MADERA COUNTY
BEHAVIORAL HEALTH ADVISORY BOARD

AGENDA

SEPTEMBER 21, 2022
11:30AM – 1:00PM

IN-PERSON MEETING AND VIRTUAL VIA ZOOM

https://us06web.zoom.us/j/87102682445?pwd=WS9Zekc0dGZUNGZpTjk0UXRJYWVRZz09

Meeting ID: 871 0268 2445
Passcode: 684012

The meeting documents are available in hard copy at Madera County Behavioral Health Services (BHS) at 209 East Seventh Street, Madera, CA 93638 and electronically at the BHS Website https://www.maderacounty.com/government/behavioral-health-services

In compliance with the American with Disabilities Act (ADA), auxiliary aids and services for this meeting will be provided upon request when given three-day notice.

Steven Mortimer Chair- District 3	Donald Horal Vice Chair-District 3	Leticia Gonzalez Board of Supervisor District 4	Bertha Avila District 1

Wendy Hicks District 2	Eric Oxelson District 3	Lori Prentice District 4	Loraine Goodwin District 4	Dawn Garcia District 5

Sadek Alammari District 1	Maria Simmons District 2	Ginger Prentice District 5	Jennifer Mullikin District 5

CALL TO ORDER

A. ROLL CALL

B. APPROVAL OF MINUTES

Action Item: Approval of the Minutes of August 17, 2022, Meeting.

C. APPROVAL OF AGENDA

Action Item: Approval of the Agenda for September 21, 2022, Meeting.

D. ANNOUNCEMENTS

E. BOARD OF SUPERVISORS APPROVED AGENDA ITEMS

8/16/22 BOS APPROVED ITEMS

1. Community Action Partnership of Madera County
2. Promesa Behavioral Health

3. Willow Glen Care Center
4. Native Solutions BOS Support Resolution for DHCS to License Driving Under the Influence Program in Oakhurst Region

9/13/22 BOS APPROVED ITEMS

1. First Behavioral Health Urgent Care Center for Telehealth Services FY22-23
2. Department of Health Care Services Agreement for Specialty Mental Health Services for Fiscal Years 2022-2027
3. Center for Discovery for Eating Disorder Treatment Services FY22-23
4. California Mental Health Services Authority Agreement with Department of State Department of State Hospitals for State Hospital beds FY22-23
5. Fremont Hospital Amendment for Psychiatric Inpatient Care FY22-23
6. Centro Binacional Para El Desarrollo Indigena Oaxaqueno for the Provision of Indigenous language interpreting services FY22-23
7. Proclamation Naming September 2022 as National Suicide Prevention Month and September 10, 2022, Declaring as World Suicide Prevention Day.

F. PUBLIC COMMENT PERIOD

The Public may address the Board on any matter pertaining to Madera County Department of Behavioral Health Services that is not on the agenda; however, the Board is prohibited by law from taking any substantive action on matters discussed that are not on the agenda. Each person is limited to 3 minutes.

G. COMMITTEE REPORTS

The Chairperson and/or Committees may report about various matters involving Madera County Behavioral Health Services. There will be no Board discussion except to ask questions or refer matters to staff. No action will be taken unless listed in a previous agenda.

1. CHAIRPERSON/COMMITTEE CHAIR REPORTS (Each report is limited to 10 minutes)
   a. Standing Committees
      1.) Executive Committee (Chair, Vice-Chair & AOD Committee Chair)
      2.) AOD Committee (Don Horal, Loraine Goodwin)
      3.) Membership Nominating Committee (Steve Mortimer, Dawn Swinton, Connie Moreno-Peraza)
   b. Ad Hoc Committees
      1.) Strategic Planning
      2.) Outreach (Ms. Loraine Goodwin)

2. DISCUSSION/ACTION ITEMS
   The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family-member driven, recovery oriented, culturally, and linguistically responsive, and cost effective. The Council requires counties to submit an annual Data Notebook and go get input from their Behavioral Health Advisory Boards. Madera County Department of Behavioral Health Services has prepared the Annual 2022 Data Notebook Survey Response for your review, input, and support to submit it timely and before October 28, 2022.

