EL DORADO COUNTY: DATA NOTEBOOK 2022

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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

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NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2022 Data Notebook survey, as well as **supplemental data** for your county, state, and country. It is meant as a **reference document only**.

Some of the survey items appear differently on the live survey due to the difference in formatting. For a more accurate preview of the online survey, please reference the **Data Notebook 2022 SurveyMonkey Preview PDF**, which you received along with this document. We recommend reviewing both documents while preparing your survey responses.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2022 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/PSQQ2HF

Please note, if you are working from a PDF, scanned image or photocopy, you will need to retype the above address into your browser bar.

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CBHPC 2022 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very 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 Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

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

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

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

What's New This Year?

The topic selected this year by the Planning Council is a focus on the "Impact of the Covid-19 public health emergency on:

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

(1) The behavioral health of vulnerable populations in California, and

(2) The ability of county behavioral health departments to provide mental health and substance use disorder (SUD) treatment services in 2020 and 2021."

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].

Example of Statewide Data for Specialty Mental Health and Access Rates

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

[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.

Subsequent data for FY 2020-2021 typically would be released by DHCS in August or September of 2022. Those readers who are interested at that time may seek to extract more current data using the DHCS internet tool for 'AB 470' Dashboards[4].

Examples of County Data are shown in Tables 2-A and 2-B on the subsequent pages, with information arranged in the same format as the statewide data.

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

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[5] Fiscal Year 2019-20.

	Specialty Mental Health Services		
	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	7,777	801,586	1.00%
Children 3-5	19,206	841,770	2.30%
Children 6-11	79,256	1,706,727	4.60%
Children 12-17	118,686	1,717,523	6.90%
Youth 18-20	31,460	724,208	4.30%
Alaskan Native or American Indian	1,200	18,572	6.50%
Asian or Pacific Islander	7,109	373,754	1.90%
Black	26,745	390,574	6.80%
Hispanic	153,661	3,369,129	4.60%
Other	10,689	365,314	2.90%
Unknown	13,657	497,605	2.70%
White	43,324	776,866	5.60%
Female	122,205	2,837,274	4.30%
Male	134,180	2,954,540	4.50%
Totals and Average Rates	256,385	5,791,814	4.43%

Notes: The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this is taken as the "Access Rate."

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

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2019-20.[6]

	Specialty MH Services		
	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	96,242	2,639,420	3.60%
Adults 33-44	84,145	2,052,352	4.10%
Adults 45-56	78,314	1,633,359	4.80%
Adults 57-68	64,195	1,410,393	4.60%
Adults 69+	12,957	1,024,999	1.30%
Alaskan Native or American Indian	2,270	37,482	6.10%
Asian or Pacific Islander	19,583	1,035,431	1.90%
Black	51,180	676,335	7.60%
Hispanic	96,024	3,779,762	2.50%
Other	29,540	734,979	4.00%
Unknown	31,204	611,186	5.10%
White	106,052	1,885,348	5.60%
Female	172,484	4,916,908	3.50%
Male	163,369	3,843,614	4.30%
Totals and Access Rates	335,853	8,760,522	3.83%

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

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

Table 2-A. El Dorado County Children and Youth: Access Rates for Specialty Mental Health Services (SMHS),[7] Fiscal Year 2019-20.

Specialty Mental Health Services

	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	^	2,255	^
Children 3-5	^	2,283	^
Children 6-11	118	4,741	2.50%
Children 12-17	250	4,909	5.10%
Youth 18-20	79	1,915	4.10%
Alaskan Native or American Indian	^	86	^
Asian or Pacific Islander	0	367	0.00%
Black	11	126	8.70%
Hispanic	81	3,894	2.10%
Other	^	325	^
Unknown	100	3,542	2.80%
White	273	7,763	3.50%
Female	234	7,837	3.00%
Male	241	8,266	2.90%
Totals and Average Rate(s)	475	16,103	2.95%

^ = Data suppressed due to small numbers

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

Table 2-B. El Dorado County Adults and Older Adults: Access Rates for Specialty Mental Health Services[8], Fiscal Year 2019-20.[9]

Specialty Mental Health Services

	FY 19-20		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	220	7,832	2.80%
Adults 33-44	204	6,901	3.00%
Adults 45-56	151	5,242	2.90%
Adults 57-68	96	5,088	1.90%
Adults 69+	15	2,080	0.70%
Alaskan Native or American Indian	^	198	^
Asian or Pacific Islander	^	826	^
Black	11	228	4.80%
Hispanic	51	4,039	1.30%
Other	14	505	2.80%
Unknown	96	3,245	3.00%
White	502	18,102	2.80%
Female	349	14,460	2.40%
Male	337	12,683	2.70%
Totals and Rates (Averages)	686	27,143	2.53%

^ = Data suppressed due to small numbers

[8] Data for Table 1-A and 1-B and Table 2-A and 2-B were all calculated using Performance Dashboard AB 470 Report Application, published by California Department of Health Care Services (DHCS) at www.dhcs.ca.gov and more specifically at: https://data.chhs.ca.gov/dataset/adult-ab470-datasets/resource/c1908f78-3716-4b91-8afa-0dc9c3c2058a.

[9] For comparison, the population of El Dorado County was **191,992** on July 1, 2021, according to www.dof.ca.gov and the U.S. Census Bureau. https://www.census.gov/quickfacts/CA.

CBHPC 2022 Data Notebook – 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.[10]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. 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 Division[11] 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)[12] available to serve individuals with SMI, and how many of these individuals (for whom the county

[10] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[11] Link to ARF data at California Department of Social Services. [Note 02-12-2022 by editor: link not working]. https://secure.dss.ca.gov/CareFacilitySearch/Search/AdultResidentialAndDaycare.
[12] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

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.

The following is a text summary of the survey questions for Part I of the 2022 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.

Questions:

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

El Dorado County

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

EDCBH paid for <u>fourteen (14) individuals</u> to reside in ARF facilities during FY 2021-22.

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?** (*Text response*)

EDCBH paid for a total of <u>1,778 bed-days</u> for these individuals during FY 2021-22.

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are <u>not</u> living in an ARF?** (*Text response*)

While facilities are limited in number in this region, BH is able to utilize these beds when needed. BH is working to expand residential treatment facilities in El Dorado County to provide several different levels of services to meet the needs of our county residents.

5) **Does your county have any 'Institutions for Mental Disease' (IMD)?**
   a. ☒ No
   b. ☐ Yes. If Yes, how many IMDs?

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**: (*Zero (0)*)** ☐ Out-of-county: (***Forty-eight (48)*****)**

EDCBH paid the costs for an out-of-county IMD stay for forty-eight (48) individuals in FY 2021-22.

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?**
   (*Text response*)

EDCBH paid for a total of 10,588 bed-days for these individuals.

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" count[13] 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.

