation efforts and access additional resources and information, please visit www.californiamat.org.

C18. Children and Adolescents Behavioral Health Services – (Required MHBG)

Please respond to the following:

1. **Does the state utilize a system of care approach to support:**
   a) **The recovery and resilience of children and youth with SED?** (***Yes*** or No)
   b) **The recovery and resilience of children and youth with SUD?** *(**Yes** or No)*

2. **Does the state have an established collaboration plan to work with other child- and youth- serving agencies in the state to address behavioral health needs:**
   a) **Child welfare?** *(**Yes** or No)*
   b) **Juvenile justice?** *(**Yes** or No)*
   c) **Education?** *(**Yes** or No)*

3. **Does the state monitor its progress and effectiveness, around:**
   a) **Service utilization?** *(**Yes** or No)*
   b) **Costs?** *(**Yes** or No)*
   c) **Outcomes for children and youth services?** *(**Yes** or No)*

4. **Does the state provide training in evidence-based:**
   a) **Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?** *(**Yes** or No)*
   b) **Mental health treatment and recovery services for children/adolescents and their families?** *(**Yes** or No)*

5. **Does the state have plans for transitioning children and youth receiving services:**
   a) **to the adult behavioral health system?** *(**Yes** or No)*
   b) **for youth in foster care?** *(**Yes** or No)*

6. **Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)**

   California's Medicaid program, Medi-Cal, provides physical health, mental health, and substance abuse treatment services to eligible low-income individuals. For individuals under the age of 21, the Early and Periodic, Screening and Diagnosis and Treatment (EPSDT) program provides comprehensive and preventive health services, including preventive dental, mental health, developmental, and specialty services.

   Medi-Cal covers a broad array of mental health services for children and youth under the age of 21. This includes the SMHS described above. TBS, ICC, IHBS

and TFC are SMHS that are available only to children and youth under the age of 21.

DHCS works very closely with the California Department of Social Services (CDSS) to address the mental health care needs of children and youth in the child welfare system (this includes children and youth in foster care as well as children and youth who are also involved in the probation system). To this effect, both departments have worked together to implement ICC, IHBS and TFC services as well as the Core Practice Model (CPM). The CPM describes a significant shift in the way that child welfare and mental health systems and individual service providers are expected to address the mental health needs of children, youth, and families in the child welfare system. The Child and Family Team (CFT) is a cornerstone of the Core Practice Model and is integral in providing ICC, IHBS, and TFC. The team is composed of youth, family, natural supports, child welfare, behavioral health, and any ancillary individuals involved in the youth's treatments. No single individual, agency or service provider works independently but rather as part of the team for decision-making that follow the values and goals of the Core Practice Model. The Core Practice Model ensures the inclusion of children and their family in a multidisciplinary decision-making process regarding the provision of services to best meet the needs of the child.

To support the implementation of ICC, IHBS, TFC and the Core Practice Model, DHCS and CDSS have established a Shared Management Structure (SMS) to provide policy and program direction with clear and consistent guidance, and develop outcome and accountability measures consistent with the Core Practice Model (CPM). The SMS consists of a Transformation Manager/Facilitator and two leadership teams—the Executive Team (ET) and the Community Team (CT). The Transformation Manager/Facilitator provides staff support and facilitation for both of the shared management teams and reports directly to the ET. The ET is composed of senior leadership from both departments and it provides leadership and decision-making in the implementation of Child Welfare/Mental Health state interagency and intra-agency collaborative policy and practice consistent with the Core Practice Model. The CT is comprised of family and youth members, advocates, providers, county representatives and state representatives from the ET. The role of the CT is to ensure that stakeholders are engaged and equal partners in leading the collaborative effort to change policy and practice. The CT provides leadership, advice, and feedback about state policies and programs relevant to service delivery, data collection, quality improvement, and accountability regarding child welfare youth and families who need mental health services.

DHCS and CDSS have also established a Memoranda of Agreement (MOA) articulating interagency policies and procedures, in order to better coordinate child

welfare and mental health systems, program, and practice efforts that will serve child welfare youth with mental health needs.

Furthermore, DHCS and CDSS have implemented a data exchange to match specified data elements regarding Medi-Cal eligible children and youth who are involved in the Child Welfare System. This data match provides the departments information about their shared populations that will allow the departments to conduct analysis regarding access to mental health services and outcomes for children in the welfare system.

Within the Mental Health Services Act (MHSA), Community Services and Supports funding must be used to provide services that are integrated. The county shall give priority to underserved populations with serious mental illness and/or serious emotional disturbance. Each client that is enrolled in a Full Service Partnership is assigned a Personal Service Coordinator that is responsible for assisting the client and the client's family with accessing needed medical, educational, social, vocational rehabilitation and/or other community services. State policies regarding the plans for transitioning children and youth receiving services are directed to counties. Counties are required to develop a coordinated system for mental health services.