   Action Item: Support MCDBHS to submit the prepared Data Notebook for 2022 to the California Behavioral Health Planning Council by or before October 28, 2022.

H. DIRECTOR'S REPORT – Connie Moreno-Peraza, LCSW, Director, Department of Behavioral Health Services (DBHS)

1. Madera County National Suicide Prevention Month -Overview of Planned Activities in September" by Sylvia Romero, PEI Coordinator & Chair MTFP
2. Madera County Crisis Services, CalAIM BHCIP CCMU-Overview of Madera County Department of Behavioral Health Services C.A.R.E.S. Team, by Bethany Shakespeare, Division Manager, Crisis Continuum Services

The Behavioral Health Services Director will report to the Board about various matters involving Madera County Behavioral Health Services. There will be no Board discussion except to ask questions or refer matters to staff, and no action will be taken unless listed on a previous agenda.

J. Presentation: "Central Valley Suicide Prevention Hotline: 988 Implementation and Impacts on Madera County" by David Lopez, LMFT, Kings View Corporation

K. AGENDA ITEMS FOR FUTURE MEETING

L. CONFIRMATION OF MEETING DATE/ADJOURNMENT

The next meeting will be October 19, 2022, 11:30am-1:00pm, in-person and/or virtual, via zoom.

BOARD MEMBERS WHO ARE <u>NOT</u> GOING TO ATTEND A MEETING, PLEASE CONTACT MELISSA TORRES, AT 673-3508, EXT. 1225, BY NOON ON THE MONDAY PRIOR TO THE MEETING.

PACKET ATTACHMENTS

Behavioral Health Advisory Board August 17, 2022, Minutes

Behavioral Health Advisory Board Agenda September 21, 2022

Madera County Department of Behavioral Health Services 2022 Data Notebook

CALBHB/C Central Region Meeting and Training Announcement

MEMBER ATTACHMENTS
Attendance Records
Behavioral Health Services Board of Supervisors Agenda Items 08/16/2022-09/13/2022

ARTICLES/DOCUMENTS OF INTEREST

CONTACT INFORMATION
Madera County Department of Behavioral Health Services

PO Box 1288

Madera, CA 93639 (559) 673-3508

MCDBHS Director: Connie Moreno-Peraza, MSW, LCSW

Secretary/BHAB Liaison: Melissa Torres, Program Assistant I

MADERA COUNTY BEHAVIORAL HEALTH

ADVISORY BOARD

MEETING MINUTES

August 17, 2022

IN-PERSON/ZOOM

MEETING

11:30 AM - 1:00 PM

CALL TO ORDER:

Attendee Name	Title	Call to Order time
Steven Mortimer	Behavioral Health Advisory Board Chairperson	11:36 AM

A. ROLL CALL

Attendee Name	Title	Status
Sadek Alammari	Board Member District 1	Present
Bertha Avila	Board Member District 1	Absent
Maria Simmons	Board Member District 2	Absent
Wendy Hicks	Board Member District 2	Absent
Steven Mortimer	Board Chairperson District 3	Present
Eric Oxelson	Board Member District 3	Present
Donald Horal	Board Member Vice Chairperson District 3	Present
Lori Prentice	Board Member District 4	Present
Lorraine Goodwin	Board Member District 4	Present
Dawn Swinton Garcia	Board Member District 5	Present
Ginger Prentice	Board Member District 5	Present
Jennifer Mullikin	Board Member District 5	Present
Supervisor Leticia Gonzalez	Board Member, Board of Supervisors Representative, District 4	Present

B. APPROVAL OF MINUTES

Consideration of approval of minutes for July 20, 2022.