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

Table 3: State of California Estimates of Homeless Individuals PIT[14] Count (January 2020)

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL	Per Cent Increase over 2019
Homeless Individuals (not in families)	28,246	107,525	135,771	5.4%
People in families with children	19,591	6,186	25,777	14.6%
Unaccompanied homeless youth[15]	2,662	9,510	12,172	1.5%
Veterans	3,405	7,996	11,401	3.8%
Chronically homeless individuals	8,046	40,776	48,812	24.3%
Total (2020) Homeless Persons in CA	47,888	113,660	161,548	6.8%
Total (2020) Homeless Persons, USA	354,386	226,080	580,455	2.2%

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

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

Questions, continued:

8) **During the most recent fiscal year (2021-2022), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?** (Mark all that apply.)
   a. ☐ Emergency Shelter add option for providing support and services in housing *a Navigation Center/Emergency shelter is being developed and will be open by December 2022 or January 2023*
   b. ☒ Temporary Housing
   c. ☐ Transitional Housing
   d. ☒ Housing/Motel Vouchers
   e. ☒ Supportive Housing
   f. ☐ Safe Parking Lots
   g. ☐ Rapid Re-Housing
   h. ☒ Adult Residential Care Patch/Subsidy
   i. ☒ Other (*Please specify) Compassion Pathways*

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)

Questions (continued):

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

   The county has an effective Children's System of Care that strives to support children and youth to remain in their homes and/or in the county, whenever possible.

10) **Has your county received any children needing "group home" level of care from another county?**
   a. ☐ No
   b. ☒ Yes. If Yes, how many? (*Thirty-seven (37) youth from another county were placed at Summitview STRTP in El Dorado County.*)

11) **Has your county placed any children needing "group home" level of care into another county?**
   a. ☐ No
   b. ☒ Yes. If Yes, how many? (*Six (6) youth from El Dorado County were placed in an STRTP in another county.*)

CBHPC 2022 Data Notebook – Part II:

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

Context and Background

The Planning Council selected this year's 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 advisory:[16]

> "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

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

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.

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[17]. 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

[17] 2020 Data Notebook, and 2021 Overview Report on this project: California Behavioral Health Planning Council, with the California Association of Local Mental Health Boards Commissions: www.calmhbc.com.

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

However, as we saw in the analyses of the responses collected from the 2020 Data Notebook, for clients who were able to overcome any technology barriers to access, they reported a fair degree of success in being able to improve their handling of mental health issues. Some clients were also able to get tele-health appointments for medication evaluation and prescriptions. Tele-health is an example of a rapid system-wide adaptation enabled by rapid policy changes for Medicaid/Medi-Cal at the federal and state levels, and 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.[18] 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"[19] 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 comments about behavioral health services in your county.

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

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

Part II: Data Notebook Questions.

Please respond by means of the Survey Monkey link provided with this Data Notebook.

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

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

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

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

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

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

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

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

h. ☐ Other (Please specify).

i. ☐ None of the above.

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

a. **1** Increased numbers of youth presenting for services who report thoughts of suicide or other thoughts of self-harm.

b. **3** Increased numbers of youth receiving services who reported significant levels of anxiety, with or without severe impairment.

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

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

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

f. **2** Increased need for youth crisis interventions by Behavioral Health crisis teams (and/or use of psychiatric emergency setting or crisis stabilization unit).

g. Choose an item. Decreased access/utilization of mental health

services for youth.

h. Choose an item. None of the above

i. Choose an item. Other (Please specify).

It would valuable to have additional data on Emergency Room visits and outcomes from the two hospitals to help the Behavioral Health Commission better understand the system of care.

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 <u>children and youth</u> in your county during the Covid-19 pandemic? *(written response)*

Expanding access to telehealth was valuable during the pandemic, to get services to children. The Wellness Centers were expanded quickly to respond to the need of children and youth when they came back to school in person.

Additional suggestions include discussions between school and Behavioral Health to provide a strong foundation to create a resilient model to quickly deliver services to help children and youth, and their families, to get the services they need to respond to the next crisis. This would include a Rapid Response Model to coordinate with EDCOE to expand services across the county.

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

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

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

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

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

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

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

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

h. ☐ None of the above

i. ☒ Other (Please specify) For individuals who were already receiving mental health services did not experience a decrease in services. However, for new clients to the system of care, it was more difficult to access services because the majority of services were through telehealth. Some clients initially did not have the capacity

to participate in telehealth because of limited broadband and access to computers.

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

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

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

c. **3** Increased numbers of adults receiving services who reported significant levels of major depression, with or without severe impairment.

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

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

f. **1** Increased need for crisis interventions by BH crisis teams (and/or use of psychiatric emergency rooms).

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

h. Choose an item. None of the above

i. Other (Please specify)

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? *(written response)*

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

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. –** (These type of telehealth appointments are a service of the local FQHC and not provided by the County SUD Programs and not overseen by the BH Commission Board.)

- ☐ **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**. If so, how has this been useful in promoting successful outcomes? *(Text answer)*.

- ☒ **No.** If not, do you have alternatives to help clients succeed?
(The FQHC provides routine drug testing for MAT clients in their program. County SUDs is able to provide care coordination, assessment, referral, placement and other DMC-ODS Services for county beneficiaries.)

- ☐ **Not Applicable**: if your board does not oversee SUD along with Mental Health.

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

a. ☐ Increase in funding for crisis services

b. ☐ Decrease in funding for crisis services

c. ☒ Issues with staffing and/or scheduling

d. ☒ Difficulty providing services via telehealth

e. ☐ Difficulty implementing Covid safety protocols

f. ☐ Other (please specify) Funding increased for crisis services through MHSA, but there was a decrease in crisis services as a result of a decrease in staffing for mobile crisis services. Sheriff's deputies were re-assigned to respond to the Caldor fire.

g. ☐ None of the above

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

a. **4** Staff quit (part of mass resignation/ social trend, etc.)

b. Choose an item. Staff re-directed or re-assigned to support the Covid-19 Team

c. **1** Staff out to quarantine for self

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

e. **5** Staff out due to disagreement to comply with safety protocols

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

g. **3** Staff out due to burnout

h. **6** Staff out due to inability to manage telework environment

i. **7** Staff unable to obtain daycare or childcare

j. Choose an item. Other, please specify.

k. ☐ None of the above.

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

a. ☒ Utilizing telework practices

b. ☒ Allowing flexible work hours

c. ☐ Bringing back retired staff

d. ☐ Facilitating access to childcare or daycare for workers

e. ☒ Hiring new staff

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

g. ☒ Other (please specify) Supplemental Paid Sick Leave for COVID-19

h. ☐ None of the above.

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

a. ☐ Asian American / Pacific Islander

b. ☐ Black / African American

c. ☒ Latino/ Hispanic

d. ☐ Middle Eastern & North African

e. ☐ Native American/Alaska Native

f. ☐ Two or more races

g. ☐ Other, please specify.

h. ☐ None of the above.

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

a. ☒ Children & Youth

b. ☒ Foster Youth

c. ☒ Immigrants & Refugees

d. ☒ LGBTQ+

e. ☒ Homeless individuals

f. ☒ Persons with disabilities

g. ☒ Seniors (65+)

h. ☒ Veterans

i. ☐ Other, please specify.

j. ☐ None of the above.

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

a. ☒ Difficulty with or inability to utilize telehealth services

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

c. ☒ Inadequate staffing to provide services for all clients

d. ☒ Lack of transportation to and from services

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

f. ☒ Client disability impairs or prevents access

g. ☒ Mistrust of medical and/or government services

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

i. ☐ Other (please specify).

APPENDIX I.