Within the MHBG, some counties receive allocations for special programs. One of those special programs, established and operationalized through departmental policy, is an integrated system of care for children who have a SED. Seven counties receive a fixed allocation for the Children System of Care (CSOC) program that is set at the level they received from the 1994 MHBG. Those counties are Humboldt, Los Angeles, Merced, Monterey, Placer, San Luis Obispo and Stanislaus. These counties are to ensure the following four goals are met: Interagency Collaboration, Defined Service Populations, Family Involvement and Outcomes. In addressing the goal of Interagency Collaboration, counties are to ensure partnerships with Child Welfare, Juvenile Justice, Social Services, and Public Health to address the needs of the client using the multidisciplinary approach in providing integrated services; Defined Service Populations which ensures consistency with existing federal and state statute; Family Involvement to foster meaningful participation of parents and family members within all aspects of services planning, evaluation and policy development and Outcomes which is useful for internal evaluation and program development purposes.

7. Does the state have any activities related to this section that you would like to highlight?

DHCS continues its collaborative efforts with CDSS in the implementation of Continuum of Care Reform. On October 11, 2015 Governor Edmund G. Brown Jr.

signed legislation (AB 403) that comprehensively reforms placement and treatment options for youth in foster care.

The Continuum of Care Reform draws together a series of existing and new reforms to the child welfare services program designed out of an understanding that children who must live apart from their biological parents do best when they are cared for in committed nurturing family homes. AB 403 provides the statutory and policy framework to ensure services and supports provided to the child or youth and his or her family are tailored toward the ultimate goal of maintaining a stable permanent family. Reliance on congregate care should be limited to short-term, therapeutic interventions that are just one part of a continuum of care available for children, youth and young adults.

The fundamental principles of the Continuum of Care Reform are:

- All children deserve to live with a committed, nurturing and permanent family that prepares youth for a successful transition into adulthood.
- The child, youth and family's experience and voice is important in assessment, placement and service planning. A process known as a "child and family team," which includes the child, youth and family, and their formal and informal support network will be the foundation for ensuring these perspectives are incorporated throughout the duration of the case.
- Children should not have to change placements to get the services and supports they need. Research shows that being placed in foster care is a traumatic experience and in order for home-based placements to be successful, services including behavioral and mental health should be available in a home setting.
- Agencies serving children and youth including child welfare, probation, mental health, education and other community service providers need to collaborate effectively to surround the child and family with needed services, resources and supports rather than requiring a child, youth and caregivers to navigate multiple service providers.
- The goal for all children in foster care is normalcy in development while establishing permanent life-long family relationships. Therefore, children should not remain in a group living environment for long periods of time.

The Continuum of Care Reform recognizes that achieving this goal requires a high degree of collaboration and coordination between Child Welfare Departments and county Mental Health Plans.

DHCS is committed to this comprehensive reform effort and supports the intent to achieve better outcomes for all children and youth. This reform effort will support the transition of children and youth placed in Short-Term Residential Therapeutic

Programs back to family-based settings as quickly as possible. It will ensure a more coordinated care approach for children and youth who have a serious emotional disturbance and/or need SMHS. By reforming the group home system from the ground up, both DHCS and CDSS seek to provide better, more appropriate care and services for children and youth in home-based settings, as well as to reduce the time a child spends in congregate care settings.

C19. Suicide Prevention – (Required for MHBG)

Please respond to the following:

1. **Have you updated your state's suicide prevention plan in the last 2 years?** (**Yes** or No)

   The Mental Health Services Oversight and Accountability Commission is tasked with developing a State Suicide Prevention Plan. DHCS provided stakeholder input into the development of the draft plan. The current plan is effective from State Fiscal Year (SFY) 2020 through SFY 2025 and is published here.

2. **Describe activities intended to reduce incidents of suicide in your state.**

   California's Suicide Prevention Plan is framed by Four Strategic Aims.

   1. Establish a Suicide Prevention Infrastructure

      Similar to other public health challenges, preventing suicide statewide demands a strong infrastructure of information, expertise, evaluation, and communication. This infrastructure must support the systematic delivery of best practices, so success is not dependent on the valiant efforts of a single person, agency, or setting. Everyone can potentially play a role in suicide prevention. Information must be disseminated through trusted channels. Leaders must sustain suicide prevention as a public health priority and define the roles that partners play in planning, delivering, and monitoring efforts. Resources must be integrated and coordinated. Data must be standardized and routinely collected and monitored.