BHAB MEMBER	DATE	YES	NO	Abstain
SADEK ALAMMARI	**8-17-22**	X		
BERTHA AVILA				
MARIA SIMMONS				
WENDY HICKS				
STEVEN MORTIMER	**8-17-22**	X		
ERIC OXELSON	**8-17-22**	1x		
DONALD HORAL	**8-17-22**	2x		
LORI PRENTICE	**8-17-22**	X		
LORAINE GOODWIN	**8-17-22**	X		
DAWN SWINTON GARCIA	**8-17-22**	X		
GINGER PRENTICE	**8-17-22**	X		
JENNIFER MULLIKIN	**8-17-22**	X		
SUPERVISOR LETICIA GONZALEZ				

Motion Passes: 9/11	**Motion Fails:**

C. APPROVAL OF AGENDA

Consideration of approval of the agenda for August 17, 2022, meeting.

BHAB MEMBER	**DATE**	**YES**	**NO**	**Abstain**
SADEK ALAMMARI	**8-17-22**	X		
BERTHA AVILA				
MARIA SIMMONS				
WENDY HICKS				
STEVEN MORTIMER	**8-17-22**	X		
ERIC OXELSON	**8-17-22**	1x		
DONALD HORAL	**8-17-22**	2x		
LORI PRENTICE	**8-17-22**	X		
LORAINE GOODWIN	**8-17-22**	X		
DAWN SWINTON GARCIA	**8-17-22**	X		
GINGER PRENTICE	**8-17-22**	X		
JENNIFER MULLIKIN	**8-17-22**	X		
SUPERVISOR LETICIA GONZALEZ				
Motion Passes: 9/11	**Motion Fails:**			

D. ANNOUNCEMENTS

No announcements were made at this time.

E. BOARD OF SUPERVISORS' AGENDA ITEMS

1. Crestwood Behavioral Health FY 22-23
2. Zaks Enterprises FY 22-23
3. BHB Appointments; B. Avila, W. Hicks
4. 7th Avenue Center FY 22-23
5. Peggy Showalter, Pharm D. FY 22-23
6. American Telepsychiatrists Amendment FY 22-23
7. Golden State Health Centers dba Sylmar FY 22-23
8. Turning Point-Hope House FY 22-23
9. Davis Guest Home FY 22-23
10. Community Social Model Advocates, Inc. FY 22-23
11. Denham Resources FY 22-23
12. CalMHSA PEI FY 22-23
13. Native Solutions DUI Program
14. Willow Glen Care Center FY 22-23
15. Promesa Behavioral Health FY 22-23
16. CAPMC DV Education Classes FY 22-23

F. PUBLIC COMMENT PERIOD –Speakers have up to 3 minutes to present an item.

1. Lori Prentice requested a presentation on sex-trafficking and minors.
2. Steven Mortimer reminded every Board Member about the Bylaws regarding attendance. He stated if they are unable to attend meetings, they are to call in advance so that they are excused. If they fail to call, they will be marked unexcused. Three unexcused

consecutive meetings or missing six meetings in a 12-month period constitutes them having resigned.

G. COMMITTEE REPORTS

1. CHAIRPERSON/COMMITTEE CHAIR REPORTS (Each report is limited to 10 minutes)
   a. Standing Committees
      1. Executive Committee (Chair, Vice-Chair & AOD Committee Chair)

         No report was provided by this committee.
      2. AOD Committee (Don Horal, Loraine Goodwin)

         No report was provided by this committee.
      3. Membership / Nominating Committee (Steve Mortimer)

         No report was provided by this committee.
   b. Ad Hoc Committees
      1. Strategic Planning
      2. Outreach (Loraine Goodwin)

         No reports were provided by these two Ad Hoc committees.

H. EDUCATIONAL PRESENTATION-

Betsy McGovern-Garcia, Program Director, Self-Help Enterprises, provided presentation on the Oakhurst Housing Project. See attached power point presentation and question and answer document.

River Grove Presentation.pptx

Q and A - River Grove - Final.pdf

I. DIRECTOR'S REPORT-

Connie Moreno-Peraza, LCSW, Director, Department of Behavioral Health Services (DBHS), provided program updates and informed the board of key CalAIM initiatives. See attached summary report.