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

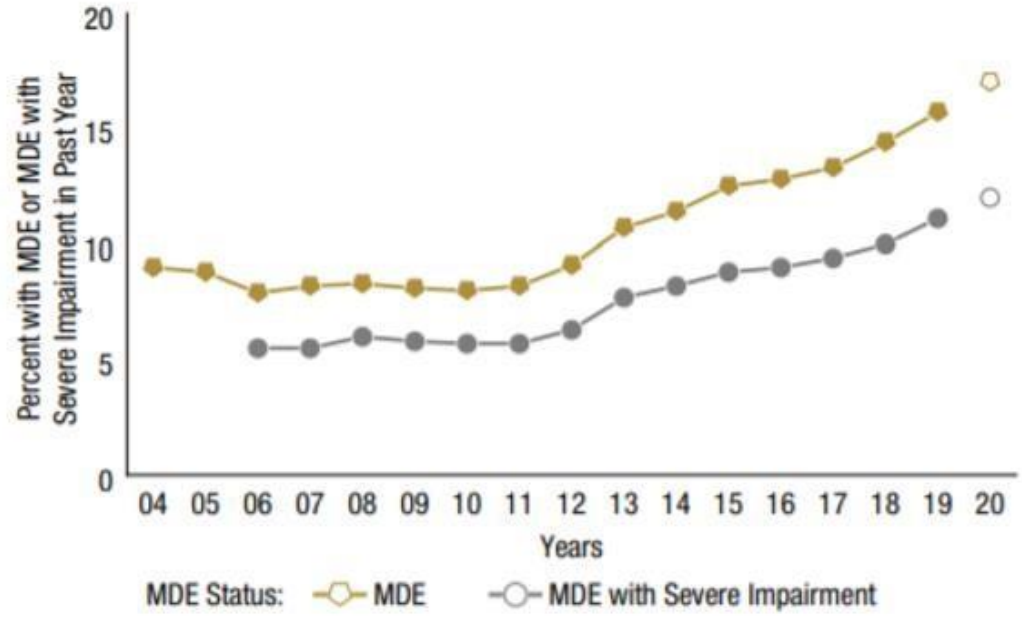
Some of the Behavioral Health problems in youth include, but are not limited to, the issues highlighted by the following series of data and figures taken from the National Survey of Drug Use and Health, (NSDUH Survey)[20] published in October, 2021, regarding data collected in 2020, which overlaps the first year of the pandemic. **Their methods of data collection changed in 2020 due to the public health restrictions and safety protocols**. Their methods changed from telephone surveys to include online survey methods in early 2020. **As a consequence, the data shown for 2020 are not connected by a solid line to that for prior years**. Also, the study authors did not perform certain tests of statistical significance between 2020 and prior years because the tests might not be valid due to the changes in methods.

Note that we are able to present these national data because they are based on live surveys. Of interest, the state level NSDUH data for California is expected to be released in the first half of 2022. Most other behavioral health data for our state and counties rely on paid claims data derived from billing records that have built-in reporting delays of 18-24 months. Thus, they would not show impacts of the pandemic which began in early 2020 or in 2021.

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

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

Figure 1. Major Depressive Episode (MDE) and MDE with Severe Impairment in the Past Year; Among Youths Aged 12-17; 2004 – 2020 (NSDUH).

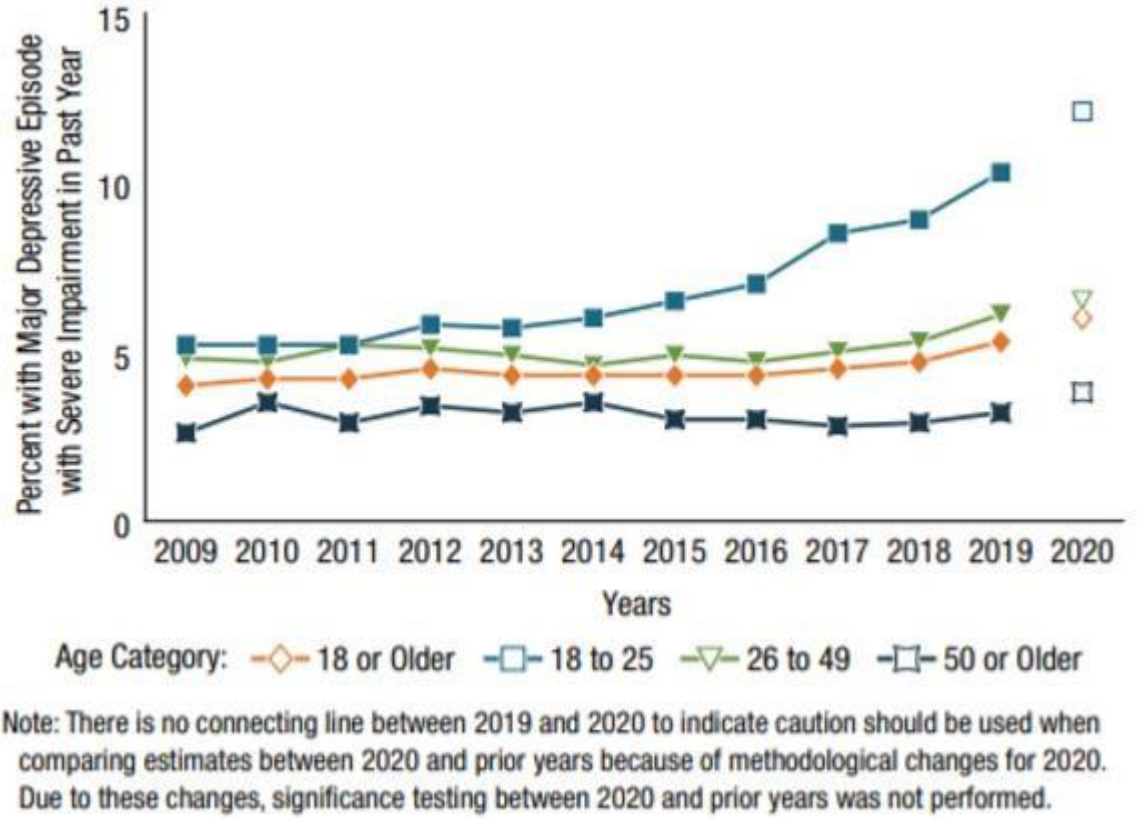


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

The following series of data and figures show some of the impacts to adults and older adults. These data represent excerpts from the 2021 NSDUH Survey[21] on survey data collected in 2020. Nonetheless, the data are illustrative of trends during this challenging period of time. As an example of concerning trends, we note that October, 2021 marked the highest 12-month loss of American lives to drug overdoses, in excess of 100,000 total. Numbers of adults experiencing major depression also increased.