   2. Minimize Risk for Suicidal Behavior by Promoting Safe Environments, Resiliency, and Connectedness

      Risk for suicide in all communities can be reduced by reducing environmental threats to safety, while building individual, family, and community resiliency. People at risk for suicide often experience extreme ambivalence about the desire to die or live, and experience a high degree of suffering. Eliminating or reducing access to a lethal method, such as a gun, creates time and opportunity for intervention during what are often transient crises. People can be taught skills to manage stressors, and to understand when they need to reach out for additional support. Increasing social connectedness can reduce stigma and isolation. Media, including the entertainment industry, can prevent suicide through responsible reporting of suicide death, by destigmatizing mental health needs, and by highlighting mental health resources.

   3. Increase Early Identification of Suicide Risk and Connection to Services Based on Risk
      Risk may elevate for some despite efforts to create safe environments and

build resiliency. Anyone can recognize the warning signs of suicide and can learn to communicate effectively with people at risk to determine the type of support needed. Screening tools can identify people at risk for suicide in many settings, while brief interventions – like those used for problem alcohol use – empower people at risk to recognize their personal warning signs, identify coping strategies and a supportive social network, reduce access to lethal means, and seek professional help to manage suicide crises. Crisis services and support also can assist with assessing for suicide risk and connection to services, and must be widely available, accessible, and varied to benefit the diverse range of people in need of help.

4. Improve Suicide-Related Services and Supports

Timely services and supports must be available to people experiencing suicidal behavior, especially attempted suicides, and people experiencing the suicide death of a loved one. Mental health and substance use disorder providers must be equipped to help those at risk and trained to deliver care that reflects best practices. For example, low-cost, high-impact post-hospitalization postcards and referral services are effective strategies for preventing future suicidal behavior and must be a standard component of aftercare following hospital or emergency department discharge. Swift response to support families, loved ones, and, in some cases, entire communities, must follow every suicide.

Utilizing Mental Health Services Act (MHSA) funds, the California Mental Health Services Authority (CalMHSA) recently updated materials related to Each Mind Matters, a large statewide program focused on suicide prevention. In May 2019, Each Mind Matters created the Mental Health Matters Month activation kit to include tools and activities designed to help build resilient communities and decrease suicide rates.

At the local level, counties may use the Prevention and Early Intervention component of MHSA funding to provide trainings such as Applied Suicide Intervention Skills Training (ASIST), Applied Suicide Intervention Skills Training for Trainers, and Assessing and Managing Suicide Risk (AMSR). During FY19-20 and ongoing, $4.3 million in MHSA administrative funding is available to support suicide hotlines throughout the State.

3. Have you incorporated any strategies supportive of Zero Suicide? (**Yes** or No)

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (**Yes** or No)

5. Have you begun any targeted or statewide initiatives since the FFY 2020 -

2021 plan was submitted? (**Yes** or No)

If so, please describe the population targeted.

California's approach to suicide prevention is broad, but efforts will specifically target those who are at most risk to die by suicide or engage in suicidal behavioral. Data indicates a need to target the needs of males, who in 2017, died by suicide at a rate more than three times higher than the rate of females in the state. Those who are aged 85 and older additionally had the highest suicide rate of any age group. Suicide rates in California are also highest among whites (17.1 per 100,000 people) and (Native Americans 15.6 per 100,000 people). In 2017, there were 640 suicides by Californians aged 18 years and older who had served in the U.S. Armed Forces, accounting for 15.3 percent of all suicides in California that year. The majority of current and former service members who died by suicide were male (96.7 percent) and white (79 percent); and 43 percent were between the ages of 25 and 64 at the time of death. Additionally, 40 percent were between the ages of 65 and 84 at death.

California's approach is to target all vulnerable populations, particularly those defined below. It is important to note, however, that regardless of group membership, suicide most often occurs among people with mental health needs.

People in Middle and Older Age

Suicide rates among people in middle age – 35 to 64 years of age – are increasing. Between 1999 and 2010, suicide rates among people in middle age have increased nearly 30 percent, especially among people aged 50 to 59.193 In 2017, people of middle age represented 25.9 percent of the U.S. population but 35.1 percent of people who died by suicide. Historically, older adults – or people over the age of 65 - have had the highest rates of suicide. In 2017, this group represented 15.6 percent of the U.S. population but accounted for 18.2 percent of all suicides. The high suicide rates among older adults may be driven by factors such as use of highly lethal means; unmet health, mental health, and substance use disorder needs, especially late-life onset of depression; personality traits and coping mechanisms; life stressors, such as the loss of loved ones; social disconnection; and impairments in functioning and disability.

People Discharged from Hospital Settings

People seen in emergency departments for self-injury, regardless of their intent to die, are 30 times more likely to die by suicide than people who do not self-injure. People discharged from psychiatric hospitalization are at especially high risk for future suicide and suicidal behavioral. Suicide risk increases during the first week of admission to a psychiatric hospital and during the first week after discharge. For veterans, one study showed that suicide risk may be elevated during the first three months following discharge from a psychiatric hospital.