8-17-22 BHAB BHS Director Report -Cor

J. ITEMS FOR FUTURE AGENDA

1. Ensure room is equipped with microphone and camera for next meeting.

K. CONFIRMATION OF MEETING DATE/ADJORNMENT

The meeting was adjourned at 12:53 pm by Chairperson, Steven Mortimer.

The next meeting will take place on September 21, 2022, 11:30 am- 1:00 pm, at 209 East 7th Street, Madera, CA 93638, Room 156. Zoom link will also be provided for members in remote areas in Madera County.

CBHPC 2022 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health Planning Council

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

For information, you may contact the following email address or telephone number:
DataNotebook@cbhpc.dhcs.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:
Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA 95899-7413

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

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

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

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

- To help local boards meet their legal mandates1 to review and comment on the county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

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

1W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

How the Data Notebook Project Helps You

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

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

[2]See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.

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

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

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.4

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

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division5 at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)6 available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

4www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
5Search for Adult Residential Facilities using the following Department of Social Services link: https://www.ccld.dss.ca.gov/carefacilitysearch/
6Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

*1. Please identify your County / Local Board or Commission.
Madera

2. For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year?
o

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

4. Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?
o

5. Does your county have any "Institutions for Mental Disease" (IMDs)?
☒ No
☐ Yes (If Yes, how many IMDs?)

Click or tap here to enter text.

6. For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?

In-County 0

Out-of-County 42

7. What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

13,450

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

Homelessness: Programs and Services in California Counties

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

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

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in- Time" count7 of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021.

Preliminary data for January, 2021 had been posted in early February 2022, but those only contained data for the individuals in shelters or other temporary housing. There was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re- posting. The count for 2022 took place in many communities during the last week in February. The federal analysis and publication of that data will not be available for at least six to twelve months. Therefore, we are presenting the previous year's data for January 2020 in Table 3 as a baseline reference for comparison to the most recent year's data for 2021 and/or 2022, whenever that data becomes available. (Please refer to your 2022 Data Notebook pdf document for Table 3.)

7Link to data for yearly Point-in-Time Count: https://www.hudexchange.info/programs/coccoc-homeless-populations- and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=CA&filter_CoC=&prog ram+Coc&group=PopSub

8. During the most recent fiscal year (2020-2021), what new programs were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark all that apply)

☐ Emergency Shelter
☐ Temporary Housing
☐ Transitional Housing
☐ Housing/Motel Vouchers
☐ Supportive Housing
☐ Safe Parking Lots
☐ Rapid re-housing
☐ Adult Residential Care Patch/Subsidy
☒ Other (please specify)

Permanent supportive housing - 16 units Sugar Pine NPLH and 7 units Esperanza MHSA

Part I: Standard Annual Questions for Counties and Local Advisory Boards (Continued)

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

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

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

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

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

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

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

9. Do you think your county is doing enough to serve the children/youth in group care?
   ☐ Yes
   ☒ No (If No, what is your recommendation? Please list or describe briefly)

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

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

10. Has your county received any children needing "group home" level of care from another county?
    ☐ No
    ☒ Yes (If Yes, how many?)

    49

11. Has your county placed any children needing "group home" level of care into another county?
    ☐ No
    ☒ Yes (If Yes, how many?)

    165 (duplicated count)

Part II: Impact of the Covid-19 Public Health Emergency on Behavioral Health Needs and Services

Background and Context

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

The major themes are as follows:

1. The major effects on behavioral health in the vulnerable populations of adults, children and youth served by California's public mental health system. We will present some national data that describes some of the major effects.
2. The effects of the Covid-19 pandemic on the ability of county behavioral health departments to provide mental health and substance use treatment services.
3. The lessons learned and successes achieved during a time when everyone was challenged to be flexible and to devise new ways to support mental health while implementing Covid-19 public health protocols.

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

In the strictest sense, we may not be able to establish that any of the changes in 2020-2021 were due to effects of the pandemic itself. Nonetheless, the continuing trends in 2020 and 2021 are cause for concern and attention, regardless of the difficulty of distinguishing cause from correlation and mere chance. Note that in our questions and discussion we often use the shorthand of speaking about the effects of Covid-19 on clients' mental health or on a county system's ability to respond to the larger challenges of the pandemic. We are not speaking in the biologic sense of what this virus does to a person's body, but rather the totality of the pandemic experience as we face this ongoing public health emergency.