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

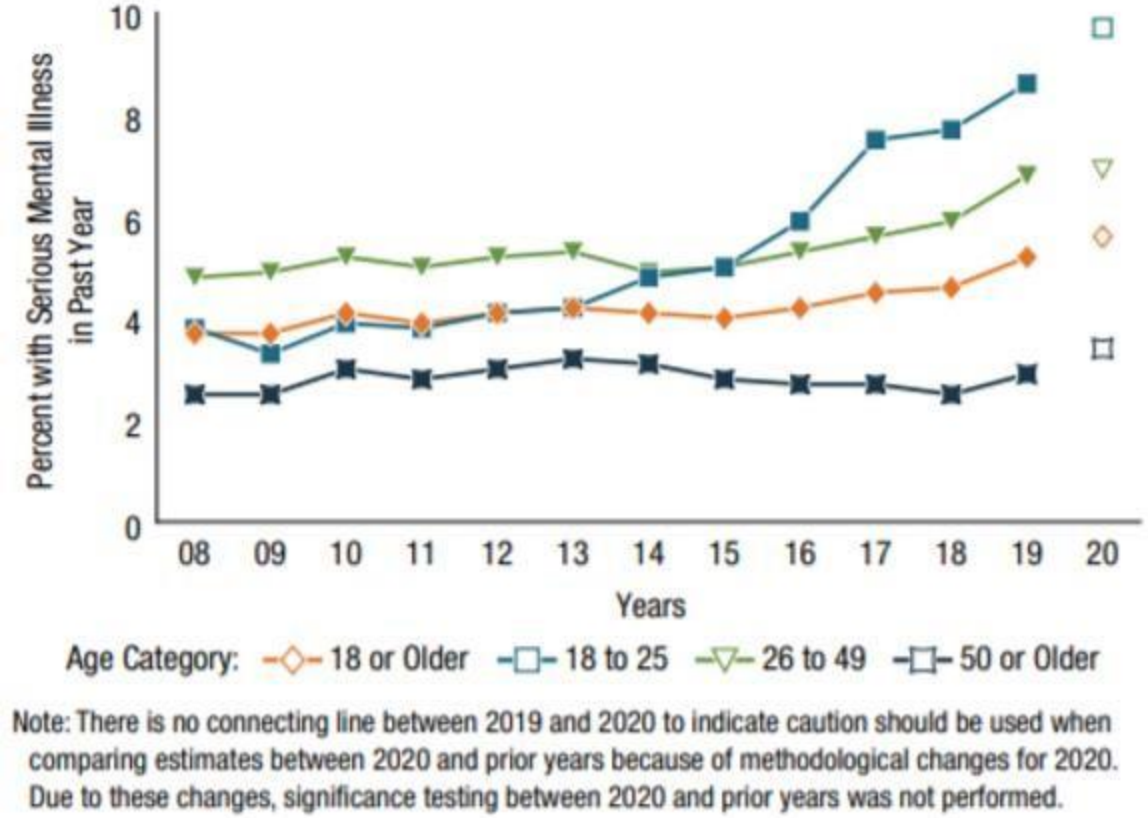
<u>Figure 2</u>. Major Depressive Episode with Severe Impairment In the Past Year: Among Adults Aged 18 or Older; 2009 – 2020 (NSDUH).



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

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

<u>Figure 3</u>. Serious Mental Illness in the Past Year; Among Adults Aged 18 or Older; 2008-2020 (NSDUH).

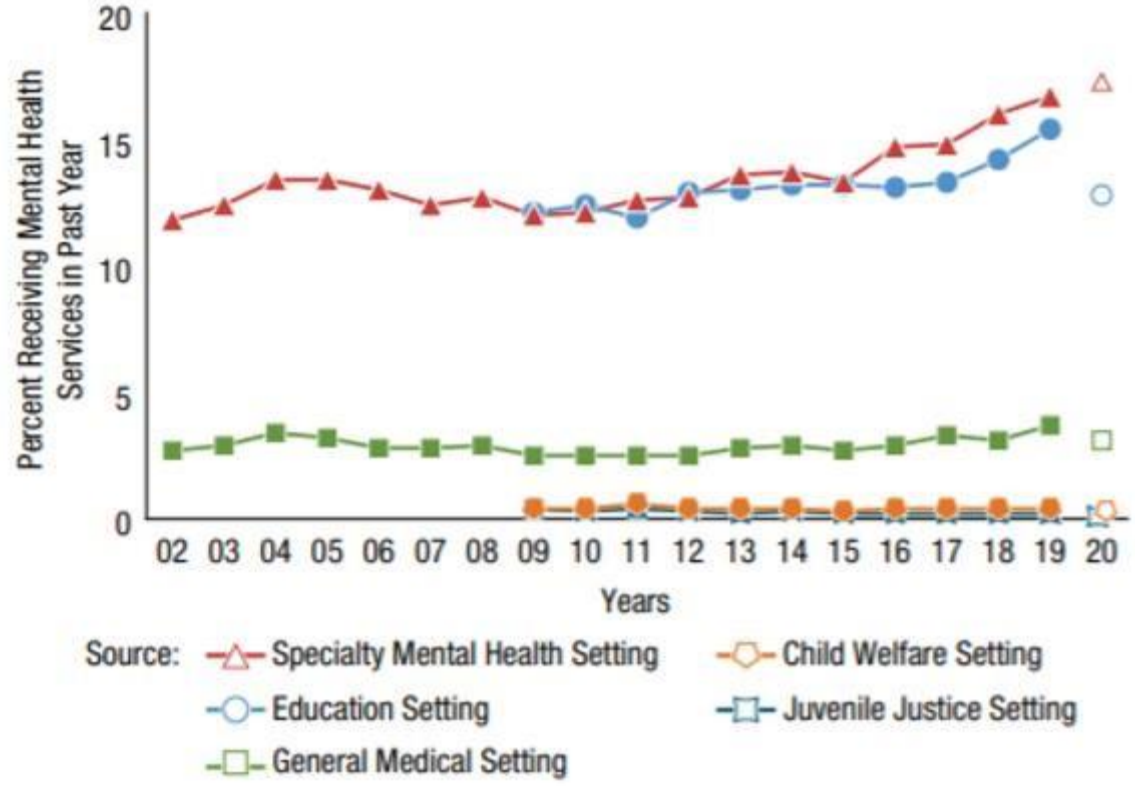


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

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

Where and how were services provided? The next figure addresses the trends in how youth aged 12 – 17 received BH services, in terms of the place where the person is most likely to have received services. For those who wish more detail, we refer the reader to extensive tables contained in the 2021 NSDUH Survey.

<u>Figure 4</u>. Sources of Mental Health Services in the Past Year: Among Youths Aged 12 – 17; 2002 – 2020 (NSDUH).



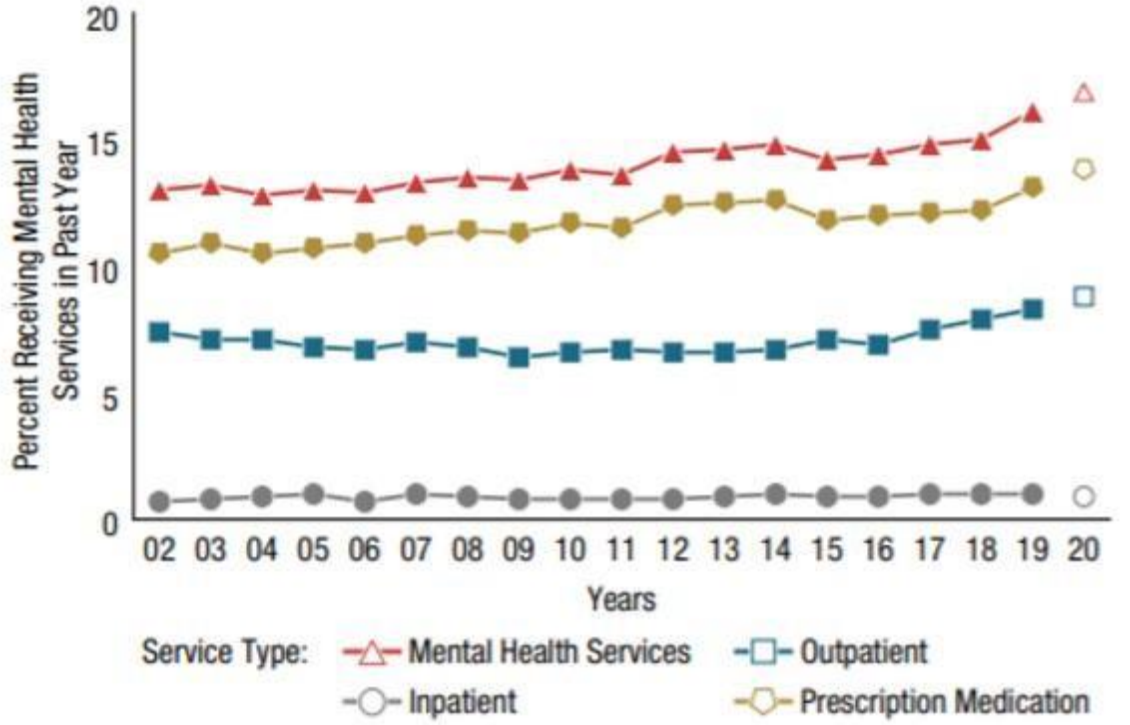
Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