Common challenges that increase risk following discharge include missed follow-up appointments for outpatient care; a lack of resources or connection to such resources; unsupportive relationships or social networks, resulting in isolation and shame; and referrals that do not match individual needs.

Veterans

Veterans account for approximately 14 percent of all suicides in the U.S. More than half of the veterans who die by suicide are 55 years of age or older, but the suicide rate among veterans between the ages of 18 and 34 has increased by 11 percent, rising from a rate of 40.4 deaths per 100,000 people in 2015 to 45 deaths per 100,000 people in 2016. Data show that nearly 70 percent of veteran suicides are by firearm, compared to less than 50 percent of all non-veteran suicides. This fact underscores the importance of considering the means by which vulnerable group members die by suicide in any suicide prevention strategy. Veterans have unique risk and protective factors related to military service, in addition to factors previously mentioned. Protective factors include a strong sense of belongingness to a unit and resilience to withstand adversity. On the other hand, transitioning out of military service may increase suicide risk. Stressful experiences during this transitional period include a loss of purpose and sense of identity, difficulties securing employment, conflicted relationships with family and friends, and other challenges related to adapting to post-military life.

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, transgender, queer, and questioning people may be at increased risk for suicide. Currently, it is difficult to evaluate risk for suicide among LGBTQ people because sexual orientation and gender identity are not reported in death records. Healthcare settings, such as hospitals and emergency departments, also do not report sexual orientation and gender identity of people seen for suicide-related services, making it even more difficult to evaluate suicidal behavior among this vulnerable group. Self-report surveys of suicidal behavior are the primary source of data. One survey of youth in primary care estimated that 20 percent of lesbian, gay, and bisexual youth have attempted suicide. Suicide risk also is elevated among transgender people. One study showed that 40 percent of transgender people attempted suicide at least once in their lifetime, with 92 percent of those making the attempt before the age of 25. Studies indicate that as many as 50 percent of transgender and gender non-conforming youth have attempted suicide. Rejection of sexual orientation and gender identity by family and caregivers may significantly increase risk for suicide among LGBTQ youth, highlighting the need to include family-based interventions in suicide prevention efforts.

Youth of Color

American Indian and Alaska Native youth and young adults have the highest rate of suicide of any cultural or ethnic group in the United States. Suicide is the second leading cause of death for American Indian and Alaska Native children and adults ages 10 to 34. A recent study found that African American children ages five to 12 – both boys and girls - are dying by suicide at twice the rate compared to white children. This finding highlights the need for continuous evaluation using the Public Health Model, as new at-risk groups emerge. Youth attempt suicide at greater rates than people of other ages. Racial and ethnic differences also are found among suicidal behavior. Latina adolescents, in particular, report the highest rates of suicidal behavior of any youth group. As many as one in seven Latina youth attempt suicide, a rate greater than any other youth group of the same age.

Rural Community Residents

People living in rural communities are at greater risk for suicide than those in more urban or densely populated communities. Many rural communities feature characteristics with risk factors for suicide, such as gun ownership, social isolation, and difficulty accessing health, mental health, and substance use disorder care, and social services. Even if services are available in rural communities, additional challenges can affect the quality and timeliness of access. These include:

- A shortage of health care providers to conduct preventative assessments and offer referrals and warm handoff to needed services, especially services focused on suicide risk
- Limited numbers of qualified, culturally competent providers and staff
- Transportation, particularly in areas where people must travel long distances to seek services
- Insurance coverage that is accepted by the practitioner or provider
- Language barriers that prevent people from communicating with service providers
- Privacy concerns, especially for residents seeking mental health services in small communities

People Working in Certain Occupations

People in certain occupations are at increased risk for suicide. Characteristics of occupations where risk might be elevated include jobs that are socially isolating; involve a high level of stress; are low paying or cause an increasing student loan debt-to-income ratio; expose employees to violence or traumatic events; are fast-paced and require long hours; or are inconsistent, such as seasonal work. Construction and mining occupations carry particularly high risk, with the largest percentage – 20 percent in 2015 — of men who die by suicide working in those trades. Arts, design, entertainment, sports, and media occupations have the

highest rates of suicide among both women and men. People in other occupations with increased risk include first responders, such as police, firefighters, and paramedics; physicians; nurses; and veterinarians.

Women During the Perinatal and Postpartum Period

Suicide is a leading cause of death during pregnancy and one year postpartum, also known as maternal suicide, and suicidal ideation has been detected in the range of 13.1 percent to 33 percent of pregnant women. Risk factors for maternal suicide include sleep disturbances, depression, anxiety, a postpartum psychosis diagnosis, and a bipolar disorder diagnosis. Maternal suicide risk is not just limited to the immediate postpartum period. The highest risk for maternal suicide occurs at nine to 12 months postpartum.