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

What were the Behavioral Health Impacts of the Covid-19 Pandemic on Children and Youth?

Behavioral health challenges faced by children and youth have been presented in news stories and medical, pediatric, or psychology journal reports. Most recently, this urgency led the U.S. Surgeon General to issue a special health advisory8:

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

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

The pandemic added to the pre-existing challenges that America’s youth faced. It disrupted the lives of children and adolescents, such as in-person schooling, in-person social opportunities with peers and mentors, access to health care and social services, food, housing, and the health of their caregivers. The pandemic’s negative impacts most heavily affected those who were vulnerable to begin with, such as youth with disabilities, racial and ethnic minorities, LGBTQ+ youth, low-income youth, youth in rural areas, youth in immigrant households, youth involved with the child welfare or juvenile justice systems, and homeless youth. This Fall, a coalition of the nation’s leading experts in pediatric health declared a national emergency in child and adolescent mental health.

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

8“Protecting Youth Mental Health: The Surgeon General’s Advisory”, by Dr. Vivek Murthy, M.D., U.S. Public Health Service, pages 1-53. December 7, 2021. https://www

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

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

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

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

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

For example, during the pandemic, the hardest-hit communities for Covid-19 cases, hospitalizations, and deaths were Hispanic/Latino, African-American, and Native-American people.9 Some of these individuals were also the most difficult to reach by the public health Covid-19 teams. And due to the prevalence of misinformation, significant numbers were hesitant to get vaccinations, even though many work in 'front-line' positions exposed to the public, and many live in multi-generational households. Thus, any exposure to Covid-19 put entire families at risk of Covid-19. There are those who distrust governmental agencies for health and social services. Data reported in early 2022 also found problems in access to specialized treatment for "long Covid"10 symptoms for some African Americans and other persons of color when compared to white people. Numerous cross-cultural challenges affect access to services for both physical and mental health, including better adapting our outreach and messaging.

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

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

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

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

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

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

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

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

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

☐ None of the above

☐ Other (please specify)

Click or tap here to enter text.

13. Of the previously identified stressors, which are the top three concerns for your county for children and youth services?
(Please select your county's top three points of impact in descending order)

Top concerns for children and youth services

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

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

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

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

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

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

Decreased access/utilization of mental health services for youth.

Other

None of the above

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

During this time our department worked to ensure that clients had access to necessary services in all clinically appropriate settings which included In-Person, Telephonic, and Tele-Health. Our department worked in collaboration with partner agencies in effort to ensure that community members were aware and had access to our services. Our department did have challenges securing placement in psychiatric facilities and residential placement in the initial start of Covid-19 Pandemic with limitations of availability of facilities.

15. Please identify the points of stress on your county's system for all adult behavioral health services during the pandemic (mark all that apply)

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

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

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

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

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

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

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

☐ None of the above

☐ Other (please specify)

Click or tap here to enter text.

16. Of the previously identified stressors, which are the top three concerns for your county for all adults' services?
(Please select your county's top three points of impact in descending order)

Top concerns for all adults

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

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

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

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

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

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

Decreased access/utilization of mental health services for adults.

Other

None of the above

17. Do you have any comments or concerns that you would like to share regarding access to, and/or performance of, behavioral health programs for <u>all adults</u> in your county during the Covid-19 pandemic?

Covid-19 triggered the great resignation which later resulted in staff shortages state-wide, Madera County is not the exception to these challenges. Additional resources and approaches to reach potential candidates have been implemented to create interest in current vacancies. Some of these efforts include, sending communications to all potential clinical candidates state-wide, distribution of a hiring flyer, leveraging of social media platforms, spreading the word in the agency and community. Retention strategies have also been implemented in the form of incentives for hard to fill direct service vacancies, bilingual pay opportunities, internal lateral transfer opportunities. Our department did have challenges securing placement in psychiatric facilities and residential placement in the initial start of Covid-19 Pandemic with limitations of availability of facilities.