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

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

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

Figure 5. Type of Mental Health Services Received in the Past Year by Adults Aged 18 and Over, 2020. (NSDUH).

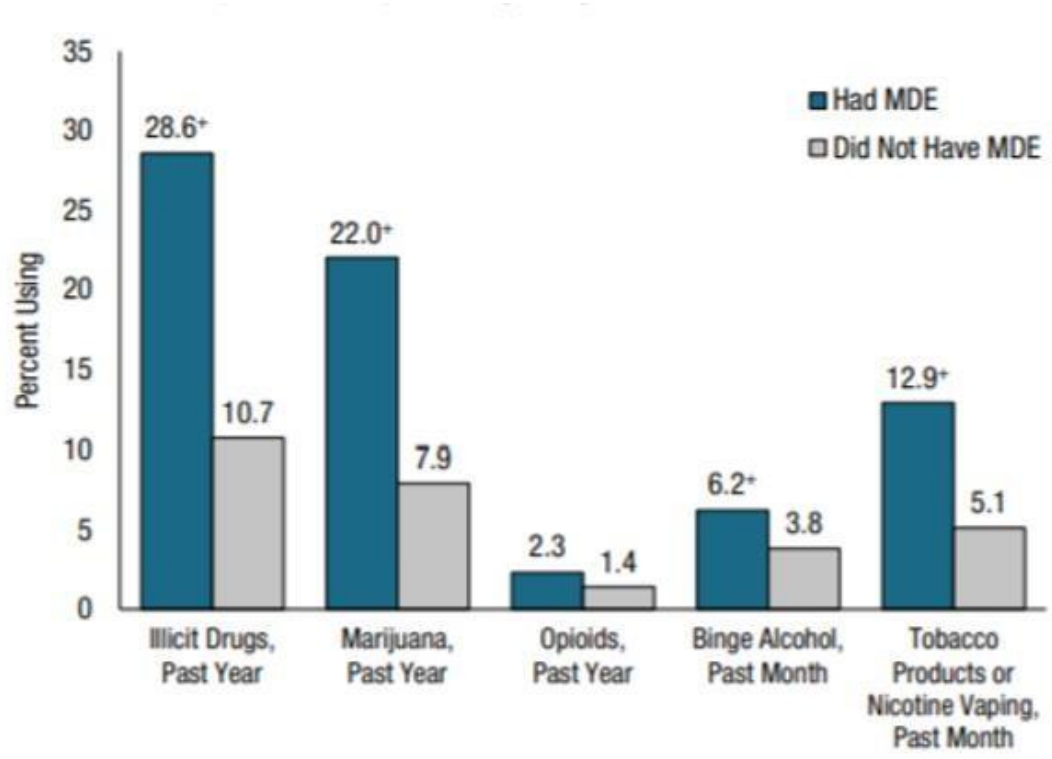


Note: Mental Health Services include any combination of inpatient or outpatient services or receipt of prescription medication.

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

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

Figure 6. Substance Use among Youths Aged 12-17, by Past Year Major Depressive Episode (MDE) Status, 2020. (NSDUH).



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

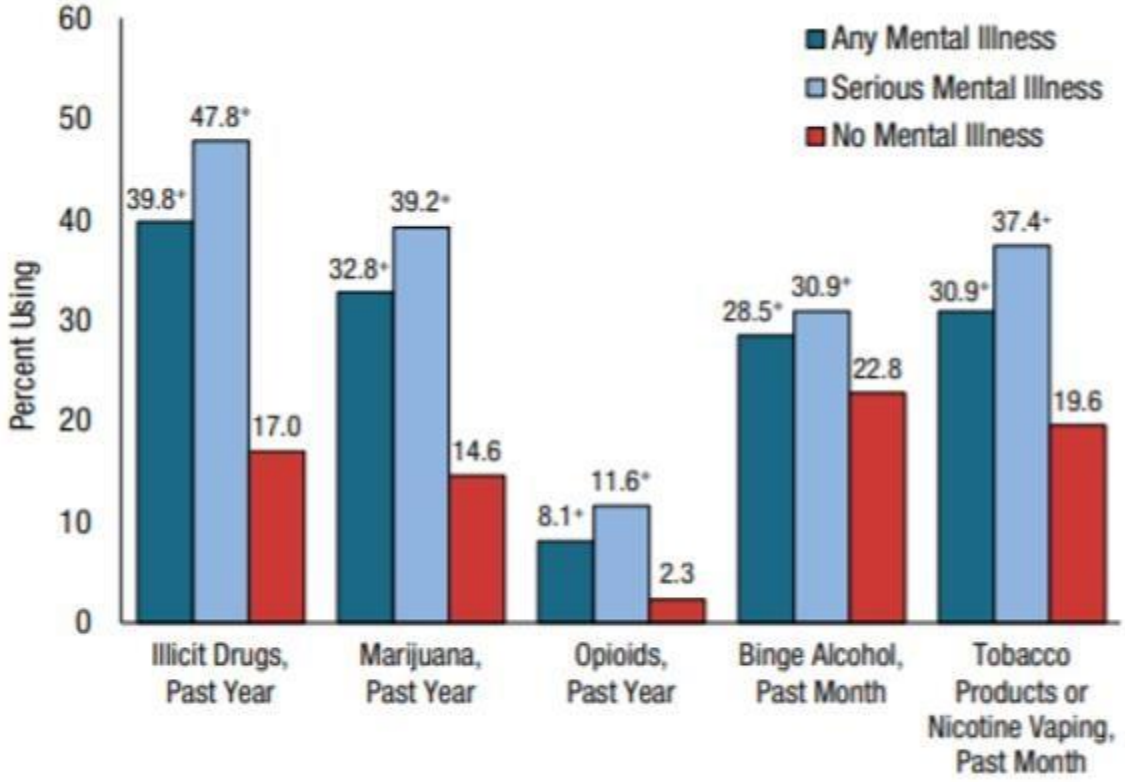
Note: Youth respondents with unknown MDE data were excluded.

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

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

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

<u>Figure 7</u>. Substance Use: Among Adults Aged 18 and Older; by Mental Illness, 2020 (NSDUH).