18. Since 2020, has your county increased the use of telehealth for <u>all adult</u> behavioral health therapy and supportive services?
☒ Yes ☐ No

19. Since 2020, has your county increased the use of telehealth for psychiatric medication management for <u>all adults</u>?
☐ Yes ☒ No

20. Does your county have tele-health appointments for evaluation and prescription of medication-assisted treatment (MAT) for substance use disorders?
    ☐ Yes ☒ No
    ☐ Not applicable (if your board does not oversee SUD along with mental health)

21. Many or most MAT programs rely on in-person visits by necessity in order to get certified to provide these services. [Some of these medications include buprenorphine, methadone, suboxone, emergency use Narcan]. As part of SUD treatment services, are you able to coordinate routine drug testing with clinics near the client?
    ☐ Yes ☒ No
    ☐ Not Applicable (if your board does not oversee SUD along with mental health)

    If Yes, how has this been useful in promoting successful outcomes?
    If No, do you have alternatives to help clients succeed?

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

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

    ☒ Increase in funding for crisis services
    ☐ Decrease in funding for crisis services
    ☒ Issues with staffing and/or scheduling
    ☐ Difficulty providing services via telehealth
    ☐ Difficulty implementing Covid safety protocols
    ☐ None of the above
    ☐ Other (please specify)

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

23. Did your county experience negative impacts on staffing as a result of the pandemic? (Please select your county's top points of impact from the dropdown menus, all in descending order of importance)

    negative impacts on staffing as a result of the pandemic

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

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

    1 Staff out to quarantine for self

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

    Staff out due to disagreement to comply with safety protocols

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

Staff out due to burnout

Staff out due to inability to manage telework environment

Staff unable to obtain daycare or childcare

Other

None of the above

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

☒ Utilizing telework practices
☐ Allowing flexible work hours
☐ Bringing back retired staff
☐ Facilitating access to childcare or daycare for worker
☒ Hiring new staff
☒ Increased use of various types of peer support staff and/or volunteers
☐ None of the above
☒ Other (please specify)

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

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

☐ Asian American / Pacific Islander
☐ Black / African American
☐ Latino/ Hispanic
☐ Middle Eastern & North African
☐ Native American/Alaska Native
☐ Two or more races
☐ None of the above
☒ Other (please specify)

The pandemic affected our ability to reach and serve all populations due to lack of information when the pandemic first hit and fear of contracting the virus thereafter. In 2022 more and more of the population was open to returning to some level of pre-pandemic normalcy, as shown in table below, however, the pandemic continues to affect many. BHS services are available to all who need them in whichever manner they are most comfortable from in-person to virtual platform and telephone.

Race	FY20.21	FY21.22
Asian American / Pacific Islander	7	13

Black or African American	61	111
Middle Eastern & North African	3	3
Native American / Alaska Native	10	27
Other Race*	521	1001
Two or More Races	6	15
Unknown/Not Reported	63	89
White or Caucasian	459	834
**Includes Hispanic/Latino*		

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

☐ Children & Youth
☐ Foster Youth
☐ Immigrants & Refugees
☐ LGBTQ+ people
☐ Homeless individuals
☐ Persons with disabilities
☐ Seniors (65+)
☐ Veterans
☐ None of the above
☐ Other (please specify)

Although our system is not set up at the moment to pull data by the specific breakdown in this question, we can report age specific data as seen in table below. In FY21.22 66 less 0-21, 866 less 22-64 and 31 less 65+ individuals were seen. From FY to FY 0-21 saw a decrease of 22%, 22-64 decreased by 23% and 65+ decreased by 2%.

Age	FY20.21	FY21.22
0-21	605	671
22-64	448	1314
65+	77	108

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

☐ Difficulty with or inability to utilize telehealth services
☒ Concerns over Covid-19 safety for in-person services
☒ Inadequate staffing to provide services for all clients
☐ Lack of transportation to and from services
☒ Client or family member illness due to Covid-19
☒ Client disability impairs or prevents access
☒ Mistrust of medical and/or government services
☒ Language barriers (including ASL for hard-of-hearing)
☐ None of the above
☐ Other (please specify)

Click or tap here to enter text.

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (please select all that apply)

☐ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions

☐ MH Board completed majority of the Data Notebook

☐ Data Notebook placed on Agenda and discussed at Board meeting

☐ Other (please specify)

Click or tap here to enter text.

☐ MH board work group or temporary ad hoc committee worked on it

☐ MH board partnered with county staff or director

☐ MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function

29. Does your board have designated staff to support your activities?
☐ No
☐ Yes (if Yes, please provide their job classification)

Click or tap here to enter text.

30. Please provide contact information for this staff member or board liaison.

Name: Melissa Torres

County: Madera County

Email Address: Melissa.Torres@maderacounty.com

Phone Number: (559)673-3508

31. Please provide contact information for your Board's presiding officer (Chair, etc.)

Name: Steve Mortimer

County Madera County

Email Address Click or tap here to enter text.

Phone Number Click or tap here to enter text.

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?

Click or tap here to enter text.

Invitation - Sacramento, Friday, October 21st + (CALBHB/C)

From: Theresa Comstock (theresa.comstock@calbhbc.com)

To: mortimersr@yahoo.com

Date: Thursday, September 8, 2022 at 02:04 PM PDT

Dear Steve, Please let me know if you (or a designated board/commission member) would like to join us in Sacramento for the CALBHB/C Central Region Meeting & Training on Friday, October 21st.*

Lodging & Expenses: If you will require lodging, a response is requested by September 17th to be added to CALBHB/C's room list for the nights of October 20th and/or 21st. CALBHB/C will book rooms and pay the hotel directly. Lodging and meetings will be at the same hotel (Courtyard Sacramento Midtown). CALBHB/C will pay travel and meal expenses for Chairs (or their designee).

CALBHB/C Central Region Meeting & Training* (Registration will open soon.)
Hybrid (In-Person in Sacramento & Zoom)
October 21st, 1 pm - 4 pm (Deli-buffet lunch available at 12 pm to registered attendees)
Tentative Agenda:

- **Presentations and Updates from Statewide Organizations**
  - CA Association of Local Behavioral Health Boards/Commissions (CALBHB/C)
  - CA Behavioral Health Planning Council (CBHPC)
  - Mental Health Services Oversight & Accountability Commission (MHSOAC)
  - Peer Provider Certification (Speaker(s) TBD)
  - MHSOAC Stakeholder Advocacy Organization (Speaker(s) TBD)
- **Issue-Based Presentation & Discussion** - Attendees are encouraged to share local issues and successes.
- **Training**: How to be an Effective Mental/Behavioral Health Board/Commission

*** Additional Meetings:** CALBHB/C's meeting coincides with the CA Behavioral Health Planning Council's week-long meetings at the same location. Folks are encouraged to also attend their meetings (they are open to the public). CA Behavioral Health Planning Council Schedule:

Performance Outcomes: Oct 18, 2 pm - 5 pm
Executive: Oct 19, 8:30 am -10:15 am
Patients' Rights Committee: Oct 19, 10:30 am - 12:30 pm
Children & Youth: Oct 19, 10:30 am - 12 pm
Workforce and Education: Oct 19, 1:30pm
Legislation: Oct 19, 1:30 pm - 5 pm
Housing and Homelessness: Oct 20, 8:30 am - 12 pm
Systems and Medicaid: Oct 20, 8:30 am - 12 pm
General Session: Oct 20, 1:30 pm - 5 pm
General Session: Oct 21, 8:30 am to 12 pm

Theresa Comstock, Executive Director
CA Association of Local Behavioral Health Boards & Commissions
717 K Street, Suite 427 Sacramento CA 95814
Office: 916-917-5444, Cell: 707-688-5197
www.calbhbc.org Newsletter Resources

CALBHB/C supports the work of CA's 59 local Mental/Behavioral Health Boards and Commissions