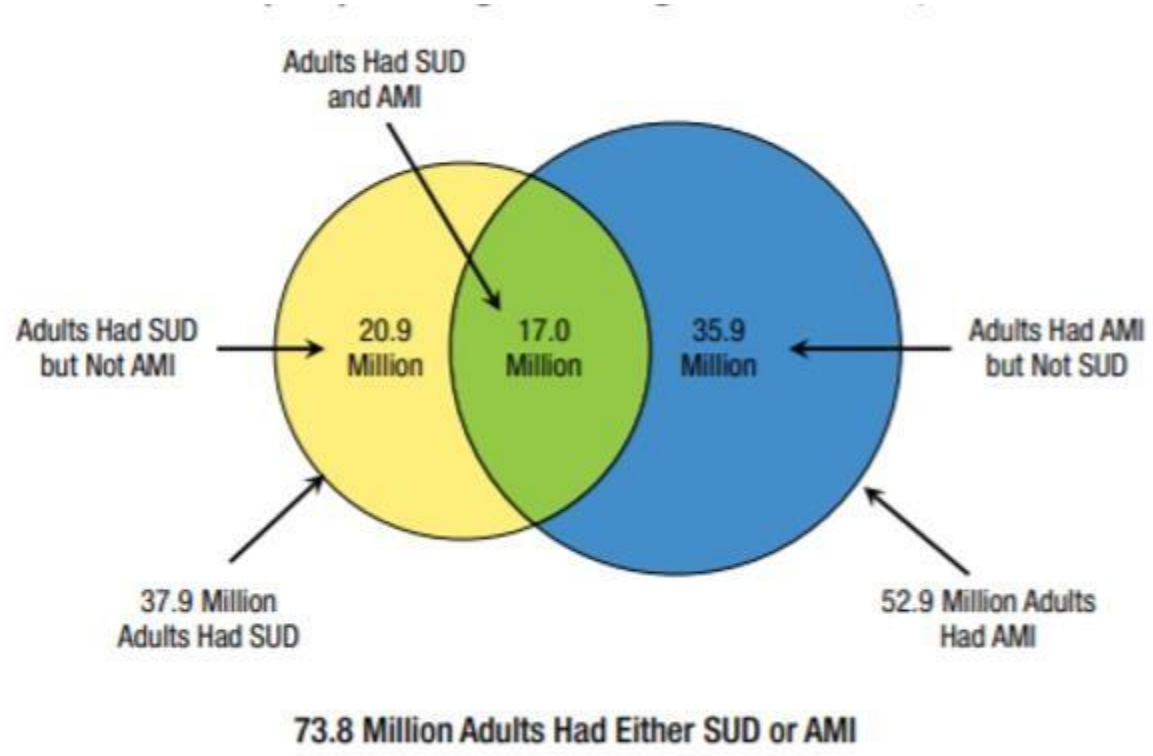
* Difference between this estimate and the estimate for adults without mental illness is statistically significant at the .05 level.

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

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

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

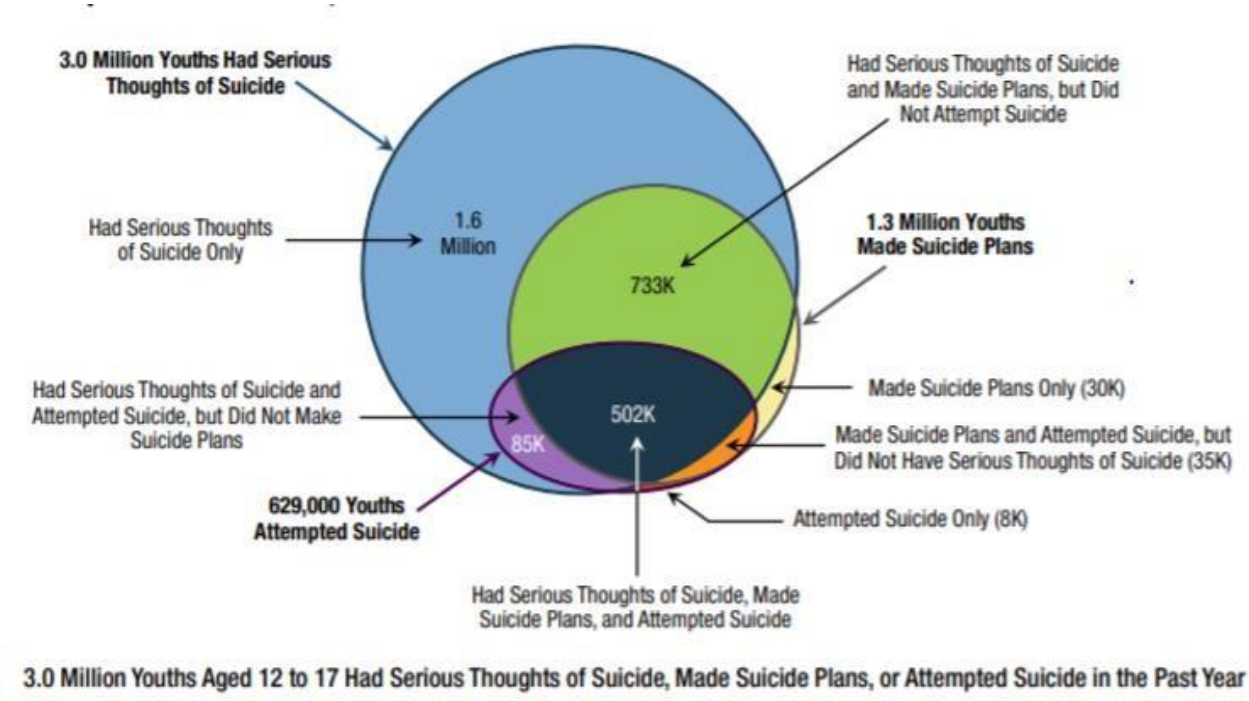
Figure 8. Past Year Substance Use Disorder (SUD) and Any Mental Illness (AMI): Among Adults Aged 18 or Older, 2020 (NSDUH).



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

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

<u>Figure 9</u>. Youths Aged 12-17 with Serious Thoughts of Suicide, Suicide Plans, or Attempted Suicide in the Past Year; 2020 (NSDUH).



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

Data in California for 2015 showed that there were 36.5 hospitalizations for self-inflicted injuries per 100,000 persons in the age group 5 - 20[22]. In the year 2019, there were 525 deaths by suicide in CA for persons age 5-20. Clearly, strategies are needed to reduce negative outcomes, including publicizing links to help-lines and reducing barriers to the access of mental health services.[23]

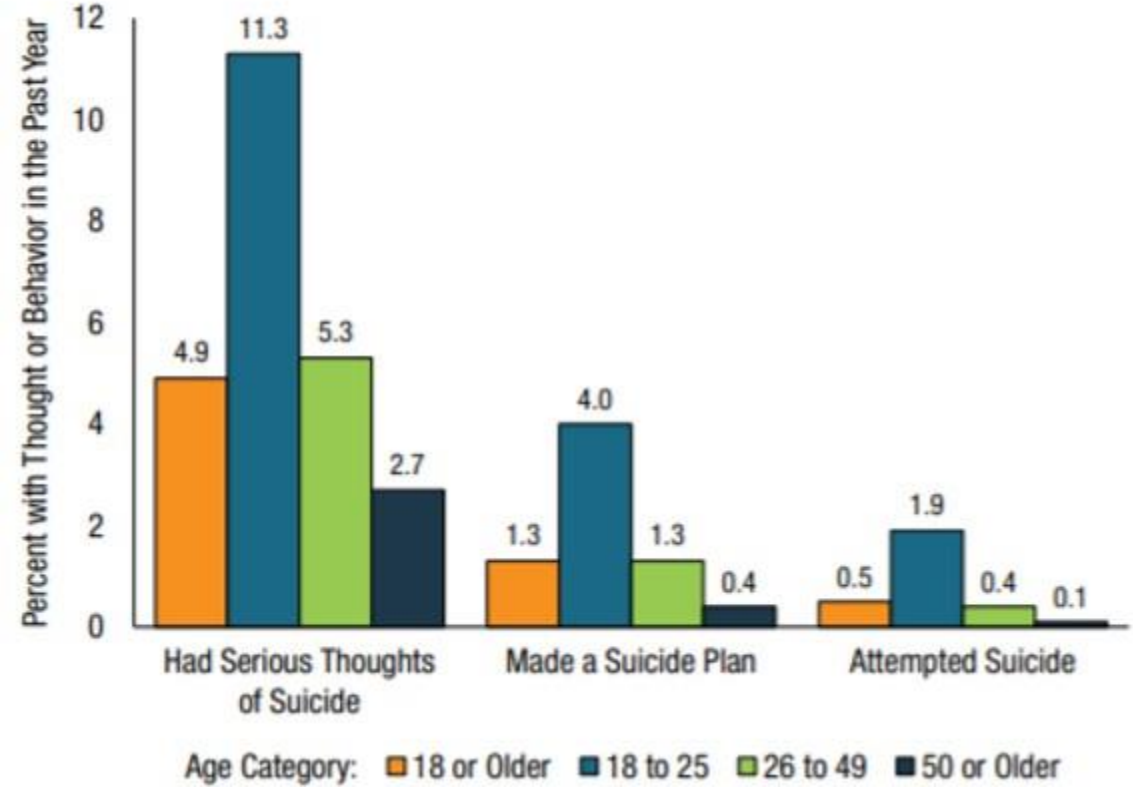
Privacy and confidentiality are key issues for adolescents, but the barriers to their access to services may involve the legal requirement for parental consent, and perhaps for parental health insurance. The most important issues are to keep the child safe and to provide timely access to competent, effective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

Next we turn our attention to data about those adults that had thoughts of suicide, made a plan, or attempted suicide in the preceding year.

[22] www.kidsdata.org, accessed 2/3/2022.

[23] Please refer to the US Surgeon General's report and recommendations for suicide prevention, referenced later in this report in the section addressing BH in adults. The Report was release in early 2020 and addresses needs and programs for both youth and adults.

<u>Figure 10</u>. Had Serious Thoughts of Suicide, Made a Suicide Plan, or Attempted Suicide in the Past Year: Among Adults Aged 18 or Older, 2020. (NSDUH).

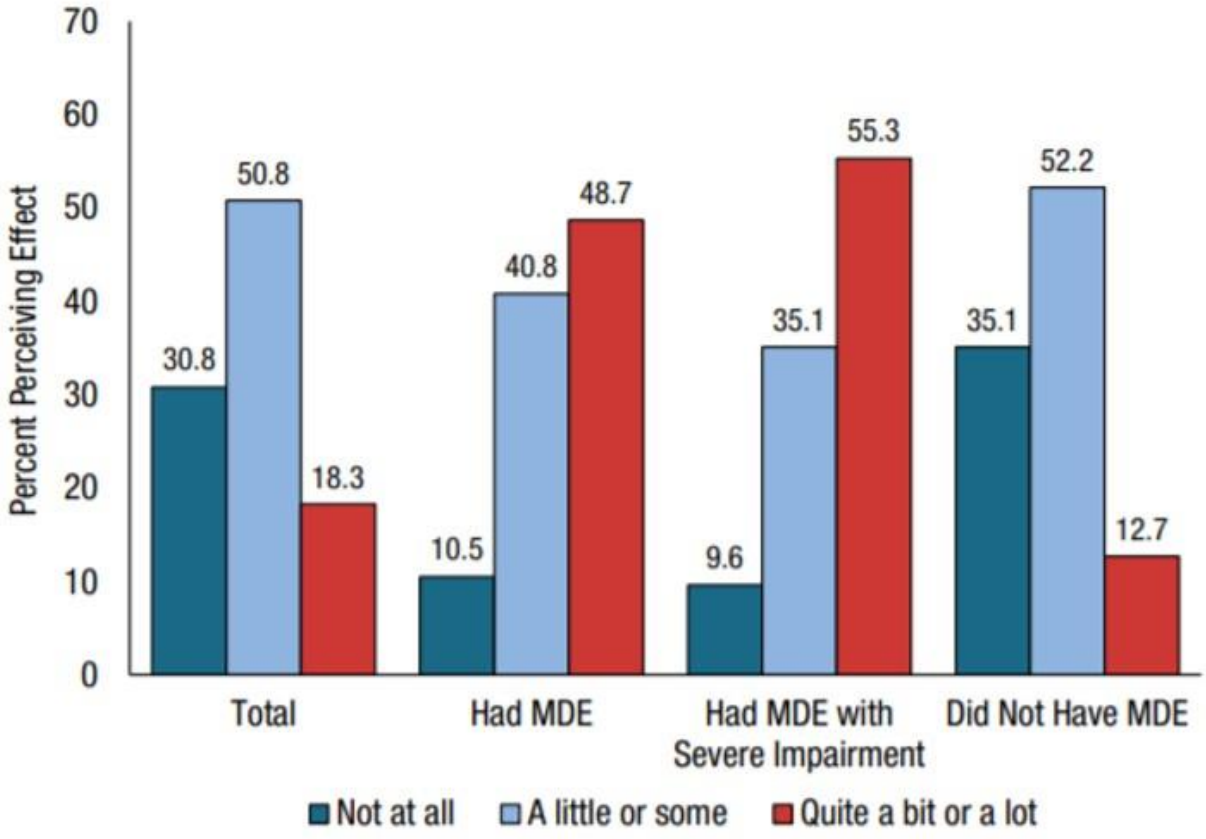


The data above show that in any given year, suicidal thoughts, or plans are perhaps more common than people might think, especially in those age 18 to 25. These data reinforce the need to have strategies[24] and programs[25] in place to help people in crisis and to publicize helplines and other resources for those of all age groups. The strategy document states:

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

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

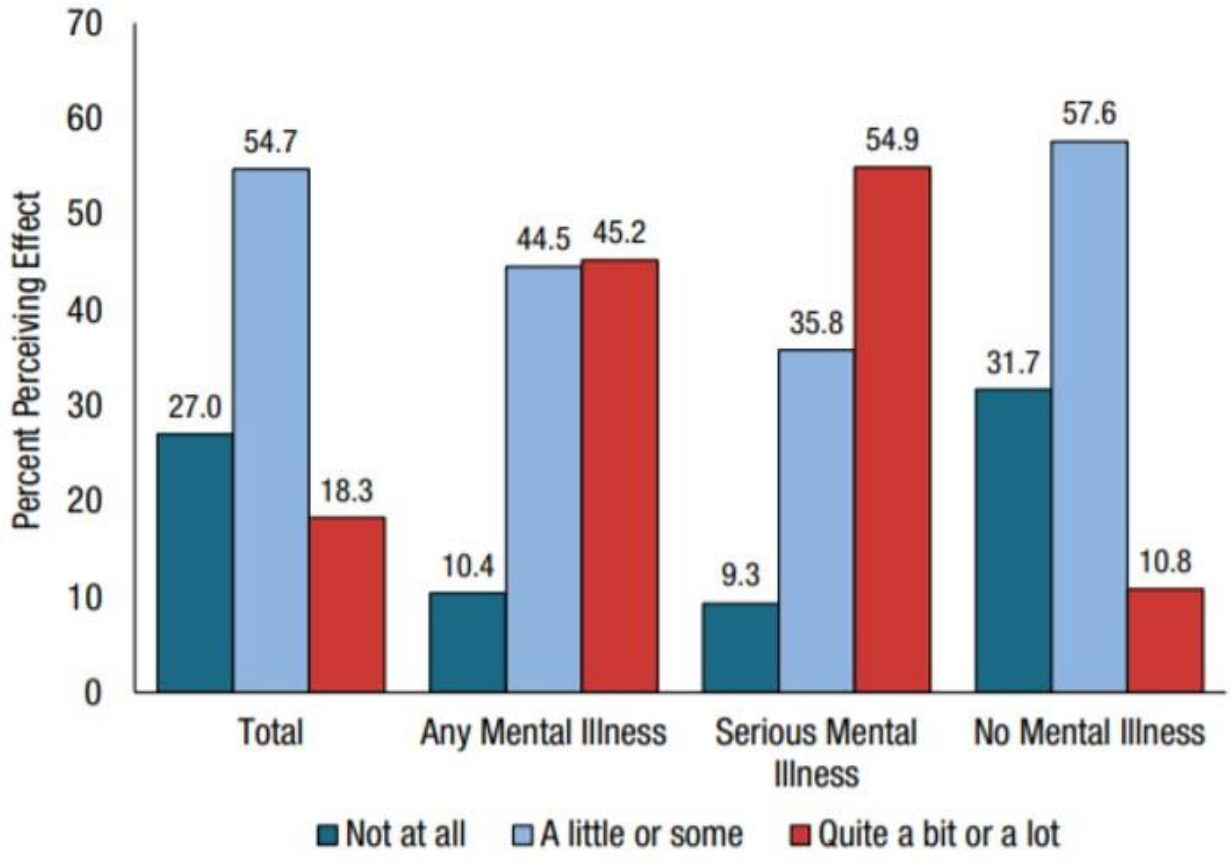
<u>Figure 11</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Youths Aged 12 to 17, by Past Year Major Depressive Episode (MDE) States, Quarter 4, 2020 (NSDUH).



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

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

<u>Figure 12</u>. Perceived Covid-19 Pandemic Negative Effect on Emotional or Mental Health: Among Adults Aged 18 and Older; by Past Year Mental Illness Status, Quarter 4, 2020 (NSDUH)

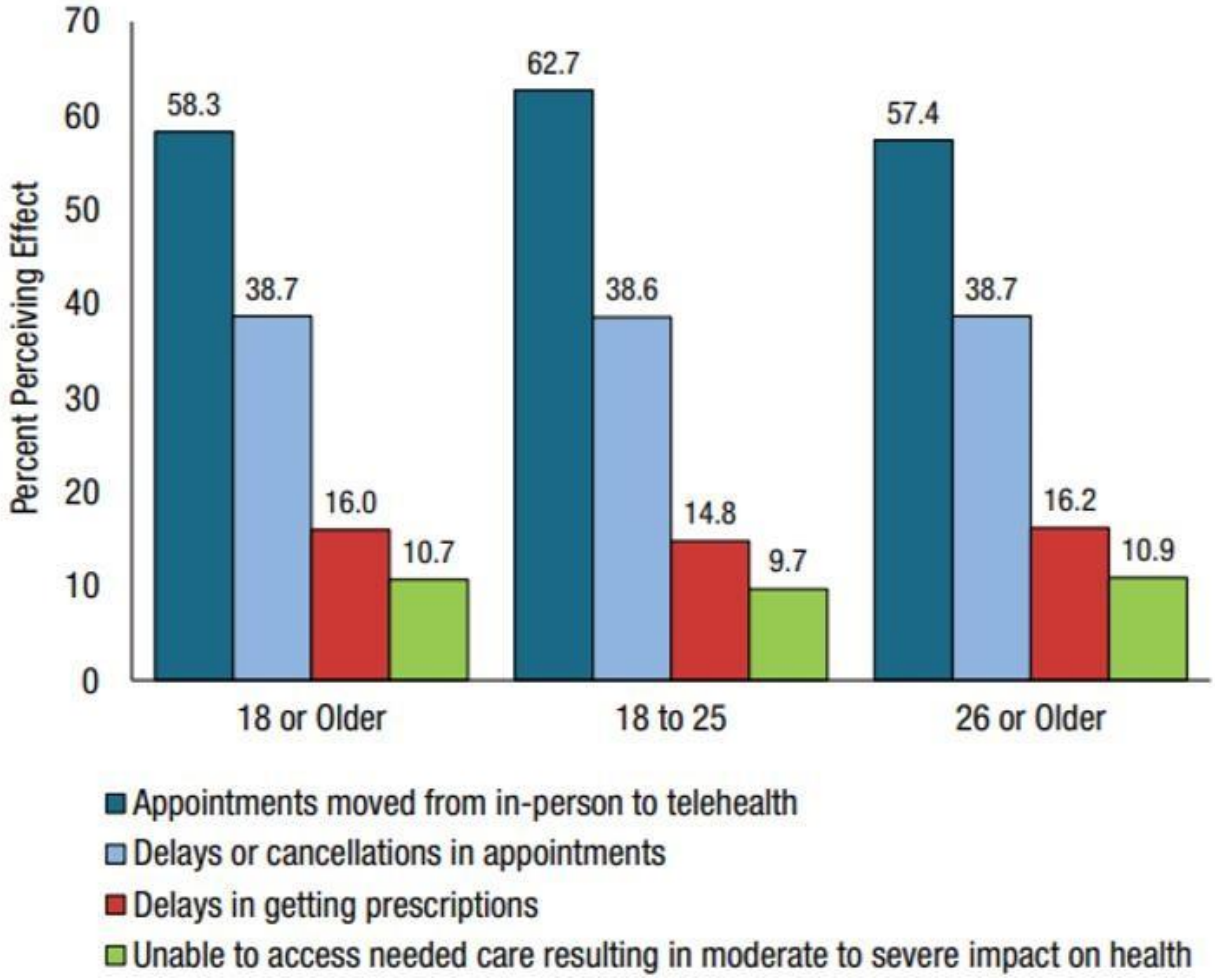


Note: The percentages do not add to 100 percent due to rounding.

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

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

Figure 13. Perceived Covid-19 Pandemic Effect on Mental Health Services, Among Adults Aged 18 and Over Who Received Services; Quarter 4, 2020. (NSDUH, 2021).



During this period, similar to the challenges at the national level depicted in the figure above, those effects and many other factors were found to have impacted mental health service delivery in California. External quality reviews (EQRO)[26] of services that had been provided during the first half of 2020 by county behavioral health departments found that operations were affected by multiple factors. These factors included changes in methods of service delivery and procedures, rapid shift to telehealth, impacts to the workforce, changes in timeliness of appointments for services, suspension of focus groups and impaired ability of advisory boards to meet as desired, and other factors. (For further details, see the Cal-EQRO report for your county for 2021).[8]

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